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 _____	06/27/2013

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) COMPLETIO 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 06/27/2013.	F 000		

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

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	345009	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/23/2013

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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 2000 Existing Health Care section of the LSC and its referenced publications. This building 0102 is Type II construction, building 0202 is Type III construction, two story, with a complete automatic sprinkler system. The census was 116. The deficiencies determined during the survey are as follows:	K 000	K 021 Corrective Action for Accomplished for Identified deficient practice: Door was repaired on 7/23/2013 Corrective Action for Those with Potential to be affected All doors in facility checked for proper closure/latching on 7/24/2103.	
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/23/13 at approximately noon	K 021	Systemic Changes to Prevent Deficient Practice Doors will be checked monthly by Maintenance to ensure compliance utilizing our Building Engines PPM How will Corrective Action be monitored? Maintenance director or designee will provide a quarterly report to the QAPI committee for further recommendations Corrective Action Complete: 7/24/2013	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lugenia Baker — TITLE: Administrator — (X6) DATE: 8/4/13

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.

DRW

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	345009	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 021	Continued From page 1 the following fire/smoke barrier was non-compliant, specific findings include, the door to the fire/smoke wall, near nurses station #4, did not close and latch properly.	K 021	K 038 **Corrective Action for Accomplished for Identified deficient practice:** Exit lights installed with 2 bulbs to meet illumination requirement on 8/9/2013 **Corrective Action for Those with Potential to be affected** All exits lights were checked for proper lighting requirements on 7/30/2013 **Systemic Changes to Prevent Deficient Practice** Exit lights will be checked quarterly by the maintenance director or designees through our Building Engines PPM to ensure proper illumination. Any identified lights out of compliance will be corrected immediately. **How will Corrective Action be monitored?** Maintenance director or designee will provide a quarterly report to the QAPI committee for further recommendations **Corrective Action Complete:** 8/10/2013	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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: 42 CFR 483.70(a) By observation on 7/23/13 at approximately noon the following exit discharge illumination was non-compliant, specific findings include, a single bulb fixture at the 600 hall and also the riser room exits. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4.	K 038		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are	K 050		

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	345009	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/23/2013

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 050	Continued From page 2 conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/23/13 at approximately noon the following fire drills were non-compliant, specific findings include, documentation indicated less than the required number of drills were held on third shift of 1st quarter 2013.	K 050	K 050 Corrective Action for Accomplished for Identified deficient practice: A fire drill for the specified time period of 9 pm to 6 am was conducted on 7/ 24/13 Corrective Action for Those with Potential to be affected Maintenance Director or designee will conduct fire drills according to regulation. Fire drill reports will be signed by the Administrator or designee to ensure compliance	
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: 42 CFR 483.70(a) By observation on 7/23/13 at approximately noon the following fire alarm system was non-compliant, specific findings include: A. The Visual/Audible (VA) device, located at nurses station #4, did not function while the	K 052	Systemic Changes to Prevent Deficient Practice As stated above, Administrator or designee will sign monthly fire drill reports to ensure compliance. How will Corrective Action be monitored? Maintenance director or designee will provide a monthly report to the QAPI committee for further recommendations Corrective Action Complete: 8/2/2013	

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	345009	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 052	Continued From page 3 building fire alarm control panel was on battery back up power. B. There was not a VA device, located in the smoke compartment with the beauty shop, near nurses station #4. This was also noted on the Fire Marshall's report.	K 052	K 052 **Corrective Action for Accomplished for Identified deficient practice:** A visual / audible device on Station 4 is functioning and new battery installed on 8/2/2013 by BFPE. A visual / audible device will be installed by 8/9/2013 in the smoke compartment near the beauty shop by BFPE. **Corrective Action for Those with Potential to be affected** All visual / audible devices were checked to ensure functioning on 7/25/2013 **Systemic Changes to Prevent Deficient Practice** Visual/Audible devices will be checked quarterly by Maintenance director or designee using Building Engines PPM **How will Corrective Action be monitored?** Maintenance director or designee will provide a quarterly report to the QAPI committee for further recommendations **Corrective Action Complete: 8/10/2013**	
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 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/23/13 at approximately noon the following Heating, Ventilating, and Air Conditioning system (HVAC) was non-compliant, specific findings include: A. The new carrier ductless HVAC system at nurses station #4 and #2 did not shut down with fire alarm activation. B. There was not an emergency shut down switch located at a readily observed station for the new carrier ductless HVAC system at nurses station #4 and #2 . C. The kitchen door did not close and latch tightly in it's frame. At the time of the survey the kitchen was experiencing a sever negative pressure.	K 067		

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	345009	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 067	Continued From page 4 NFPA 96 (Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 1998 Edition) Section 5-3* Replacement Air. - " Replacement air quantity shall be adequate to prevent negative pressures in the commercial cooking area(s) from exceeding 0.02 in. water column (4.98 kPa). "	K 067	K 067 **Corrective Action for Accomplished for Identified deficient practice:** Carrier HVAC units were wired into Fire System to automatically shut off during Fire Alarm on 8/9/2013	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/23/13 at approximately noon the following items were non-compliant, specific findings include: A. The combustion area above and behind the gas dryers including the sprinkler head was filled with lint/dust. B. Special locking was being installed in the facility. It was discussed that plan review and approval from licensure would need to be obtained. Request approval in writing for proper installation.	K 130	Emergency shut off switch installed on by BFPE by 8/9/2013 Kitchen negative pressure corrected on 7/30/13. **Corrective Action for Those with Potential to be affected** All air handler units were identified to ensure they are connected to the fire system to automatically shut off. on 7/31/232013 No other areas identified to need emergency cut off switch NO other areas identified with negative pressure.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a)	K 147	**Systemic Changes to Prevent Deficient Practice** Air handler units including Carrier HVAC units will be checked during Monthly fire drills to ensure functioning and included on monthly fire drill report.	

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K 147	Continued From page 5 By observation on 7/23/13 at approximately noon the following electrical item was non-compliant, specific findings include, the lights on the Automatic Transfer Switch (ATS) showing normal and emergency power were not operational.	K 147	Negative pressure identified in Kitchen will be checked monthly by Maintenance Director or designee through Building Engines PPM. How will Corrective Action be Monitored: Maintenance director or designee will provide a monthly report to the QAPI committee for further recommendations. Corrective Action Complete: 8/10/2013 K 130 Corrective Action for Accomplished for Identified deficient practice: The combustion area above and behind the gas dryers including the sprinkler head was cleaned of lint and dust on 7/25/2013 Requesting a waiver for the special locking plan review. Corrective Action for Those with Potential to be affected Sprinkler heads in building were checked for dust and lint on 7/30/2013 Systemic Changes to Prevent Deficient Practice:	

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	345009	A. BUILDING 02 - BUILDING 2 B. WING _____	07/23/2013

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K 000	INITIAL COMMENTS There were no Life Safety Code Deficiencies noted at time of survey.	K 000	Sprinkler heads will be checked quarterly by the Maintenance Director or designee through Building Engines PPM Combustion area around gas dryers will be checked monthly by the Maintenance Director or Designee through Building Engines PPM. How will Corrective Action be Monitored: Maintenance director or designee will provide a quarterly report to the QAPI committee for further recommendations for Sprinkler heads and monthly for the Gas Dryers Corrective Action Complete: 8/10/2013 K 147 Corrective Action for Accomplished for Identified deficient practice: Light on the Automatic Transfer Switch was corrected on 8/1/2013. Corrective Action for Those with Potential to be affected No other areas identified upon our inspection of facility on 7/26/2013.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Allyce A Poole | TITLE: Administrator | (X6) DATE: 8/6/13

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.

Systemic Changes to Prevent Deficient Practice

Automatic Transfer Switch light will be checked monthly during Generator testing by the Maintenance Director or Designee.

How will Corrective Action be Monitored:

Maintenance director or designee will provide a quarterly report to the QAPI committee for further recommendations.

Corrective Action Complete: 8/10/2013