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 03/02/2015

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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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff, Physician Assistant, and laboratory staff interviews, the facility failed to promptly notify the	F 157	Corrective action for resident affected: Resident #1 lab was called to physician on 2/16/2015. A Comprehensive medical	3/20/15

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

Electronically Signed | 03/13/2015

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F 157	Continued From page 1 physician of a laboratory result indicating an abnormally high sodium level for 1 of 1 residents (Resident #1) receiving a diuretic (a medication that increases the amount of urine excreted). The findings included: Resident #1 was admitted to the facility on 2/11/15 from another facility. His cumulative diagnoses included a recent history of pneumonia, acute on chronic systolic (contraction of the left ventricle of the heart) and diastolic (relaxation of the left ventricle of the heart) congestive heart failure, and atrial fibrillation (a type of abnormal heart rhythm). Resident #1's admission Minimum Data Set (MDS) assessment was not completed at the time of the survey. A review of the resident's medical record included an Admission/Nursing Observation Form which described the resident as alert, disoriented, and able to follow simple commands. The resident was assessed as being dependent on staff for bathing, dressing, toileting/transfers; and required staff assistance for ambulation and eating. Resident #1's admission orders dated 2/11/15 included the following medications: 25 milligrams (mg) spironolactone (a diuretic) given once daily by mouth; and 60 mg furosemide (a diuretic) given once daily by mouth. On 2/13/15 at 3:50 PM, a Physician's Telephone Order was received for the following (in part): "Check BMP (Basic Metabolic Panel) on 2/14/15 Call MD (Medical Doctor) on call if Na (sodium) level > (greater than) 150."	F 157	record review for Resident #1 was completed for notification of physician lab compliance on 2/16/2015 by the Administrator Corrective action for residents having potential to be affected: A comprehensive medical record review for all residents was completed for timeliness of physician notification (see below) of lab results was completed by the Administrator and DHS on 2/20/15 Systemic changes made: Education by the Clinical Competency Coordinator (CCC) /Administrator/ DHS for all licensed nurses on notification of physician of lab results was completed on 3/10/15. Education was delivered by one of the following: one on one communication by CCC in person or by phone and printed materials sent via email with acknowledgements. New practice for licensed nurses include keeping the lab requisition with them until labs have been received and reported to MD. Physician notification of lab results will either be specified by the physician or notification of physician by end of the following shift. Monitor Performance: DHS/ADHS/Administrator/CCC/Weekend Supervisor will audit lab results and timeliness of physician notification. This	

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F 157	Continued From page 2 A review of the medical record included the following Skilled Daily Nurses Notes: 2/14/15 at 8:41 AM: The note indicated that blood was drawn for a BMP lab earlier that morning. However, the lab later called and notified the nurse that the wrong sample tube was used in the blood collection. The note indicated that the oncoming nurse would obtain another blood sample. 2/14/15 at 3:00 PM: "MD contacted to inform of difficulty obtaining blood for BMP, he verbalized understanding." 2/14/15 at 10:00 PM: "Lab results pending." On 2/15/15 at 6:10 AM, laboratory results from the blood collection obtained on 2/14/15 at 4:30 PM for Resident #1 were printed at the facility. A Print Date/Time stamp was noted on the bottom of the page of the lab results. The lab results included a serum (the fluid portion of the blood) sodium level of 153. The serum sodium level was noted in bold font with the letter "H" adjacent to the numerical result. A key at the bottom of the laboratory report indicated that the letter "H" referred to a "High" value. A hand-written notation made on the lab report read, "Called in to on call MD." This notation was initialed and dated 2/16/15. On 2/16/15 at 7:15 AM, a Physician's Telephone Order was received for the following: "Discontinue (furosemide) for indication of increased sodium; Start 0.45% NS (normal saline) at 75 ml/hr (the rate of the intravenous infusion indicated in milliliters per hour) x 1 Liter (total volume), collect urinalysis for urine sodium and urine osmolality (a measure of the	F 157	audit incudes reviewing each medical record for lab orders daily, including weekends and holidays, and verifying that the lab was noted in the lab book, lab drawn, and physician notification. Audits will be completed daily for one month, weekly for one month, and monthly for three months with results reported to the Quality Assurance Performance Improvement Committee for any concerns and further recommendations.	

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concentration of a solution)." On 2/16/15 at 7:20 AM, another Physician's Telephone Order was received with instructions to, "Add serum osmolality to today's lab draw."

A review of the medical record included a Skilled Daily Nurses Note dated 2/16/15 at 8:47 AM. The note read: "Resident had lab draw on 2/14/15 with orders to notify MD if sodium >150, per lab results, sodium 153, on call MD notified with new orders given, PIV (peripheral intravenous line) started to top of right hand with 0.45 NS at 75 ml/hr for a total of one liter."

An interview was conducted on 2/25/15 at 12:42 PM with the Physician Assistant (PA) who was assigned to care for Resident #1. During the interview, the PA confirmed that she saw the resident on 2/12/15 and 2/13/15 and wrote orders for the lab work (BMP) to be drawn on 2/14/15. Upon inquiry, the PA stated that she would have expected the lab work (specifically referring to the high sodium level) to be called in to the on-call physician when it became available on 2/15/15. The orders written by the PA indicated the on-call physician needed to be called for a sodium level greater than 150.

An interview was conducted with Nurse #1 on 2/25/15 at 3:09 PM. Nurse #1 was the nurse assigned to care for Resident #1 on Saturday, 2/14/15, from 7:00 AM to 11:00 PM. Nurse #1 recalled that she drew the blood for Resident #1's lab work around 4:30 PM on 2/14/15 and checked the lab printer/fax at 10:00 PM to see if the lab results were back. No results were available at the time so she documented in the Nurses Progress Notes that the labs were pending. Upon inquiry as to whether or not she included

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the pending labs in her report to the oncoming nurse, Nurse #1 stated, "I feel like I did." Nurse #1 indicated that a pending lab was information that would normally be passed along in report.

An interview was conducted with Nurse #2 on 2/25/15 at 2:10PM. Nurse #2 was the nurse assigned to care for Resident #1 on the 3rd shift from 11:00 PM on 2/14/15 to 7:00 AM on 2/15/15. Upon inquiry, Nurse #2 stated that the outgoing nurse did not report to her that there were labs pending for Resident #1 when she came on to work her shift.

An interview was conducted with Nurse #3 on 2/24/15 at 1:24 PM. Nurse #3 was the nurse assigned to care for Resident #1 on the 3rd shift from 11:00 PM on 2/15/15 to 7:00 AM on 2/16/15. Nurse #3 recalled noticing on Resident #1's MAR that a lab had been drawn for him on 2/14/15. Nurse #3 stated that she looked in his chart for the results and found the lab report was not there. After looking around for it, she then discovered the lab report was, "sitting in the fax." Nurse #3 assumed the MD hadn't been called with the results, so shortly before 7:00 AM she paged the physician on call. The physician returned the call at 7:15 AM. New physician orders were received and Nurse #3 reported that she started intravenous fluids for Resident #1 as ordered.

An interview was conducted with the facility's Director of Health Services (DHS) on 2/25/15 at 1:30 PM. The DHS indicated that the facility had identified a concern regarding the delay in reviewing and reporting the printed laboratory results from the blood collection obtained on 2/14/15 for Resident #1. The DHS confirmed that Resident #1's blood sample was collected for the

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F 157	Continued From page 5 lab work on 2/14/15, the lab result form had a print date/time stamp of 2/15/15 at 6:10 AM, and the on-call physician was not notified of the lab results until the morning of 2/16/15. An interview was conducted on 2/25/15 at 2:00 PM with a representative from the laboratory contracted to provide services to the facility. Upon inquiry, the lab representative reported that the results of the lab drawn on 2/14/15 at 4:30 PM were completed at the laboratory 2/14/15 at 8:00 PM. The lab representative noted that lab results were sent via an automated system (and at an automated time) to the facility unless a result was designated as a critical value or there was a request to do otherwise. The lab representative confirmed that the lab results from Resident #1's blood draw of 2/14/15 were sent to the facility on 2/15/15 at 6:10 AM as indicated by the date/time stamp on the laboratory results form.	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff and Physician Assistant interviews, the facility failed to monitor a resident's daily weights as ordered by	F 309	Corrective action for resident affected: Resident #1 daily weight was obtained and physician notified on 2/16/2015. A	3/20/15

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F 309	Continued From page 6 the physician for 1 of 1 residents (Resident #1) receiving a diuretic (a medication that increases the amount of urine excreted) for the treatment of congestive heart failure. The findings included: Resident #1 was admitted to the facility on 2/11/15 from another facility. His cumulative diagnoses included a recent history of pneumonia, acute on chronic systolic (contraction of the left ventricle of the heart) and diastolic (relaxation of the left ventricle of the heart) congestive heart failure, and atrial fibrillation (a type of abnormal heart rhythm). Resident #1's admission Minimum Data Set (MDS) assessment was not completed at the time of the survey investigation. A review of the resident's medical record included an Admission/Nursing Observation Form which described the resident as alert, disoriented, and able to follow simple commands. The resident was assessed as being dependent on staff for bathing, dressing, toileting/transfers; and required staff assistance for ambulation and eating. Resident #1's admission orders dated 2/11/15 included the following medications: 25 milligrams (mg) spironolactone (a diuretic) given once daily by mouth; and 60 mg furosemide (a diuretic) given once daily by mouth. Additionally, a physician's order was written on 2/11/15 to obtain daily weights secondary to the resident's diagnosis of congestive heart failure. On 2/12/15, Resident #1 was seen by the Physician Assistant (PA) who was assigned to help care for him. The PA's note indicated that	F 309	comprehensive record review was completed for Resident #1 for compliance with weights 2/16/2015 by the Administrator Corrective action for residents with potential to be affected: A comprehensive record review was completed by the Administrator and DHS on all residents to identify orders for daily weights and to identify other residents with potential risk and for compliance on 2/20/15. Systemic Changes: Clinical Competency Coordinator/DHS/Administrator conducted education of licensed nurses who are responsible to ensure that the daily weight is obtained and orders followed was completed on 3/10/15 by one of the following methods: one on one education in person or by phone and /or handout via email with acknowledgement. In addition, daily weights are now recorded on a specifically identified MAR for visual alert for the Licensed Nurses. Monitor Performance: DHS/Administrator/ADHS/Weekend Supervisor will audit daily,including weekends and holidays, all medical records for physician orders for daily weights, documentation compliance, and physician notification as follows: daily for	

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F 309	Continued From page 7 the resident was on an increased dose of furosemide and spironolactone and his weights would be monitored daily. A review of Resident #1's February Medication Administration Record (MAR) included documentation of the daily weights. The resident's weight on 2/12/15 was noted as 117.0 pounds (#) and his weight was recorded on 2/13/15 as 104.8# (representing a weight decrease of 12.2# compared to 2/12/15). On 2/13/15, the PA saw the resident and noted the results of his 2/13/15 lab work and 2/13/15 weight. The PA's Assessment and Plan read, in part: "1) Hypernatremia (referring to a high sodium level in the blood) --quite elevated (sodium) =156, will gently hydrate with D5W (an intravenous solution of 5 percent dextrose in water), check BMP (Basic Metabolic Panel) in AM (morning), also encourage oral fluids, possibly getting too much (furosemide). 2) CHF (congestive heart failure): also recently increased (furosemide) and (spironolactone), watching weights if greater than 2 # (pounds) over weekend, will need to call MD (Medical Doctor) on call, recent CXR (chest x-ray) didn't show any vascular congestion, will decrease (furosemide) to 20 mg through may need increase later, also watch (potassium) ....4) HTN (hypertension or high blood pressure): low; decrease (furosemide) and hold parameters for BP (blood pressure), watch daily weight." On 2/13/15 at 3:50 PM, a Physician's Telephone Order was received for the following (in part): Decrease furosemide to 20 mg by mouth given once daily; Obtain daily weights and call the Medical Doctor on call for a weight gain greater	F 309	one month then weekly for one month, then monthly for three months with reporting to Quality Assurance Performance Improvement Committee for any concerns and recommendations.	

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than 2 pounds.

A review of Resident #1's February MAR included documentation of the daily weights with a notation made on the MAR to, "Call MD if > 2 pound increase." The resident's weight on 2/14/15 was noted as 102.7# (representing a weight loss of 2.1# compared to the weight recorded on 2/13/15).

Further review of Resident #1 ' s February MAR revealed Resident #1's daily weight on 2/15/15 was not documented. On 2/16/15, the resident's weight was noted as 106.2# (an increase of 3.5# from the last weight recorded on 2/14/15).

An interview was conducted on 2/25/15 at 12:42 PM with the Physician Assistant (PA) who had been assigned to care for Resident #1. During the interview, the PA confirmed that she had seen the resident on 2/12/15 and 2/13/15. She recalled that orders had been written to monitor Resident #1's daily weights, with parameters which indicated when the on-call physician needed to be contacted with concerns. Upon inquiry, the PA stated that she would have expected the weights to be done daily as ordered and the physician to have been called if there was more than a 2 pound increase in the resident's daily weight.

An interview was conducted on 3/2/15 at 10:30 AM with the facility's Director of Health Services (DHS). During the interview, the missing record of Resident #1's daily weight from 2/15/15 was discussed. Upon inquiry as to who would have been responsible for obtaining this daily weight on 2/15/15, the DHS indicated it would have been the 3rd shift nurse's (Nurse #2) responsibility to

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F 309	Continued From page 9 ensure the weight had been obtained and recorded. An interview was conducted on 3/2/15 at 11:30 AM with Nurse #2. Nurse #2 was the 3rd shift nurse assigned to care for Resident #1 from 11:00 PM on 2/14/15 to 7:00 AM on 2/15/15. Upon inquiry, Nurse #2 indicated that she thought the daily weight had probably been done for Resident #1 on 2/15/15. However, she acknowledged that she could not be certain that the weight was obtained or what the result was. Nurse #2 reported that all of Resident #1's daily weights should have been recorded on his MAR.	F 309		