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 _____	03/12/2020

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)
E 0001 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Establish an Emergency Preparedness Program (EP).** Based on record review and staff interview the facility failed to establish and maintain a comprehensive Emergency Preparedness Program (EP) which described the facility's comprehensive approach for meeting the health safety and security needs of the staff and resident population during an emergency or disaster situation. The findings included: The facility's EP Program was reviewed on 3/12/2020 and did not include the following required elements: 1. The EP manual did not include a process for cooperation and collaboration with local, tribal, regional, State, and Federal EP officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the Long Term Care (LTC) facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. 2. The LTC facility did not develop and maintain an EP training and testing program that is based on the emergency. 3. The LTC facility did not conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The facility had not conducted a full-scale exercise that was community based nor a tabletop exercise that included a group discussion led by a facilitator. An interview was conducted with the Administrator on 3/12/2020 at 2:49 PM. The Administrator stated he was aware of need for two exercises each year and he would need to check with the Maintenance Director for documentation of the EP exercises. The Administrator was unable to provide information on why the facility's EP Program did not contain all the elements required for a comprehensive program.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews the facility failed to maintain the main dining room at Station 2 in good repair and resident's rooms in good repair for 3 of 5 halls observed. The findings included: 1. On 3/8/20 at 12:45 PM an interview was conducted with Resident #64. The resident stated every time it rained the tiles on the ceiling get circled and maintenance would have to change them. There were multiple tiles observed on the ceiling with brown circles. The Resident stated the bottom drawer of the dresser closest to the bathroom was in disrepair. The wall across from the bathroom was scuffed up and the baseboard was observed to be pulled away from the wall and there was an open area at the top of the baseboard along the wall. On 3/12/20 at 10:40 AM an observation of room [ROOM NUMBER] was conducted with the Director of Maintenance (DM). The DM stated there was condensation of the pipes in the ceiling that would drip down and cause circles on the tiles and they had been replacing the tiles on a weekly basis. The DM stated they would need to replace the ceiling tiles that were circled and the dresser was custom built and could not be repaired but would need to be replaced and would require the room be shut down for about 2 weeks for this to be done. The DM continued and stated one of the residents in the room used a wide wheelchair that scrubbed against the wall when the resident was coming in and out of the room. The DM stated the baseboard could be replaced but she would be unable to paint without shutting down the room. The DM further stated they were currently getting bids to replace the roof on the building. The DM stated in September 2019 she had put in a request to the corporate office to replace some of the furniture but had not received a response. 2. On 3/8/20 at 11:21 AM an observation of room [ROOM NUMBER] revealed multiple (14) ceiling tiles that had brown circles. The walls in front of and behind the bed had rough spackling where the wall had been patched. On 3/12/20 at 10:25 AM the Director of Maintenance (DM) stated in an interview there was condensation on the pipes in the ceiling that would drip down and cause the circles on the ceiling tiles. The DM further stated they did have 2 leaks in the roof and they were currently getting bids to replace the roof on the building. The DM continued and stated they had been replacing ceiling tiles weekly that were circled but she was not aware of the problem in this room. 3. On [DATE] at 9:25 AM an observation of room [ROOM NUMBER] revealed the left window was open approximately 2 inches and had a crank to be used to close the window. The crank on the right window was missing and there was a hole where the crank had been. There was a bedside commode over the toilet in the bathroom and the seat hinges and the bar at the back of the commode were rusty. On 3/12/20 at 10:56 AM an observation was made of room [ROOM NUMBER] with the Director of Maintenance (DM). The window on the left was open about 2 inches and the crank would not work to close the window. The DM was observed to manually pull the window closed and stated the crank did not work and they had attempted to replace the cranks but the windows were old and they had been unable to find a crank that worked with the windows. The crank on the right window was missing. An observation of the bathroom revealed a bedside commode placed over the toilet. When the seat was raised the seat hinges and a metal bar at the back of the commode were observed to be rusty. Housekeeper #1 was asked to come to the room and observe the commode and stated the floor tech was supposed to replace any bedside commodes that had rusted and he must have missed this one. The housekeeper was asked if she cleaned the room yesterday and she stated she did but was working so fast she did not notice the bed side commode with the rusty seat hinges. On 3/12/20 at 10:58 AM the Housekeeping Supervisor (HS) stated in an interview that when the nursing assistants or housekeepers observed a rusty bedside commode in the bathroom, they had been instructed to take it out and replace it. The HS further stated they had made rounds and replaced the bedside commodes that needed to be replaced and this one was missed. 4. During a resident interview on [DATE] at 9:12 AM the resident stated the main dining room on Station 2 had a hole in the wall and was concerned that roaches and other pests could come in through that hole. On [DATE] at 9:17 AM an observation of the main dining room on Station 2 revealed the back wall was scuffed up. The wall at the door to the dining room closest to the nurse's station had rough spackling on the wall and the wall separating the dining room from the hallway under the windows had dents in the wall. The Baseboard along the back wall of the dining room had separated from the wall. There was a large oval hole that had been cut out of the wall that was approximately 6 inches by 4 inches and covered with plexiglass. At the far end of the dining room there was a quarter sized hole near the bottom of the wall. There was a large section of tile missing on the floor near the wall to the outside of the building near the windows. At the time of the observation there were activities being held in the dining room. On [DATE] at 9:30 AM the Activity Director stated in an interview that their heating/cooling system was old and did not cool the dining room well during the summer. The Activity Director further stated they put a portable air conditioning unit in the dining room during the summer and the large and small holes in the wall were where the unit was vented to the outside. On 3/12/20 at 10:25 AM an interview was conducted with the Director of Maintenance (DM). The DM stated they used a portable AC unit in the main dining room in the summertime and there were holes in the wall to vent the unit when in use. The DM further stated the small hole at the bottom on the back wall was sealed on the outside so pests could not get in. On 3/12/20 an observation of resident's rooms revealed the following: 5. 3/12/20 at 2:20 PM room [ROOM NUMBER]: The wall near the bathroom door was scuffed and the wall heating/air conditioner unit was observed to have rusty spots and the top vent was rusty. 6. 3/12/20 at 2:22 PM room [ROOM NUMBER]: There was a large piece of vinyl placed over a scuffed wall and was bowing out and pulling

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

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.

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 _____	03/12/2020

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) away from the wall. 7. 3/12/20 at 2:24 PM room [ROOM NUMBER]: Missing veneer on the dresser with particle board showing on the bottom 2 drawers closest to the door. Heating/air conditioning unit with rusty spots with rusty vents at the top. The stain on the nightstand was rubbed off around the drawers. There was an approximately 12 inch long gouged area in the wall paper behind the bed. There were rusty hinges and a rusty metal bar on the seat of the bedside commode over the toilet in the bathroom. 8. On 3/12/20 at 2:26 PM room [ROOM NUMBER]: Heating unit had rusty areas and rusty vents and the veneer on the dresser was peeling off the second drawer from the bottom closest to the door to the room. 9. On 3/12/20 at 2:28 PM room [ROOM NUMBER]: Heating unit with rusty spots. 20 inch long gouged area behind the headboard on the bed. Veneer at edge of dresser near the bathroom missing and bottom 2 drawers of 2 dressers had areas where the veneer was missing. 10. On 3/12/20 at 2:30 PM room [ROOM NUMBER]: Missing drawer pulls on 2 separate nightstands and areas of veneer were missing on the bottom of 2 drawers on the nightstand. Heating unit with rusty spots. 11. On 3/12/20 at 2:32 PM room [ROOM NUMBER]: Missing drawer pull on nightstand of A bed. Heating unit with rusty spots. Dresser closest to the door had wood on the side of the third drawer that was missing. Veneer were missing on an area of the wardrobe. In the bathroom the towel bar was missing and one bracket had pulled off the wall leaving damage to the wall tile. The bedside commode over the toilet had a rusty bar and hinges at the back of the bedside commode. 12. On 3/12/20 at 2:34 PM room [ROOM NUMBER]: Gouges in the wall near the door. Gouges behind the bed that had been plastered. Rusty metal tracking around the ceiling tiles. 13. On 3/12/20 at 2:37 PM room [ROOM NUMBER]: There were 4 areas of torn wallpaper behind the bed that were 3 to 12 inches long. Heating unit has some rusty spots. Metal hand bars around the toilet had rusty areas. 14. On 3/12/20 at 2:40 PM room [ROOM NUMBER]: Dresser near the door to the room had wood beside the drawers that had missing stain. Heating unit with rusty spots. 15. On 3/12/20 at 2:43 PM room [ROOM NUMBER]: Area behind the bed with spackling. Bedside commode over the toilet in the bathroom had a rusty bar and rusty hinges at the back of the commode. 16. On 3/12/20 room [ROOM NUMBER]: Baseball sized hole in the wall near the door to the room under the light switch. Gouges in the wall behind the bed. 17. On 3/12/20 2:48 PM room [ROOM NUMBER]: The corner of the wall near the bathroom, entire area scuffed and missing paint. 18. 3/12/20 2:50 PM room [ROOM NUMBER]: Heating unit with rusty spots. Dresser closest to the door has multiple small areas of missing veneer. Missing plaster at corner of the wall near the door to the room. 19. 3/12/20 2:53 PM room [ROOM NUMBER]: Bedside commode over the toilet in the bathroom has rusty bar and hinges at the back of the commode. 20. 3/12/20 2:55 PM 500 Hall. Handrail loose from the wall between rooms [ROOM NUMBERS]. Handrail is attached but moves when pulled on. An interview was conducted with the Director of Maintenance (DM) on 3/12/20 at 10:25 AM. The DM stated they use a portable air conditioning unit in the dining room in the summer and the holes on the 2 outside walls are to vent the unit and the holes are sealed to prevent pests from getting in. A second interview was conducted with the Director of Maintenance on 3/12/20 at 10:40 AM. The DM stated some of the furniture in the rooms needed to be replaced and she had put in a request to corporate in September 2019 but had not received a response. The DM further stated some of the rooms and the heating units needed to be painted but the rooms would need to be shut down for 2 days in order for the work to be completed. On 3/12/20 at 10:58 AM the Housekeeping Supervisor (HS) stated in an interview that when the nursing assistants or housekeepers observed a rusty bedside commode in the bathroom, they had been instructed to take it out and replace it. The HS further stated they had made rounds and replaced the bedside commodes that needed to be replaced. On 3/12/20 at 4:05 PM an interview was held with the Administrator and the Director of Nursing (DON). The Administrator stated the building was old and they had done some work on the building but a lot needed to be done. 21. On 3/11/2020 at 11:31 AM an observation of room [ROOM NUMBER] revealed a three foot strip of wall paper was torn off and missing from the floor to ceiling above the head of bed A. The wall heating/ air conditioner unit was observed to have rusty spots and the top vent was rusty. An interview was conducted with the Director of Maintenance (DM) on 3/12/2020 at 1:34 PM. The DM stated to repair the wall they would need to pull all the old wall paper off then rehang new wallpaper. She stated the heating/air conditioning units were old and needed to be repainted, however the room would need to be shut down for 2 days in order for the the work to be completed. On 3/12/2020 at 4:05 PM an interview was held with the Administrator and the Director of Nursing (DON). The Administrator stated the building was old and they had done some work on the building but a lot needed to be done.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility failed to complete a comprehensive assessment at least annually for 1 of 29 residents reviewed (Resident #32); and failed to comprehensively assess a resident who smoked for 1 of 29 residents reviewed (Resident #17). The findings included: 1. Resident #32 was admitted to the facility on [DATE]. Her cumulative [DIAGNOSES REDACTED]. Resident #32 had an annual comprehensive Minimum Data Set (MDS) assessment completed on 11/17/18. The next annual comprehensive MDS assessment for Resident #32 had an assessment reference date (ARD) of 10/20/19. A review of the 10/20/19 annual MDS was conducted and revealed Sections C, D, E, F, J (Sections J0300, J0400, J0500, and J0600) were not completed in their entirety. Additionally, Section L (Oral/Dental Status) indicated staff were unable to examine the resident's oral/dental status. Resident #32 was residing in the facility on the date of the assessment. Section Z0500 of the MDS assessment documented the annual MDS was signed as completed on 11/22/19. Resident #32's Care Area Assessments (CAAs) completed for the MDS assessment dated [DATE] were reviewed. The CAA worksheets for [MEDICAL CONDITION] Medication Use and Nutritional Status documented a start date of 11/21/19. A comprehensive assessment includes both completion of the MDS and the CAA process. An interview was conducted on 3/12/20 at 9:48 AM with MDS Nurse #1 and MDS Nurse #2. When asked, the MDS nurses reviewed Resident #32's annual MDS assessment dated [DATE]. Upon inquiry, the MDS nurses stated the 10/20/19 MDS assessment would not be considered to have been completed. The MDS nurses reported the latest date Section Z0500 should have been completed for this assessment would have been 11/2/19 (14 days after the ARD of 10/20/19). An interview was conducted on 3/12/20 at 2:45 PM with the facility's Administrator and Director of Nursing (DON). During the interview, the concerns identified in regards to MDS assessments were discussed. The Administrator and DON reported they would expect the MDS to be complete, accurate, and completed on time. 2. Resident #17 was admitted to the facility on [DATE] and had a [DIAGNOSES REDACTED]. A Smoking Observation Form for Resident #17 dated 9/14/19, Section 1 read: All patients/residents will be assessed on admission, re-admission and/or with a significant change in condition. If the answer to the first 2 questions are No, the assessment is complete. The patient/resident will be assessed at least quarterly only if the answer to either of the first 2 questions are Yes. The first question was, does the resident smoke? Yes was marked. The second question was, does the resident have a past history of smoking? Yes was marked. The Observation section of the form that assessed the resident's ability to smoke safely was not completed. The resident's Care Plan last reviewed on 3/3/20 contained no information related to the resident's smoking. On 3/8/20 at 1:30 PM Resident #17 was observed sitting on a bench smoking outside the entrance to the skilled nursing facility (on facility property) near Station 2. On 3/11/20 at 9:55 AM, Resident #17 was observed sitting in the courtyard outside the main dining room at Station 2 (on facility property) with a lit cigarette in his hand. The Administrator stated in an interview on 3/11/20 at 11:05 AM that prior to admission residents were screened and told they were a smoke free facility and if the resident smoked the resident was instructed to sign out and go off the property to smoke. The Nurse Navigator stated in an interview on 3/11/20 at 11:16 AM the Smoking Observation Form was used on admission to identify if a new resident was a smoker and if so, were they safe to smoke. The Nurse Navigator further stated the facility is a non-smoking facility so they use the form to identify the residents that smoke so they could offer smoking cessation treatments such as nicotine patches. The Nurse Navigator verified the Observation section of the form had not been completed for Resident #17. On 3/11/20 at 11:45 AM the Director of Nursing (DON) stated in an interview that prior to admission residents were informed they were a non-smoking facility and were offered a nicotine patch but some did refuse. The DON further stated the residents were instructed to go to the road to smoke. On 3/11/20 at 1:57 PM the DON stated she spoke with their nurse consultant who told her because they were a non-smoking facility they did not have to complete the smoking assessments even though they knew they had residents that smoked.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.**

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 _____	03/12/2020

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 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to transmit a discharge Minimum Data Set (MDS) assessment within the required time frame for 2 of 29 residents (Resident #1 and Resident #2) sampled for MDS completion and submission of activities. Findings included: 1.a. Resident #1 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's most recent MDS (Minimum Data Set) was coded as a discharge assessment with an ARD (Assessment Reference Date) date of 10/7/19 revealed Resident #1 had short term memory deficits and needed limited assistance with walking. A review of Resident #1's most recent MDS dated [DATE] and coded as a discharge assessment, revealed the assessment was open, and had not been closed and transmitted. Review of the nursing notes indicated Resident #1 was discharged on [DATE] to home. b. Resident #2 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #2's most recent MDS was coded as a discharge assessment with an ARD of 11/16/19 revealed Resident #2 was independent with cognitive functioning and self-care. A review of Resident #2's most recent MDS dated [DATE] and coded as a discharge assessment, revealed the assessment was open, and had not been closed and transmitted. During an interview with the MDS RNs (MDS#1 and MDS#2) on 3/11/20 at 2:52PM, she revealed the assessment had been left open in error. MDS#1 indicated the assessments would be closed and transmitted today, 3/11/20. MDS#1 further indicated these 2 assessments would be marked as late assessments. During an interview with the Director of Health Services (DHS) on 3/12/20 at 10:58AM, she revealed the Administrator would be responsible for the work of the MDS department. During an interview with the Administrator on 3/12/20 at 11:45AM, he revealed his expectation was that all assessments would be transmitted by the ARD date. The Administrator was not aware of any late assessments.
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 staff interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) assessment to: 1) Reflect the provision of [MEDICAL TREATMENT] treatments for 1 of 2 residents reviewed who received [MEDICAL TREATMENT] (Resident #279); 2) Report an indwelling urinary catheter for 1 of 1 resident reviewed with a urinary catheter (Resident #45); 3) Indicate the Activities of Daily Living (ADL) assistance required for 1 of 29 sampled residents whose MDS assessments were reviewed (Resident #32); 4) Indicate a physician documented a gradual dose reduction (GDR) for a [MEDICAL CONDITION] medication as clinically contraindicated for 1 of 29 sampled residents whose MDS assessments were reviewed (Resident #32); 5) Report PASRR Level II status for 1 of 3 residents reviewed who were determined to have a PASRR Level II status (Resident #24); and, 6) Complete a Brief Interview of Mental Status and Mood for 1 of 29 sampled residents whose MDS assessments were reviewed (Resident #52). The findings included: 1. Resident #279 was admitted to the facility on [DATE] from the hospital. His cumulative [DIAGNOSES REDACTED]. On 12/3/19, Resident #279 was reviewed by the physician at the facility due to his recent admission. The physician documented the resident had a [DIAGNOSES REDACTED]. Resident #279's electronic medical record (EMR) included a Census. Notes in this portion of his EMR reported the resident went out on Therapeutic Leave on 12/4/19 (Wednesday) at 11:08 AM for [MEDICAL TREATMENT]. On 12/4/19 at 10:38 AM, the resident's Physician's Assistant (PA) at the facility documented Resident #279 was seen for a follow-up due to debility. Plans for care included [MEDICAL TREATMENT] three times a week on Mondays, Wednesdays, and Fridays. A Nursing Progress Note written on 12/5/19 at 3:43 PM included a notation which indicated the resident had a [DIAGNOSES REDACTED]. Transportation logs from the facility's contracted service documented, in part, that Resident #279 was transported both to and from [MEDICAL TREATMENT] on 12/4/19 (Wednesday), 12/6/19 (Friday), and 12/9/19 (Monday). Resident #279's admission Minimum Data Set (MDS) assessment was completed on 12/9/19. Section I of the MDS reported the resident had [MEDICAL CONDITIONS], or [MEDICAL CONDITION]. Section O of the MDS indicated the resident neither received [MEDICAL TREATMENT] while he was not a resident nor received [MEDICAL TREATMENT] while he was a resident at the facility. An interview was conducted on [DATE] at 3:05 PM with MDS Nurse #1. During the interview, MDS Nurse #1 confirmed Section O of the 12/9/19 MDS assessment indicated Resident #279 neither received [MEDICAL TREATMENT] while he was not a resident nor received [MEDICAL TREATMENT] while he was a resident at the facility. Upon review of the resident's Nursing Notes, MDS Nurse #1 reported these notes indicated the resident had [MEDICAL TREATMENT] scheduled on Mondays, Wednesdays, and Fridays. However, she stated, We are looking at the notes to see if he actually went out to [MEDICAL TREATMENT] and/or came back. A follow-up interview was conducted on 3/12/20 at 9:39 AM with MDS Nurse #1 and MDS Nurse #2. During the interview, the nurses were asked to review Resident #279's Census notes in his EMR, along with the transportation logs obtained from the facility's transportation service. After the information was reviewed, the MDS nurses acknowledged Resident #279 should have been coded on his admission MDS (dated 12/9/19) as having received [MEDICAL TREATMENT] both while he was not a resident and while he was a resident. The MDS nurses reported Resident #279's MDS would need to be modified. An interview was conducted on 3/12/20 at 2:45 PM with the facility's Administrator and Director of Nursing (DON). During the interview, concerns regarding inaccurate coding of the MDS assessments were discussed. The Administrator and DON reported they would expect the MDS to be complete, accurate, and completed on time. 2. Resident #45 was admitted to the facility on [DATE] with re-entry on 9/8/19 from the hospital. His cumulative [DIAGNOSES REDACTED]. A Nursing Progress Note written on 1/21/20 at 2:47 PM included a notation which indicated the resident returned from a urology appointment in stable condition. A urinary catheter was reported to be in place upon his arrival back to facility. On 1/28/20, a Hospice admission note for Resident #45 included reference to the following treatment: Reinforce placement of foley bag and tubing while repositioning the patient. The note also reported the resident ' s Goals/Expected Outcomes included: Patient catheter remains patent throughout EOL (end of life) process. A significant change Minimum Data Set (MDS) assessment was completed for Resident #45 on 1/29/20. Section H of this MDS assessment reported the resident did not have an indwelling urinary catheter in place. He was reported to be always incontinent of bladder. An observation was conducted on 3/8/20 at 12:49 PM as Resident #45 was resting in bed. A urinary catheter bag was observed to be hanging on the frame of his bed. An interview was conducted on [DATE] at 2:58 PM with MDS Nurse #1. During the interview, MDS Nurse #1 confirmed Section H of Resident #45's MDS assessment (dated 1/29/20) indicated he did not have an indwelling urinary catheter. Upon review of the resident's Nursing Notes, MDS Nurse #1 reported these notes indicated the resident returned from urology with a urinary catheter. However, she stated, I was going by the nurse's notes. MDS Nurse #1 reported she was uncertain whether or not Resident #45 had an indwelling urinary catheter in place during the MDS assessment's 7-day look back period. On [DATE] at 3:20 PM, an interview was conducted with Nurse #5. During the interview, the nurse reported she started working at the facility around the time Resident #45 had an indwelling urinary catheter inserted. Nurse #5 reported once the catheter was inserted, it continued to be in place to date ([DATE]). The nurse stated Resident #45 did not attempt to pull out the catheter and she added, it would be documented in the nursing notes if he had pulled it out. A follow-up interview was conducted on 3/12/20 at 9:36 AM with MDS Nurse #1 and MDS Nurse #2. During the interview, information obtained from Resident #45's electronic medical record (EMR) and nurse interview were discussed. MDS Nurse #1 reported that based on this information, Resident #45's MDS assessment from 1/29/20 should have been coded to reflect he had an indwelling urinary catheter. MDS Nurse #2 stated they would need to modify the MDS assessment to reflect the use of a urinary catheter for this resident. An interview was conducted on 3/12/20 at 2:45 PM with the facility's Administrator and Director of Nursing (DON). During the interview, concerns regarding inaccurate coding of the MDS assessments were discussed. The Administrator and DON reported they would expect the MDS assessments to be complete, accurate, and completed on time. 3. Resident #32 was admitted to the facility on [DATE]. Her cumulative [DIAGNOSES REDACTED]. Resident #32's quarterly Minimum Data Set (MDS) was dated 1/20/20. Section G (Functional Status) of the MDS assessment reported the resident did not walk in her room or corridor during the 7-day look back period. All other Activities of Daily Living (ADLs) were reported to have occurred only 1 - 2 times each during the 7-day look back period. The ADLs reported as having only occurred 1 -2 times each during the 7 days included bed mobility, transfers, locomotion on/off the unit, dressing, eating, toileting and personal hygiene. An interview was conducted on 3/12/20 at 9:48 AM with MDS Nurse #1 and MDS Nurse #2. When asked, the MDS nurses reviewed Section G of Resident #32's quarterly MDS assessment dated [DATE]. The MDS nurses agreed Section G was not coded correctly to indicate the ADL assistance required for this resident. MDS Nurse #2 reported the MDS assessment would need to be modified. An interview was conducted on 3/12/20 at 2:45 PM with the facility's Administrator and Director of Nursing (DON). During the interview, concerns regarding inaccurate coding of the MDS assessments were discussed. The Administrator and DON reported they would expect the MDS to be complete, accurate, and completed on time. 4. Resident #32 was admitted to the facility on [DATE]. Her cumulative [DIAGNOSES REDACTED]. Resident #32's electronic medical record (EMR) included a 11/13/19 Consultant Pharmacist Communication to the physician. The report indicated 25 mg quetiapine (an antipsychotic medication) was administered to the resident for

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 _____	03/12/2020

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) agitation, yelling, and screaming. It also noted Resident #32 was due for a gradual dose reduction (GDR) in an attempt to find the lowest effective dose of antipsychotic drug therapy. The pharmacist requested consideration of a trial dose reduction. On 11/15/19, the resident's health care provider indicated an attempted GDR was likely to result in impairment of function or increased distressed behavior, and the clinical benefits outweighed the potential risks. Resident #32's quarterly Minimum Data Set (MDS) assessment was dated 1/20/20. Section N of the MDS assessment revealed the resident received both an antipsychotic medication and an antidepressant medication on 7 out of 7 days during the look back period. Item N0450D of the MDS reported the resident's physician did not document a GDR as clinically contraindicated. An interview was conducted on 3/12/20 at 9:48 AM with MDS Nurse #1 and MDS Nurse #2. When asked, the MDS nurses reviewed Section N of Resident #32's quarterly MDS assessment dated [DATE]. The MDS nurses reported Section N of the assessment should have been coded to report the physician did address a GDR and determined it was clinically contraindicated on 11/15/19. MDS Nurse #2 stated the assessment would need to be modified. An interview was conducted on 3/12/20 at 2:45 PM with the facility's Administrator and Director of Nursing (DON). During the interview, concerns regarding inaccurate coding of the MDS assessments were discussed. The Administrator and DON reported they would expect the MDS assessments to be complete, accurate, and completed on time. 5. Resident #24 was admitted to the facility on [DATE] and had a [DIAGNOSES REDACTED]. Review of the resident's Pre-Admission Screening and Resident Review (PASRR) record revealed on 7/8/19 the resident was screened as a Level II PASRR. The Admission Minimum Data Set (MDS) assessment dated [DATE] noted the resident was not a level II PASRR and serious mental illness was not checked. An interview was conducted with the MDS Director and the MDS Coordinator on 3/10/20 at 11:53 AM. The MDS Coordinator was observed to review the resident's Admission MDS and stated the resident was not coded as a Level II PASRR and they would need to modify the MDS. The MDS Coordinator further stated at the time of the resident's admission assessment they did not have computerized medical records and the resident's PASRR information would have been on paper and at that time Admissions would send out an e-mail with each admission if the resident was a PASRR Level II. The MDS Director stated moving forward she would talk with their consultant to see how they could verify the PASRR level prior to completing the MDS. An interview was conducted with the Director of Nursing (DON) on 3/12/20 at 4:04 PM. The DON stated they had people from their sister facilities coming in to assist with coding the MDS during the time the resident's MDS was completed and they would be paying a lot more attention to the MDS in the future. 6. Resident #52 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly review of the Minimum (MDS) data set [DATE] under Section C, Brief Interview of Mental Status (BIMS) C0100, read Should Brief Interview for Mental Status Be Conducted? The question was checked, Yes. Each section thereafter, read: not assessed. A review of Section D0100, Mood, read, Should Resident Mood Interview Be Conducted? The question was checked, Yes Each section thereafter, read not assessed. In an interview was conducted with the Director of Nursing on 3/12/2020 at 2:45 PM. The DON stated she would expect the MDS would be complete and accurate. In an interview was conducted with the MDS Coordinator on 3/12/2020 at 3:13 PM. The MDS Coordinator stated staff from a sister facility had been helping out with the MDS. She stated after they helped, she realized all they were doing was putting dashes in Sections C, D, E.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and responsible party interview, the facility failed to develop, implement and communicate the initial 48-hour baseline plan of care to the responsible party for 4 Residents (Resident #43, #73, #78 and #279) of 6 newly admitted residents reviewed. The findings included: 1. Resident #73 was admitted in the facility on 2/14/20. The [DIAGNOSES REDACTED]. Record review revealed there was no initial 48-hour baseline care plan developed for this resident. The record revealed the care plan was done by the Nurse Navigator in the resident's record on 2/17/20 and not within the timeframe. An interview with the Responsible Party (RP) on 3/8/20 at 3:10 PM was conducted. The RP stated that the facility did not her information of the initial 48-hour baseline care plan from admission to the facility. Interview with Nurse #3 on 3/12/20 at 8:44 AM, stated that she admitted the resident but did not do a baseline care plan. She stated that the admission process was divided in two parts and that the incoming nurses will follow up with the admission. She stated that the baseline care plan would have been assigned to the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) to complete. An interview with the Nurse Navigator was conducted on 3/1/20 at 9:35 AM. She stated that she helped with the care plan at times and that she didn't remember discussing the care plan to the responsible party. She also stated that the MDS nurses do the care plan meeting. 2. Resident #78 was admitted in the facility on 2/7/20. The [DIAGNOSES REDACTED]. Record review revealed there was no initial 48-hour baseline care plan developed for this resident. Telephone interview with the resident's RP was done on 3/10/20 at 4:53 PM. The RP stated the facility did not discuss or provided a copy of the 48-hour baseline care plan from the resident's admission to the facility. The MDS Nurse (Minimum Data Set) was interviewed on 3/11/20 at 10:57 AM. The MDS Nurse stated that they were not assigned to do the baseline care plan. She stated that the ADON and DON were responsible completing the admission process which includes the baseline care plan for each admitted resident. The MDS nurse further stated that when they schedule a care meeting, they discuss the comprehensive care plan with the Interdisciplinary Care Team (IDT) meeting with RP/family included. An interview with the DON on 3/12/20 at 10:37 AM and she stated that the baseline care plan was assigned to the ADON, Weekend Supervisor and the DON. She further stated that her review showed the baseline were not completed within 48-hour from admission. 3. A review of the medical record revealed Resident #43 was admitted to the facility on [DATE] with a left below knee amputation. The Admission Minimum (MDS) data set [DATE] noted Resident #43 to be cognitively intact who required limited assistance with bed mobility, dressing and personal hygiene to extensive assistance for transfers and toilet use. A review of Resident #43's care plan revealed no care plan for a surgical wound. In an interview on 3/12/2020 at 12:15 PM the MDS nurse assigned to Resident #43 stated when nurses do the admission they should start the 48 hour care plan. She indicated it looked like the care plan was started for Resident #43 on 1/31/2020. In an interview on 3/12/2020 at 4:08 PM PM the Director of Nursing stated there was not a baseline care plan developed for Resident #43. 4. Resident #279 was admitted to the facility on [DATE] from the hospital. His cumulative [DIAGNOSES REDACTED]. The resident's electronic medical record revealed the earliest start date for his care plan was 12/12/19. Resident #279's care plan (dated 12/12/19) included the following areas of focus: --12/12/19 Falls. Patient/Resident at risk for falls related to unsteady gait. --12/12/19 Mobility. Impaired physical mobility/deconditioning related to recent hospitalization --12/12/19 Discharge Planning. --12/12/19 Activities of Daily Living (ADLs) Functional/Rehabilitation Potential: ADL Decline related to [MEDICAL CONDITION] (stroke). An interview was conducted on 3/12/20 at 9:42 AM with MDS Nurse #1 And MDS Nurse #2. During the interview, MDS Nurse #2 reviewed Resident #279's care plan and confirmed the first start dates for his care areas were documented as 12/12/19. Based on the information reviewed, the MDS nurses stated Resident #279's baseline care plan was not completed with the required time frame. An interview was conducted on 3/12/20 at 2:08 PM with the facility's Director of Nursing (DON). During the interview, Resident #279's baseline care was discussed. The DON acknowledged this resident's baseline care plan was not completed within the required time frame. The DON reported both the Assistant Director of Nursing and she herself had assumed primary responsibility for completing baseline care plans for newly admitted residents. Upon further inquiry, the DON stated she would expect residents' baseline care plans to be completed within 48 hours of admission. Accordingly, she reported Resident #279's baseline care plan should have been completed by 12/4/19.
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**

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 _____	03/12/2020

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) Based on observations, record review and staff interviews, the facility failed to develop a comprehensive care plan which addressed: 1) Activities of Daily Living (ADL's), Urinary Incontinence, Falls, Nutrition and Pressure Ulcer for 1 of 29 sampled residents (Resident #43); 2) The use of [MEDICAL CONDITION] medications (any drug capable of affecting the mind, emotions, and/or behavior) for 1 of 6 residents reviewed for unnecessary medications (Residents #32); 3) The potential for accidents related to 1 of 1 resident reviewed who smoked (Resident #17); and, 4) Dementia for 1 of 4 residents reviewed for dementia care (Resident #233). The findings included: 1. Resident #43 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's most recent Minimum Data Set (MDS) comprehensive admission assessment with an Assessment Reference Date (ARD) of 1/31/20 revealed Resident #43 had moderate cognitive impairment, and the resident required assistance with Activities of Daily Living (ADL). In reviewing the associated Care Area Assessment (CAA), it revealed the following care plan areas would be developed: ADL Functional/Rehabilitation Potential; Urinary Incontinence; Falls; Nutrition; and Pressure Ulcer. During a record review of Resident #43's care plan on 3/10/20 at 9:17AM, it was discovered there was only one care plan for Resident #43 relating to showers. A care plan had not been developed for the care plan areas identified in the MDS assessment dated [DATE]; ADL Functioning/Rehabilitation Potential, Urinary Incontinence, Falls, Nutrition, and Pressure Ulcer. A review of the nursing notes indicated Resident #43 had treatment orders for wound care, including updated orders that revealed a change in the treatment orders. During a record review of progress notes, Resident #43 was receiving physical therapy, occupational therapy and speech therapy. The progress note dated 2/25/20 by Physician Assistant (PA) stated, patient undergoing rehabilitation for decreased mobility/activities of daily living. Further review of the progress notes revealed Resident #43 had falls on 1/31/20, [DATE], and 2/13/20. The fall on 2/13/20 resulted in an injury which required the resident to be transferred to the hospital for treatment. A progress note dated [DATE] by the registered dietician (RD) revealed Resident #43 was on prostat 30 ml by mouth once a day to provide 100K calories, 15 grams of protein. Will place on Decubib-Vite 1 capsule once a day to assist with healing. Resident #43 was observed on 3/10/20 at 10:10AM participating in occupational therapy. Resident #43 was observed on 3/10/20 at 11:30AM while the wound care nurse was providing treatment to the resident's wound. During an interview with Resident #43 on 3/10/20 at 11:35AM, he revealed the care is good. He additionally stated he is here to get stronger and return home. During an interview with MDS#1 nurse on 3/12/20 at 12:15PM, she indicated she was not sure why the care plan was not started. During an interview with the Administrator on 3/12/20 at 11:45AM, he revealed his expectation is that all care plans will be developed in a timely manner based on the comprehensive MDS assessment. 2. Resident #32 was admitted to the facility on [DATE]. Her cumulative [DIAGNOSES REDACTED]. The resident's medications orders included the following, in part: --30 milligrams (mg) duloxetine delayed release capsule (an antidepressant medication) to be given as one capsule once daily (initially ordered 9/17/16 and continued up until the date of the review on 3/12/20); and, --25 mg quetiapine tablet (an antipsychotic medication) to be given as one tablet by mouth twice daily (initially ordered on [DATE] and continued up until the date of the review on 3/12/20). Resident #32's last annual MDS assessment had an assessment reference date (ARD) of 10/20/19. Section N of this assessment reported Resident #32 received both an antipsychotic and antidepressant medication on 6 out of 7 days during the look back period. A review of the resident's Care Area Assessment (CAA) Worksheets dated 11/21/19 revealed the care area for [MEDICAL CONDITION] Drug Use was triggered on the 10/20/19 MDS assessment due to the use of antidepressant and antipsychotic medications. The CAA Worksheet indicated [MEDICAL CONDITION] drug use would be addressed in Resident #32's care plan. The resident's most recent quarterly MDS assessment was dated 1/20/20. Section N of the MDS assessment revealed the resident continued to receive both an antipsychotic medication and an antidepressant medication on 7 out of 7 days during the look back period. Resident #32's current care plan as of the date of the review (3/12/20) included the following areas of focus, in part: --Problem: Behavioral Symptoms (Start date 9/20/19 with no revisions made to the problem, goal, or approaches); Resident has verbal behavioral symptoms related to [DIAGNOSES REDACTED]. The long term goal target date was noted to be 1/31/20. A review of the planned approaches was conducted and revealed only non-pharmacological interventions were included. --Problem: Cognitive Loss/Dementia (Start date 9/20/19 with no revisions made to the problem, goal, or approaches): Resident has impaired decision making and memory deficits related to [DIAGNOSES REDACTED]. The long term goal target date was noted to be 1/31/20. A review of the planned approaches was conducted and revealed one approach (dated 9/20/19) indicated medications would be administered as ordered, monitored for adverse effects, and behaviors documented with the Medical Doctor/Physician's Assistant notified of changes or decline. The use of antidepressant or antipsychotic medications was not specifically addressed in Resident #32's current plan of care. An interview was conducted on 3/12/20 at 9:48 AM with MDS Nurse #1 and MDS Nurse #2. During the interview, the MDS nurses reviewed Resident #32's current care plan. They reported Resident #32's 10/20/19 comprehensive annual MDS was completed by MDS nurses from sister facilities who came to help out the facility with MDS assessments. Upon inquiry, the MDS nurses reported the nurses who worked on the annual MDS assessment should have also have completed Resident #32's care plan. Upon further inquiry, the MDS nurses reported [MEDICAL CONDITION] medications (including antidepressant and antipsychotic medications) should be included on the resident's care plan. MDS Nurse #2 confirmed the medications were, Not there. An interview was conducted on 3/12/20 at 2:29 PM with the facility's Director of Nursing (DON). During the interview, concern regarding Resident #32's care plan failing to address [MEDICAL CONDITION] medication use was discussed. When asked, the DON stated the resident's care plan should include issues from her medical history. The DON reported she would expect [MEDICAL CONDITION] medications to be care planned. 3. Resident #17 was admitted to the facility on [DATE] and had a [DIAGNOSES REDACTED]. A Smoking Observation Form dated 9/14/19 noted the resident was a current smoker but the assessment of the resident ' s ability to safely and independently smoke was not completed. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 12/21/19 revealed the resident was cognitively intact, had no behaviors and was independent with transfers, walking in room/corridor, dressing, personal hygiene and bathing. The MDS noted the resident required limited assistance for eating and toileting. The MDS revealed the resident's balance was steady at all times during transitions from a seated to standing position and had no impairment in range of motion of the upper or lower extremities. Section J1300 noted the resident was a current tobacco user. The resident's Care Plan last reviewed on 3/3/20 revealed no information regarding the resident's smoking or storage of cigarettes and lighter for the resident. On 3/8/20 at 1:30 PM Resident #17 was observed sitting on a bench smoking outside the entrance to the skilled nursing unit (on facility property) at Station 2. On 3/10/20 at 4:20 PM an interview was conducted with Resident #17. The resident stated he hid his cigarettes in his room where no one could find them. The resident was asked if he still had [MEDICAL CONDITION] and the resident stated he had had 2 or 3 [MEDICAL CONDITION] since he had been in the facility. On 3/11/20 at 9:25 AM Resident #17 was observed sitting in the courtyard outside the main dining room at Station 2 (on facility property) and had a lit cigarette in his hand. On 3/11/20 at 11:05 AM the Administrator stated in an interview that prior to admission residents were screened and told they were a smoke free facility. The Administrator further stated Resident #17 had been instructed to sign out and go off the property to smoke but had been non-compliant with this. The Administrator continued and stated the resident was responsible for storing his own cigarettes and lighter. The Director of Nursing (DON) stated in an interview on 3/11/20 at 11:45 AM that prior to admission residents were informed they were a non-smoking facility and were instructed to go out to the road to smoke. The DON further stated the resident has his own cigarettes and lighter and did not know where the resident stored them. On 3/12/20 at 4:05 PM the DON stated because they were a non-smoking building, the smokers were supposed to sign themselves out and go off the property to smoke and they do not care plan the resident's smoking. 4. Resident #233 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the nursing note dated 1/14/2020 revealed that Resident #233 was delirious, confused and had visual hallucinations. A review of Resident #233's physician order [REDACTED]. A review of the nursing note dated [DATE]20 revealed Resident #233 had intermittent confusion, became aggressive with the sitting companion and had visual hallucinations. A review of the behavioral monitoring log for February 1, 2020 to February 29, 2020 indicated Resident #233 hallucinated, had increased agitation and [MEDICAL CONDITION]. A review of the medical record revealed Resident #233 was seen by psych services on 2/28/2020 for individual psychotherapy. Resident #233 was on [MEDICATION NAME] for hallucinations, [MEDICATION NAME] for anxiety, and Rytary for [MEDICAL CONDITION] with no new recommendations. A review of the most recent quarterly minimum data set (MDS) assessment dated [DATE] indicated Resident #233 was alert with moderate cognitive impairment and required extensive assistance for activities of daily living (ADLS). The resident was coded for behaviors. Resident #233's care plan did not address

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 _____	03/12/2020

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) cognitive decline nor behaviors. There was no care plan to address the antipsychotic and antianxiety medications Resident #233 had received. A physician note dated 3/5/2020 indicated Resident #233 had a decrease in mental clarity, speech was more slurred, and increased hallucinations. Resident #233 had a poor sleep pattern and night terrors were worse. An interview was conducted with the Director of Nursing (DON) on 3/11/2020 at 4:30 PM. The DON stated that the care plan should address the cognitive and behavioral patterns to include the use of [MEDICAL CONDITION] medications for residents with dementia.
F 0689 **Level of harm** - Minimal harm or potential for 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** Based on observations, record review and staff and resident and Resident Council interviews, the facility failed to provide a safe environment for 1 of 1 resident observed to smoke on facility grounds (Resident #17). The facility failed to secure smoking materials and residents that smoked were allowed to keep their cigarettes and lighters. The facility also failed to provide a smoke free environment for non-smokers in the facility. The findings included: Resident #17 was admitted to the facility on [DATE] and had a [DIAGNOSES REDACTED]. An Admission/Quarterly Smoking Observation Form dated 9/14/19: Section 1 read: All patients/residents will be assessed on admission, re-admission and/or with a significant change in condition. If the answer to the first 2 questions are No, the assessment is complete. Does the resident smoke? Yes, was marked. Does the resident have a past history of smoking? Yes, was marked. The Observation section of the form that assessed the resident ' s ability to smoke safely and independently was not completed. The December 2019 Resident Council Meeting Minutes noted a problem with resident ' s smoking outside entrances to the facility. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 12/21/19 revealed the Resident #17 was cognitively intact, had no behaviors and was independent with transfers and walking in the room and corridor and required limited to no assistance with activities of daily living. The MDS noted during transfers the resident was steady at all times and had no limited range of motion of the upper or the lower extremities. Section J1300 noted the resident currently used tobacco. The resident's Care Plan last reviewed on 3/3/20 revealed no information related to the resident's smoking. On 3/8/20 at 12:41 PM an interview was conducted with Resident #64 and a family member was present during the interview. The Family Member stated on a pretty day the resident would like to sit outside the skilled nursing unit at Station 2 but was unable to do this due to residents sitting outside smoking and Resident #64 had respiratory problems. The Family Member further stated the facility had been a smoke free facility for five years. On 3/8/20 at 1:30 PM Resident #17 was observed sitting on a bench outside the entrance to the skilled nursing unit on facility property and smoking a cigarette. There were no receptacles available to extinguish a cigarette. On 3/10/20 at 1:15 PM upon exiting the door to the outside of Station 2 there was a strong smell of cigarette smoke though no one was observed smoking at the time. On 3/10/20 at 3:30 PM a Resident Council Meeting was held with alert and oriented residents. The residents reported they still had concerns about residents smoking by the entrances to the building and felt it was not fair to the residents that did not smoke to be exposed to the secondhand smoke. The Residents stated they had complained about the smoking but lately they had not tried to sit outside due to the weather and did not know if the situation had improved or not. On 3/10/20 at 4:27 PM Resident #17 was observed to walk down the hall to his room with a rollator. The Resident was interviewed and stated he hid his cigarettes and lighter in his room where no one would find them. The resident was asked if he still had [MEDICAL CONDITION] and the Resident stated he had had 2 or 3 [MEDICAL CONDITION] since he was admitted to the facility. On 3/11/20 at 9:00 AM Resident #7, who was alert and oriented, stated in an interview that she went out to the courtyard to smoke because a lot of others do, too. The Resident stated she kept her cigarettes and lighter herself. This resident was not observed to smoke during the survey. On 3/11/20 at 9:55 AM Resident #17 was observed to smoke in the courtyard outside the main dining room at Station 2 on facility property. There were no receptacles available to extinguish a cigarette. An interview was conducted with the Administrator on 3/11/20 at 11:05 AM. The Administrator stated the resident had been told they were a non-smoking facility and would need to go to the property line to smoke but the resident had been non-compliant with this. The Administrator further stated that residents were screened before admission and told they were a non-smoking facility. The Administrator was asked where the area was the resident was supposed to go to smoke. The Administrator walked down a long sidewalk and turned right onto the parking lot where he continued to walk further and turned left on another sidewalk and stopped near the corner of the main street in front of the facility. There was a facility sign on the corner surrounded by flowers and pine straw. There were no receptacles present in which to extinguish a cigarette and no place to sit. The Administrator further stated the resident was responsible for storing his own cigarettes and lighter. On 3/11/20 at 11:20 AM an interview was conducted with the Nurse Navigator who stated the facility was a non-smoking facility and the Smoking Observation Form was used on admission to identify residents that smoked so they could offer smoking cessation treatments such as nicotine patches. The Nurse Navigator verified that the smoking assessment for Resident #17 had not been completed. On 3/11/20 at 11:45 PM the Director of Nursing (DON) stated in an interview that prior to admission residents were informed they were a non-smoking facility and if the resident was a smoker they were offered a nicotine patch but some did refuse. The DON further stated the residents that smoked were instructed to go to the road to smoke and they currently had 2 residents that smoked. The DON continued and stated both residents were independent and had their own cigarettes and lighter. The DON stated she had asked a family member to stop bringing cigarettes to Resident #7 and the Family Member stated the resident had smoked for a long time and would not quit smoking. The DON further stated she did not know where the residents kept their cigarettes or lighters. On 3/11/20 at 1:57 PM the DON stated she spoke with their nurse consultant who told her because they were a non-smoking facility they did not have to complete the smoking assessment even though they know they have residents in the building that smoke. On 3/11/20 at 3:59 PM an interview was conducted with Nurse #2 who stated there were 4 residents that smoked in the building and one of them had a nicotine patch. The Nurse further stated the residents smoked outside the door near Station 2 or in the courtyard outside the main dining room at Stations 2. The Nurse stated if she found smoking materials in a resident's room she would take them out and put them in a drawer at the nurse's station. The Nurse continued and stated one resident stated it was her right to smoke and would not allow the staff to take her smoking materials. On 3/12/20 at 4:05 PM an interview was conducted with the Administrator and the DON. The Administrator and DON stated they were aware of only 2 residents in the facility that smoked and they were supposed to sign themselves out and go off the property to smoke. The DON and Administrator stated they were not aware that the Resident Council complained they could not go outside due to residents smoking.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and record review, the facility failed to label a nutritional product used for a gastrostomy tube feeding with the minimum required information (name of the formula, date and time the formula was hung, and nurse's initials) and to change the piston syringe used for the gastrostomy tube every 24 hours for one of one resident (Resident #3) reviewed with a gastrostomy tube feeding. The findings included: Resident #3 was admitted to the facility on [DATE] from a hospital with a history of [MEDICAL CONDITIONS] and placement of a gastrostomy tube (a surgically placed tube inserted directly into the stomach for administration of food, fluids, and medications). A gastrostomy tube is frequently referred to as a [DEVICE]. The resident's most recent quarterly Minimum Data Set (MDS) assessment was dated 11/9/19. The MDS revealed Resident #3 had severely impaired cognitive skills for daily decision making. She required extensive assistance from staff for bed mobility, locomotion off the unit, dressing, and personal hygiene. The resident was totally dependent on staff for transfers, eating, and toileting. Section K of the MDS assessment reported Resident #3 received nutrition via a feeding tube, with 51% or more of calories and 501 ml fluid or more per day received from the tube feeding. Resident #3's current care plan included the following, in part: --The resident has the potential for nutrition and hydration deficits related to the use of a feeding tube. She receives nothing by mouth. (Problem Onset: 5/25/19). Current physician's orders [REDACTED]. An observation was conducted on 3/8/20 at 11:58 AM as the resident was lying in bed with the head of her bed raised approximately 45 degrees. She did not respond verbally at the time of the observation. The observation included a plastic bag containing a piston syringe hanging on the pole supporting the enteral (tube feeding)

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 _____	03/12/2020

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 0693 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) pump. The plastic bag with the syringe was dated 3/5/20. The tube feeding formulation was contained in an enteral feeding bag (not a ready to hang or RTH container which is a sterile, pre-filled formula container). The enteral feeding bag had approximately 250-275 ml remaining in the bag; the enteral feeding pump was set to deliver 80 ml/hr of the formula. The enteral feeding bag was not labeled with the name of the nutritional formula, the date/time the bag was filled and was hung, nor the initials or name of the nurse who hung the enteral feeding bag. A bag of water with approximately 10 ml water left in the bag was also hung on the pole. The bag containing the water was not labeled with the date/time or name/initials of the nurse who hung the bag. An observation was conducted on 3/8/20 at 3:10 PM of the resident's enteral pump. The pump was turned off and there was no formula nor water hung at that time (in accordance with the physician's orders [REDACTED]. However, the piston syringe was still observed to be hanging on the enteral feeding pump pole in a plastic bag dated 3/5/20. An observation was conducted on [DATE] at 8:30 AM of the resident's enteral feeding supplies. The observation revealed the piston syringe was still hanging on the enteral feeding pump pole in a plastic bag dated 3/5/20. The tube feeding formulation was contained in an enteral feeding bag (not an RTH container). The enteral feeding bag had approximately 400 ml remaining in the bag; the enteral feeding pump was set to deliver 80 ml/hr of the formula. The enteral feeding bag was not labeled with the name of the nutritional formula, the date/time the bag was filled and the formula was hung, nor the initials or name of the nurse who hung the enteral feeding bag with formula. A bag of water with approximately 300 ml water left in the bag was also hung on the pole. The bag containing the water was not labeled with the date/time or name/initials of the nurse who hung the bag. An observation was conducted on 3/10/20 at 8:00 AM of the resident's enteral feeding supplies. The observation revealed both the enteral feeding bag with formula and water bag were dated, timed, and initialed. However, the enteral feeding bag was not labeled with the name of the nutritional formula. A piston syringe was hanging on the enteral feeding pump pole placed in a plastic bag (not dated). An observation was conducted on 3/12/20 at 11:50 AM of the resident's enteral feeding supplies. The observation revealed the resident's enteral feeding pump was flashing as being held. The nutritional formula in the enteral bag was empty; the bag was not labeled with the name of the nutritional formula, the date/time the formula was hung, or the nurse's name/initials. The water in the enteral bag was empty; the bag was not labeled with date/time the formula was hung, or the name/initials of the nurse who hung the bag. An interview was conducted on 3/12/20 at 11:51 AM with Nurse #9. Nurse #9 was the hall nurse assigned to care for Resident #3. Upon inquiry, the nurse reported the tube feeding and flushes had just been stopped to allow the nursing assistant to provide daily care to the resident. She stated the resident received [MEDICATION NAME] 1.5 as her tube feeding formula. Nurse #9 reported the date and time the formula was hung should be written on a label placed on the bag, along with the nurse's initials. When asked, Nurse #9 also stated the piston syringe used in conjunction with the tube feeding should be changed out nightly and labeled with the date it was put into use. An interview was conducted on 3/12/20 at 2:38 PM with the facility's Director of Nursing (DON). During the interview, concerns were shared in regards to the facility's failure to label an enteral feeding formula with the name of the product, date/time it was hung, and name or initials of the nurse who hung the bag. Additionally, the concern identified regarding a piston syringe being used on multiple days was discussed. The DON reported her expectation was for staff to label an enteral feeding bag with the formula name, date/time it was hung, and initials of the nurse who hung the bag. The DON also stated she would expect a water bag to be dated, timed, and initialed. She reported a piston syringe should only be used for 24 hours before being replaced by a clean syringe.
F 0732 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Post nurse staffing information every day.** Based on observations, record review and staff interviews, the facility failed to post accurate staffing data by including staff providing care for residents in assisted living with staff providing care for the residents on the skilled nursing halls and failed to post accurate census by including residents from the assisted living hall with residents on the skilled nursing hall for 5 of 5 days during the survey conducted on 3/8/2020 through 3/12/2020. The findings included: During the initial tour of the facility on 3/8/2020 at 12:10 PM, the Daily Nursing Hours for Healthcare Centers Form staff posting form dated 3/8/2020 indicated 1 registered nurses(RN) for a total of 8 hours, 4 Licensed Practical Nurses (LPN) for a total of 32 hours, and 10 nurses assistants(NA) for a total of 80 hours staffed the skilled nursing unit on 7:00 am to 3:00 pm shift. The form indicated that the resident census was 104. The facility had 68 residents in certified beds. Review of the POS [REDACTED]. The 3/10/2020 posting listed 5 nurses, 13 NAs with a census of 101. The 3/11/2020 posting listed 5 nurses, 10 NAs with a census of 101. An interview was conducted with Nurse #3, who was the charge nurse, on 3/8/2020 at 12:20 PM. The nurse stated that the care coordinator filled out the daily staffing sheets and the census was the total number of residents in the building including Assisted Living. An interview was conducted with the care coordinator on 3/12/2020 at 9:11 AM. The care coordinator stated she filled out the daily staffing according to the total number of residents in the building including the Assisted Living residents. The care coordinator stated that the 700 Hall residents were all non-certified beds and were included in the daily census. An interview was conducted with the Director of Nursing (DON) on 3/12/2020 at 3:30 PM. The DON stated the facility had a total of 71 skilled nursing certified beds and 68 of those beds were occupied at the time of the interview. The DON stated that the number of certified beds were counted with the number of uncertified beds due to their being licensed nurses caring for the residents. The DON stated the care coordinator completed the daily staffing sheets in the morning when she came to work at 5:00 A.M. The DON indicated that she was not aware that the certified beds had to be posted separately from the uncertified beds.
F 0810 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide special eating equipment and utensils for residents who need them and appropriate assistance.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews with staff and medical record review, the facility failed to provide assistive eating devices for 1 of 1 resident (Resident #32) in accordance with physician's orders [REDACTED]. The findings included: Resident #32 was re-admitted to the facility on [DATE]. Her cumulative [DIAGNOSES REDACTED]. Resident #32's physician orders [REDACTED]. The resident's last annual MDS assessment had an assessment reference date (ARD) of 10/20/19. Section K of the assessment reported Resident #32 weighed 150 pounds (#). A review of the resident's Care Area Assessment (CAA) Worksheet dated 11/21/19 revealed the care area for Nutritional Status was triggered from the 10/20/19 MDS assessment. An Analysis of Findings revealed the resident was at nutritional risk related to dementia and [MEDICAL CONDITION]. She required built up utensils, a plate guard, and 2-handled lidded cup. The resident was reported to be on a mechanically chopped diet and had a history of [REDACTED].#32's care plan. The resident's most recent quarterly MDS assessment was dated 1/20/20. Section K of the MDS assessment revealed the resident weighed 140 #. Resident #32's current care plan as of the date of the review (3/12/20) included the following areas of focus, in part: --Nutritional Status (Started 9/20/19): The resident has the potential for alteration in nutrition related to [DIAGNOSES REDACTED]. Interventions included use of a plate guard; 2 handled lidded cup; and built up utensils (Approach Start Date: 11/21/2019). An observation was conducted as Resident #32 fed herself the noon meal in a dining room on 3/8/20 at 12:47 PM. The resident was observed to use built-up utensils and a two-handled lidded cup as assistive eating devices to feed herself. However, no plate guard was provided to the resident at that meal. A nursing assistant (NA) was observed to be sitting between Resident #32 and another resident during the meal. The NA was overheard as she provided cueing to Resident #32 to pick up a utensil to eat. An observation was conducted on 3/10/20 at 9:30 AM. The resident was observed to be sitting in her wheelchair in a dining room at a table by herself with a breakfast meal tray placed in front of her. Resident #32 was observed to be feeding herself a pancake with syrup using her fingers. At the time of the observation, Resident #32 had consumed 75-100% of her meal. Observation of the resident's meal card indicated she received a Regular Diet with chopped meat. Adaptive equipment required for the resident was specified on her meal card and included a plate guard, 2 handled lidded cup, and bendable build up utensils (each typed in capital letters). Additional Special Instructions noted on the meal card indicated left turned built up utensils were to be provided at mealtime. During this meal observation, Resident #32 was observed to only have a 2-handled cup available as an adaptive eating device. There was no plate guard and there were no built up utensils available for use. Regular utensils placed on her tray appeared to be clean and not used by resident. An observation was conducted on 3/10/20 at 12:18 PM as the resident's tray was being taken off of the lunch cart for residents sitting in the dining room awaiting meal service. Resident #32 was observed to be sitting at a table with three other female residents in the dining room. The resident's meal tray was observed as it was taken off of the lunch cart at 12:28 PM. Resident #32's lunch tray was observed

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 _____	03/12/2020

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 0810 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) to include built up utensils and a 2-handled lidded cup. No plate guard was sent for her as an assistive eating device. An observation was conducted on 3/11/20 at 8:16 AM as the resident was wheeled into the dining room for breakfast and her meal tray was delivered to her. At the time the meal tray was delivered, built up utensils were observed to be on her tray. However, neither a 2-handled lidded cup nor a plate guard were available for the resident. The resident was observed as she began feeding herself with the built up utensils. On 3/11/20 at 8:56 AM, Resident #32 was observed to still be feeding herself the breakfast meal. No plate guard and no 2-handled, lidded cup was available to her. At that time, approximately 1 ounce of coffee (in a mug with 1 handle) apeared to have been drank. No juice or milk appeared to have been consumed. Resident #32 was observed to be using the built up utensils provided. However, she appeared to have some difficulty getting the food placed on the utensil without food falling off of it and was observed to have several pieces of scrambled egg lying on her clothing protector, on her meal tray, and on the table directly in front of her. An interview was conducted on 3/11/20 at 2:35 PM with the Food Service Supervisor (FSS). When asked, the FSS reported Resident #32 should have assistive feeding devices sent with her meals. These devices included a plate guard, built up utensils, and a two-handled lidded cup. The FSS reported the nursing staff could come and get the adaptive (assistive) equipment if they were not to her on the meal tray when delivered from the Dietary Department. When asked if she would expect the assistive eating devices to be sent with the resident's meal tray, the FSS stated, Yes. An observation was conducted on 3/12/20 at 11:50 AM as NA #4 set up Resident #32's meal tray on a table in the dining room where the resident was sitting. Regular utensils were observed to have been sent from Dietary for the resident's use. A 2-handled lidded cup was sent on her tray, but there wasn't a plate guard or built up utensils on the tray. As NA #4 stepped out of the dining room after completing meal set-up for Resident #32, she was asked about the missing assistive eating device(s) for this resident. NA #4 reported she needed to go the kitchen to get Resident #32's built up utensils. When asked about the plate guard, the NA looked at the tray she had just removed from the dining room and confirmed a plate guard had not been sent for this resident. NA #4 reported she would go and get a plate guard from the kitchen as well. An interview was conducted on 3/12/20 at 2:29 PM with the facility's Director of Nursing (DON). During the interview, concerns were shared with the DON regarding failure of the facility to provide assistive eating devices to Resident #32 as ordered by the physician and as care planned. The DON responded by stating, They're supposed to have them.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on observations, staff interviews and record reviews, the facility's Quality Assessment and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions that were put in place following the annual recertification and complaint survey conducted on 4/18/19. This was for recited deficiencies in the areas of encoding/transmitting resident assessments (F640), baseline care plans (655), and posted nurse staffing information (F732). These deficiencies were recited during an annual recertification and complaint survey conducted on 3/12/20. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This tag is cross referenced to: 1) F640 - Based on record review and staff interview, the facility failed to transmit a discharge Minimum Data Set (MDS) assessment within the required time frame for 2 of 29 residents (Resident #1 and Resident #2) sampled for MDS completion and submission of activities. During the facility's annual recertification and complaint investigation on 4/18/19 the facility was cited for F640 for failing to transmit an annual MDS assessment within the required time frame for 1 of 3 residents (Resident #2) reviewed for MDS completion and submission activities. An interview was conducted on 3/12/20 at 4:40 PM with the facility's Administrator. Upon inquiry, the Administrator confirmed neither he nor the Director of Nursing (DON) worked at the facility during its last recertification on 4/18/19. However, he reported since coming to the facility, a questionnaire had been put out for residents and family members to provide input and put into place performance improvement plans to address the concerns shared. The facility was currently doing audits on these concerns to enable tracking and measuring performance in the areas identified. During the interview, the repeat citations from this survey and the last (conducted on 4/18/19) were discussed. The Administrator stated resident care plans had been followed by the facility's Quality and Assurance Performance Improvement (QAPI) committee. He also indicated the repeat citations would be followed by the QAPI committee to ensure they were corrected. 2) F655 - Based on record review, staff interviews and responsible party interview, the facility failed to develop, implement and communicate the initial 48-hour baseline plan of care to the responsible party for 4 Residents (Resident #43, #73, #78 and #279) of 6 newly admitted residents reviewed. During the facility's annual recertification and complaint survey conducted on 4/18/19 the facility was cited for F655 for failing to complete and implement a baseline care plan in conjunction with the interdisciplinary team and failed to conduct a care plan meeting with the resident and/or resident representative for 4 of 7 sampled new admission residents (Residents #135, 139, 142 and 79). An interview was conducted on 3/12/20 at 4:40 PM with the facility's Administrator. Upon inquiry, the Administrator confirmed neither he nor the Director of Nursing (DON) worked at the facility during its last recertification on 4/18/19. However, he reported since coming to the facility, a questionnaire had been put out for residents and family members to provide input and put into place performance improvement plans to address the concerns shared. The facility was currently doing audits on these concerns to enable tracking and measuring performance in the areas identified. During the interview, the repeat citations from this survey and the last (conducted on 4/18/19) were discussed. The Administrator stated resident care plans had been followed by the facility's Quality and Assurance Performance Improvement (QAPI) committee. He also indicated the repeat citations would be followed by the QAPI committee to ensure they were corrected. 3) F732 - Based on observations, record review and staff interviews, the facility failed to post accurate staffing data by including staff providing care for residents in assisted living with staff providing care for the residents on the skilled nursing halls and failed to post accurate census by including residents from the assisted living hall with residents on the skilled nursing hall for 5 of 5 days during the survey conducted on 3/8/2020 through 3/12/2020. During the facility's annual recertification and complaint survey conducted on 4/18/19 the facility was cited for F732 for failing to post the Daily Nursing Hours that reflected the census and staffing numbers for 2 of 4 days reviewed for sufficient staffing. An interview was conducted on 3/12/20 at 4:40 PM with the facility's Administrator. Upon inquiry, the Administrator confirmed neither he nor the Director of Nursing (DON) worked at the facility during its last recertification on 4/18/19. However, he reported since coming to the facility, a questionnaire had been put out for residents and family members to provide input and put into place performance improvement plans to address the concerns shared. The facility was currently doing audits on these concerns to enable tracking and measuring performance in the areas identified. During the interview, the repeat citations from this survey and the last (conducted on 4/18/19) were discussed. The Administrator stated resident care plans had been followed by the facility's Quality and Assurance Performance Improvement (QAPI) committee. He also indicated the repeat citations would be followed by the QAPI committee to ensure they were corrected.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and review of manufacturer's specifications the facility failed to clean and disinfect a shared glucometer (a device used to monitor a resident's blood glucose or blood sugar level) per manufacturer's specifications for 1 of 3 residents observed to receive a finger stick blood sugar (Resident #231). The findings included: The manual for the glucometer used by the facility read: To disinfect your meter, clean the meter surface with one of the approved disinfecting wipes. Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use. Containers of disinfectant wipes were noted on the medication carts and observed to be used by staff to clean the glucometers. The container noted the wipes were bactericidal, virucidal and tuberculocidal. The contact time was 2 minutes for [MEDICAL CONDITION] (MRSA), [MEDICATION NAME] resistant [MEDICATION NAME] resistant staphylococcus and many other bacteria. On 3/12/20 at 11:35 AM, Nurse #1 was observed to remove a glucometer from the medication cart used to check finger stick blood sugars for residents on the unit. The nurse was observed to remove a pack of disinfectant wipes from the medication cart and clean off the glucometer. The package noted the ingredient in the wipe was alcohol. The nurse was asked how she was trained to clean the glucometer. The Nurse stated she was trained to clean the glucometer with bleach wipes and to let the glucometer air dry but there were no bleach wipes on her cart today. The Nurse was observed to obtain a container of disinfectant wipes and wiped the glucometer for 3 seconds and disposed of the wipe

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 _____	03/12/2020

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 8) and allowed the glucometer to air dry. The glucometer was observed to be dry in less than one minute. The nurse was observed to check a fingerstick blood sugar on Resident #231. On 3/12/20 at 1:31 PM an interview was conducted with the Staff Development Coordinator (SDC) who was also the Infection Control Preventionist in the facility. The SDC stated he trained the staff to clean the glucometer with bleach wipes and to let the glucometer air dry for 2 minutes. The SDC further stated they had one resident in the facility with a blood borne pathogen and that resident had a glucometer in the room for the staff to use for that resident. The SDC stated this was the only resident with a known blood borne pathogen in the facility since the nurse started working in the facility. On 3/12/20 at 4:00 PM an interview was conducted with the Director of Nursing (DON) and the Administrator. There was a discussion about the glucometer needing to be wet for 2 minutes and the DON seemed surprised but made no comment.
F 0883 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to offer the influenza vaccine and the pneumococcal vaccine and record education pertaining to the benefit and potential risk for 4 out of 5 residents (Resident #32, #329, #78, #58) reviewed for immunizations. Findings Included: The facility policy for influence (flu) vaccinations with the effective date of February 1, 2008 and revised date of September 30, 2019 stated, All patients who have no medical contraindications to the vaccine will be offered the influenza vaccine annually. It further stated, Current and newly admitted patients will be offered the influenza vaccine beginning on October 1st of each year, Patients admitted during the flu season will be offered the vaccine within two (2) weeks of the patient's admission to the facility, if not previously vaccinated during the season and Each patient's immunization status will be determined prior to influenza vaccine administration and documented in the patients' medical record. The facility policy for pneumococcal vaccinations with an effective date of February 1, 2008 and a revised date of July 15, 2016 stated, All patients who reside in this healthcare center are to receive the pneumococcal vaccine with the current CDC guidelines unless contraindicated by their physician or refused by the patient or patient family. It further stated, The admission process will include determining whether or not the patient has received the pneumococcal vaccine in the past., Vaccination Information Statement will be provided to inform the patient of the side effects, benefits and risks of the vaccine. The Immunization Record will be part of each patient's clinical record. 1.a. Resident # 32 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's most recent Minimum Data Set (MDS) quarterly assessment with an ARD (Assessment Reference Date) of 1/20/20 revealed Resident #32 was severely cognitively impaired. Further review of the MDS assessment revealed Resident #32 had not received the influenza vaccine nor was it offered, it did reveal Resident #32 had the pneumococcal vaccine. A review of Resident #32's face sheet listed a daughter as the responsible party. Record review of the Resident #32's immunization information from October through March did not show Resident #32 was provided education for the benefits and potentials risk of the influenza vaccine or the pneumococcal vaccine. The resident's clinical record did not show a consent/refusal form. The Infection Prevention nurse's (IP) master list of immunizations did not show a record of consent/refusal form for this resident. b. Resident # 329 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's most recent MDS admission assessment with an ARD date of [DATE] revealed Resident #329 was cognitively intact. Further review of the MDS assessment revealed Resident #329 had not received the influenza vaccine, nor was it offered; the pneumococcal vaccine had not been received or offered. Record review of Resident #329's immunization information from October did not show Resident #329 was provided education for the benefits and potential risk of the influenza vaccine or the pneumococcal vaccine. The resident's clinical record did not show a consent/refusal form. The IP's master list of immunizations did not show a record of consent/refusal form for this resident. c. Resident #78 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's most recent MDS admission assessment with an ARD date of 2/9/20 revealed Resident #78 was moderately cognitively impaired. Further review of the MDS assessment revealed Resident #78 had received the influenza vaccine and the pneumococcal vaccine outside the facility. A review of Resident #78's face sheet listed a daughter as the responsible party. Record review of Resident #78's immunization information from February did not show Resident #78 was provided education for the benefits and potential risk of the influenza vaccine or the pneumococcal vaccine. The resident's clinical record did not show a consent/refusal form. The IP's master list of immunizations did not show a record of consent/refusal form for this resident. d. Resident #58 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the resident's most recent MDS admission assessment with an ARD date of 2/11/20 revealed Resident #58 was cognitively intact. Further review of the MDS assessment revealed Resident #58 had not received the influenza vaccine, the resident had received the pneumococcal vaccine outside the facility. Record review of Resident #58's immunization information from February did not show Resident #58 was provided education for the benefits of the potential risk of the influenza vaccine or the pneumococcal vaccine. The resident's clinical record did not show a consent/refusal form. The IP's master list of immunizations did not show a record of consent/refusal form for this resident. During an interview with the Infection Prevention nurse (IP) on 3/11/20 at 11:10AM revealed no record of consent/refusal or contact with the resident representative for Resident's #32, #329, #78, and #58. The IP stated there is no record of Resident #32, #329, #78, or #58 being offered or receiving the influenza vaccine or the pneumococcal vaccine, education for the benefits and potential risks was not provided. The IP stated, education of the benefits and risks of the vaccines would be provided with the consent/refusal form to be signed by the resident or the resident representative. The IP stated he is not tracking vaccines nor is he tracking new admission paperwork to verify if a consent/refusal was completed. Additionally, IP stated the policy on pneumococcal vaccines states to offer the vaccine at admission, at present time this is not happening. The pneumococcal vaccine is being offered if the physician orders [REDACTED]. The admitting nurse would obtain the consent/refusal forms for the influenza vaccine and the pneumococcal vaccine. The consent/refusal form would be given to the IP who would follow up with the resident or resident representative and, if applicable, provide the injection. This information would be recorded on the IP's master log of immunizations and in the clinical record.