JUN 24 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345009	A. BUILDING _____ B. WING _____	C 06/09/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID VMJO11.	F 000	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	**Residents affected by practice:** Nurse #1, Nurse #2, and CNA #1 were educated on June 9, 2011 regarding performing correct infection control practices regarding hand-washing and glove usage. Nurse #1 and Nurse #2 were educated on June 9, 2011 regarding performing acceptable infection control practices during treatment procedures. **Residents having the potential to be affected by practice:** Current residents have the potential to be affected. Nursing staff education regarding performing acceptable infection control practices during resident care will be completed by 7/1/11. Education on infection control practices specific to glove usage during resident care and wound care has been added to the general orientation of new nursing employees.	7/01/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynn Harper RN — TITLE: Administrator — (X6) DATE: 6/23/2011

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/15/2011
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT MAYVIEW	613 EAST WHITAKER MILL ROAD RALEIGH, NC 27608

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F 441	Continued From page 1 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to ensure that staff remove their gloves and wash their hands prior to handling clean supplies for 2 of 3 residents observed receiving care (Resident #89 and 141) and failed to remove soiled gloves after incontinent care prior to applying barrier cream for 1 of 2 residents observed to receive incontinent care. (Resident #67). The findings include: 1. Resident #89 was admitted to the facility on 1/21/11 and had a diagnosis of Hemiarthroplasty Left Hip. On 6/8/11 at 11:30AM, Nurse #1 was observed to provide wound care for a pressure ulcer on the resident ' s left heel. The nurse was observed to don gloves and clean the wound with saline soaked gauze. The nurse applied a dressing and wrapped the heel with gauze. The nurse then applied skin prep to the resident ' s right heel and put socks on the resident ' s feet. The Nurse was observed to collect the unused dressing supplies and place in a plastic bin while wearing the same gloves worn to provide wound care. The nurse then removed her gloves and washed her hands. In an interview on 6/8/11 at 12:56 PM, Nurse #1 stated that she should have removed her gloves and washed her hands before handling the clean	F 441	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. **System changes:** Staff will be educated during general orientation regarding infection control practices related to resident care. The Clinical Competency Coordinator and/or designee will randomly observe nursing staff providing resident care with acceptable infection control techniques daily for two weeks, then 3 times per week for 2 weeks, then 2 times per week for 2 weeks then monthly thereafter. **Maintain compliance:** The audits performed by the Clinical Competency Coordinator and/or designee will be reviewed by the Performance Improvement/Quality Improvement team to identify trends in practice and any changes in protocol. The audits will be brought to the Performance Improvement/ Quality Improvement Committee monthly for 3 months and then quarterly.	7/01/11

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F 441	Continued From page 2 dressing supplies. The Nurse stated that each resident was assigned a bin for dressing supplies and the bins were stored in the medication room. The Staff Development Coordinator stated in an interview on 6/9/11 at 8:57 AM that the nurse should have removed her gloves and washed her hands before handling the clean dressing supplies. The Director of Nursing stated in an interview on 6/9/11 at 9:38 AM that the nurse should have removed her gloves and washed her hands before handling the clean dressing supplies. The Administrator stated in an interview on 6/9/11 at 10:12 AM that the nurse should have removed her gloves and washed her hands prior to handling the clean dressing supplies. 2. Resident #141 was admitted to the facility on 5/17/11 with diagnoses including Sacral Decubitus. On 6/8/11 at 3:49 PM, Nurse #2 was observed to provide wound care for Resident #141. The nurse was observed to don gloves and clean the wound with saline soaked gauze. The nurse used gauze to apply an ointment that promotes healing to the outer edges of the wound and then used gauze to apply an ointment used to debride dead tissue to the center of the wound. The nurse then applied a dressing over the wound. At the completion of care the nurse handled one of the tubes of ointment while wearing the same gloves used to provide wound care.	F 441		

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F 441	Continued From page 3 Nurse #3 stated in an interview on 6/8/11 at 4:15 PM that she should have removed her gloves and washed her hands before touching clean items. The Staff Development Coordinator stated in an interview on 6/9/11 at 8:52 AM that the nurse should have removed her gloves and washed her hands before handling clean supplies. The Director of Nursing stated in an interview on 6/9/11 at 9:41 AM that the nurse should have removed her gloves and washed her hands before handling clean supplies. The Administrator stated in an interview on 6/9/11 at 10:20 AM that the nurse should have removed her gloves and washed her hands before handling clean supplies. 3. Resident # 67 was admitted to the facility on 12/30/10 with diagnoses including Chronic Left Hip Dislocation, Urinary Retention and Dementia. During an observation on 6/8/11 at 11:45AM, Nurse Aide #1 entered Resident #67 ' s room, closed the door and gathered supplies to perform incontinence and catheter care. NA #1 washed her hands and donned gloves. NA #1 then performed catheter care and incontinent care using a washcloth and peri-wash. NA#1 was observed to clean between the resident ' s labia with downward motion and then preceded to clean the catheter tubing away from the resident. NA #1 then rolled the resident to her right side and washed the resident ' s buttocks. She then dried the resident. NA #1, at this point, turned with her gloves still on and opened the resident ' s drawer and pulled out a bottle of lotion. NA #1	F 441		

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F 441	Continued From page 4 then squirted the lotion onto her gloved, right hand and applied the lotion to the resident ' s buttock area. NA #1 then placed the lotion bottle back on the top of the dresser. NA#1 then removed her gloves and carried the bath basin to the bathroom, re-gloved and rinsed out the basin. During an interview with NA #1 on 6/8/11 at 12:05PM she stated that she should have removed her dirty gloves before reaching into the drawer for the lotion and then re-gloved with clean gloves to apply the lotion. During an interview with the Staff Development Coordinator (SDC) on 6/8/11 at 1:30PM she stated that the nursing staff is expected to change their gloves between dirty and clean procedures. During an interview with the Director of Nursing on 6/9/11 at 9:15AM she stated that nursing assistants should always change their gloves and wash their hands between going from dirty to clean procedures.	F 441		

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID VMJO11.	F 000		

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.

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	345009	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/28/11 at approximately noon the building construction type was non-compliant, specific findings include; paperback insulation used in the outside wall soffet connecting the business office to the dining room above the glass windows and above the fire separating wall.	K 012	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirementsunder state and federal law. K 012 **Corrective Action to ensure paper backed insulation removed from facility premises.** Facility will have all paper backed insulation removed from facility by contractor. **Corrective Action for those with potential to be affected.** Maintenance Director will inspect facility to ensure no paper backed insulation exists. **Systemic Changes to Prevent Deficient Practice.** Maintenance Director will inspect all newly installed insulation to ensure no paper backed insulation is installed. **How will Corrective Action be monitored?** Maintenance Director and maintenance staff will ensure they are subcontracted with vendors who do not use paper backed insulation.	07/20/2011
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lynn Hayes	Administrator	7/15/11

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K 051	Continued From page 1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/28/11 at approximately noon the fire alarm system was non-compliant, specific findings include; A. The smoke head in the activities room sounded the building fire alarm system during the survey. The head could not be cleaned and reset so it was removed. Replacement units were ordered during survey. B. The telephone line component of the fire alarm system was in a trouble condition during the survey. C. The pull station handle at the 1st floor dining exit was broken.	K 051	K 051 **Corrective Action to ensure smoke heads work properly as well as telephone dialer .** Facility maintenance staff will engage BFPE to replace smoke head, pull station and ensure phone auto dialer will remain out of "trouble mode". **Corrective Action for Those with Potential to be affected.** Maintenance Director will inspect facility smoke heads and pull stations to ensure that they will remain free of alarms. All pull stations will be inspected in order to ensure all are operable **Systemic Changes to Prevent Deficient Practice.** Maintenance Director will perform monthly inspections of facility smoke heads and pull stations in order to ensure they remain fully functional. **How will Corrective Action be monitored?** Maintenance Director and staff will ensure periodic system inspections are performed routinely by BFPE. Results of inspections will be reviewed by the Administrator weekly x 3 months.	7/22/2011
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/28/11 at approximately noon the following sprinkler systems items were non-compliant, specific findings include; A. The facility could not confirm the sprinkler	K 062	K 062 **Corrective Action to ensure reliable automatic sprinkler systems are continuously maintained and are inspected and tested periodically.** Facility Maintenance Director will engage BFPE to procure and install 2 new sprinkler gauges. Both gauges will be calibrated when installed. Outside bell will be replaced also.	07/22/2011

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K 062	Continued From page 2 system gauges had be celebrated within the past 5 years. B. The sprinkler system certification noted the "outside bell does not work".	K 062	K 062 **Corrective Action for Those with Potential to be affected.** Maintenance Director will inspect sprinkler gauges periodically (monthly) and record the results of the inspection on a Performance Improvement log. Sprinkler tests will include tests of audible alarm. .	07/22/2011
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	**Systemic Changes to Prevent Deficient Practice.** Facility will contract with outside vendor to inspect sprinkler system and insure proper function and alarm capability as per Life Safety Code.	07/15/2011
	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/28/11 at approximately noon the Heating, Ventilating, and Air Condition (HVAC) system was non-compliant, specific findings include; during testing of the fire alarm system, when testing for HVAC shut down, the return at nurses station #3 was not working. Upon further discussion the unit was under repair and not functioning during the survey.		**How will Corrective Action be monitored?** Maintenance Director and staff will ensure periodic system inspection is performed routinely by both facility staff as well as outside vendor. Results of inspections will be reviewed by the Administrator weekly x 3 months.	07/22/2011
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K 067 **Corrective Action to ensure Heating Ventilating and Air Conditioning comply with provisions of section 9.2 and are installed in accordance with the manufacturers specifications.** Facility Maintenance Director has replaced non functional relay unit at Nurse Station #3. **Corrective Action for Those with Potential to be affected.** Maintenance Director will inspect all HVAC units to ensure proper function and operation in accordance with Life Safety Code., all malfunctioning units will be referred to outside vendor for repair.	07/04/2011 7/22/2011

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K 144	Continued From page 3 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/28/11 at approximately noon the following operational inspection and testing was non-compliant. Specific findings include: documentation for monthly load test was conducted without recording percent rated load or temperature rise. A load bank test had not been completed within the past year. NFPA 99 3-4.4.2 Record keeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110 6-4.2 (1999 edition) generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. NFPA 110 6-4.2.2 (1999 edition) Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPPS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. (load bank testing)	K 144	K 067 **Systemic Changes to Prevent Deficient Practice.** Facility will contract with outside vendor to perform periodic inspections of heating and air conditioning units. **How will Corrective Action be monitored?** Maintenance Director and maintenance staff will ensure periodic system inspection is performed routinely by both facility staff as well as outside vendor.Results of inspections will be reviewed b the Administrator weekly x 3 months. K 144 **Corrective Action to ensure** **Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA** Maintenance staff will run weekly generator tests. Generator will be performed under load for 30 minutes monthly. Annual load bank test will be scheduled now. **Corrective Action for Those with Potential to be affected.** Maintenance Director will record results of weekly generator tests. as well as monthly load tests. Load bank test will be done now and annually. **Systemic Changes to Prevent Deficient Practice.** The results of the weekly and monthly generator tests will be reviewed by the Administrator and routine maintenance will be ordered in response to the outcomes.	7/22/2011 07/22/2011

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			K-144 How will Corrective Action be monitored? Maintenance Director and staff will ensure periodic system inspection is performed routinely by both facility staff as well as outside vendors as indicated. Results of inspections will be reviewed by the Administrator weekly x 3 months.	07/22/2011

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	345009	A. BUILDING 02 - BUILDING 2 B. WING _____	06/28/2011

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K 000	INITIAL COMMENTS There were no Life Safety Code Deficiencies noted at time of survey.	K 000		

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

Lynn Haynes | Administrator | 7/15/11

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