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

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 _____	07/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT MAYVIEW	613 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 The facility was found to be in compliance with the Medicare/Medicaid Long Term Care regulations, 42 CFR part 483, subpart B during the recertification survey of 07/11/2012.	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.

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345009	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/09/2012

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
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type II(211) construction, two story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Corrective Action to ensure smoke barrier: 700 hall door hinge has been corrected and closes completely. Corrective Action for those with the potential to be affected: Maintenance director and/or maintenance staff will inspect cross corridor smoke doors to ensure proper closure. Systemic changes to Prevent Deficient Practice. Maintenance director and/or maintenance staff will inspect cross corridors monthly for proper closure during fire drills. How will corrective actions be monitored. Maintenance director will report findings to administrator monthly and will be reviewed at Quality Assurance meeting x 3 months.	8-17-12
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation on August 9th 2012 at approximately 1:00 PM onward the following was noted: 1) The cross corridor smoke door located on 700 hall did not close smoke tight. One of two doors was dragging on the floor and not closing completely. 42 CFR 483.70(a)	K 027		
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038	K038 Corrective Action to ensure exit access Accessible.	8-17-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather Odell | TITLE: Administrator | (X6) DATE: 8/24/12

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	345009	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/09/2012

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

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K 038 SS=D	Continued From page 1 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation on August 9th 2012 at approximately 1:00 PM onward the following was noted: 1) The exit door on 1st floor ground exit located next to the house keeping office was catching at the threshold and was requiring greater than 15 lbs. of force to open. 42 CFR 483.70(a)	K 038	Threshold of 1st floor exit door was corrected. Corrective Action for those with the potential to be affected: Maintenance director and/or maintenance staff will inspect exit door thresholds for proper closing. Systemic changes to Prevent Deficient Practice. Maintenance director and/or maintenance staff will inspect exit door thresholds monthly. How will corrective actions be monitored. Maintenance director will report findings to administrator monthly and will be reviewed at Quality Assurance meeting x 3 months.	
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD Is not met as evidenced by: Based on observation on August 9th 2012 at	K 052	K 052 Corrective Action for Fire Alarm Panel. Vendor BFPE has been contacted to correct audible trouble signal.	8-31-12

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	345009	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/09/2012

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THE OAKS AT MAYVIEW	513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608

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K 052	Continued From page 2 approximately 1:00 PM onward the following was noted: 1) Upon testing the Fire Alarm Control Panel (FACP) it was observed that an audible trouble signal did not sound at the remote annunciator located at the 1st floor nurse station when a loss of phone or AC power trouble was initiated on the fire alarm system. 42 CFR 483.70(a)	K 052	Corrective Action for those with the potential to be affected: Maintenance director and/or maintenance staff will inspect fire panel for audible trouble signal at the remote annunciator monthly. Systemic changes to Prevent Deficient Practice. Maintenance director and/or maintenance staff will inspect fire panel for audible trouble signal at the remote annunciator monthly and vendor BFPE will check quarterly. How will corrective actions be monitored. Maintenance director will report findings to administrator monthly and will be reviewed at Quality Assurance meeting x 3 months.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.6 This STANDARD is not met as evidenced by: Based on observation on August 9th 2012 at approximately 1:00 PM onward the following was noted: 1) In the kitchen area there are sprinkler heads in the facility rated for Intermediate Temperature Classification, Glass Bulb Color of Green temperature rating of (200°F) in place of Ordinary Temperature Classification, Glass Bulb	K 056	K 056 Corrective Action for Sprinkler system.	8-21-12

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K 056	Continued From page 3 Color of Red temperature rating of (155°F). 2) In the 1st floor mechanical room (Boiler Room) the sprinkler heads are not clean and maintained in gooed condition. 42 CFR 483.70(a)	K 056	Vendor BFPE replaced kitchen sprinkler heads with new 155 temperature rated heads. BFPE replaced/and or cleaned boiler room sprinkler heads.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation on August 9th 2012 at approximately 1:00 PM onward the following was noted: 1) By observation there was an excessive amount of lint accumulation on and behind the dryers in the laundry area creating a potential fire hazard. 42 CFR 483.70(a)	K 130	Corrective Action for those with the potential to be affected. Sprinkler heads were inspected for correct temperature and dust. Systemic changes to Prevent Deficient Practice. Maintenance director and/or maintenance staff will inspect sprinkler heads monthly for dust. This will also be inspected quarterly by BFPE. How will corrective actions be monitored. Maintenance director will report findings to administrator monthly and will be reviewed at Quality Assurance meeting x 3 months.	
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. This STANDARD is not met as evidenced by: Based on observation on August 9th 2012 at	K 144	K 130 Corrective Action for Dryor lint. Dryer and area behind dryer was cleaned.	8-9-12

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K 144	Continued From page 4 approximately 1:00 PM onward the following was noted: 1) Upon testing the generator it was observed that an audible/visual signal was not provided for at the generator annunciator panel located at the 1st floor nurse station when the generator was placed under load. 42 CFR 483.70(a)	K 144	Corrective Action for those with the potential to be affected. Dyers and areas behind dryers were cleaned. Systemic changes to Prevent Deficient Practice. Laundry staff will clean out vents after each use. Maintenance director and/or maintenance staff will clean dryers and areas behind dryer s weekly. How will corrective actions be monitored. Administrator will inspect dryers and areas behind dryers weekly x 4 weeks then monthly. Results will be review at Quality Assurance meeting X 3 months. K 144 Corrective action for Generator. Vendor Gregory Poole has been contacted and will be on site to correct audible/visual signal on generator annunciator panel.	8-27-12

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	345008	A. BUILDING 02 - BUILDING 2 B. WING _____	08/09/2012

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

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, two story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows: There were no Life Safety Code Deficiencies noted at time of survey.	K 000	Corrective Action for those will the potential to be affected, Vendor Gregory Poole will inspect Generator panel and make correct Audible/visual signal on annunciator panel. Systemic changes to Prevent Deficient Practice. Audible/visual signal will be inspected by maintenance director and/or maintenance staff during monthly generator tests. How will corrective actions be monitored. Maintenance Director will report findings of generator tests to administrator monthly and will be reviewed at Quality Assurance meeting x 3 months.	

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

Administrator 8-24-12

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.