| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345009 | A. BUILDING _____ B. WING _____ | C 12/12/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE OAKS AT WHITAKER GLEN-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 |
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| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, nurse practitioner and staff interview the facility failed to follow physician ' s orders for laboratory (lab) tests to be done for 1 of 6 residents reviewed (Resident #4) and failed to follow physician ' s orders for fluid restrictions and nutritional supplements for 1 of 6 residents reviewed (Resident #1).<br><br>The findings included:<br><br>1. Resident #4 was admitted to the facility on 10/23/18 and had a diagnosis of Infected sacral ulcer. A review of the hospital discharge summary dated 10/23/18 revealed orders from Infectious Disease Associates who saw Resident #4 while in the hospital. Plan of Treatment read: "Drug cefepime (antibiotic) 2 grams (GM) IV (intravenous) Q (every) 12 hours. *dose may need to be adjusted based on ongoing renal function." Home Health/SNF (Skilled Nursing Facility) orders: Please draw requested labs every Monday: CMP (Complete Metabolic Panel), CBC (Complete Blood Count) with diff (differential), CRP (C-Reactive Protein), ESR (Erythrocyte Sedimentation Rate). Fax lab results to (number listed) within 24 hrs (hours)."<br><br>A separate sheet read: "Scheduled follow up 11/6/18. PLEASE DRAW LABS EVERY MONDAY beginning on 10/29/18. The | F 658 | IMMEDIATE CORRECTIVE ACTION<br><br>Resident #4 lab was to be drawn on 11/5/2018, the lab was drawn on 11/7/2018 and faxed to the infection disease physician.<br>Resident #1 is no longer resides in the facility.<br><br>METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED<br><br>The Director of Nursing, Assistant Director of Nursing and Nurse Managers reviewed 100% of the certified Medicare / Medicaid beds for lab orders to ensure they have been drawn or scheduled to be drawn as appropriate and that nutritional orders ( supplements / fluid restrictions) have been carried out as prescribed.<br><br>SYSTEMIC CHANGES<br><br>The DHS, Clinical Competency Coordinator and / or Nurse Managers educate the Licensed Nurses regarding routine lab orders and how to add a resident to the Residents master lab log, daily lab draw form and resulting the lab. | 12/24/18 |

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

Electronically Signed | 12/21/2018

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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| F 658 | Continued From page 1<br>medications we order can be very toxic to our patient ' s kidneys and/or liver and monitoring the labs is how we determine if we need to stop or change a medication dose. If you would, please note the following on every lab requisition: FAX LAB RESULTS TO (listed phone number) per MD (medical doctor) order."<br><br>Review of the clinical record revealed laboratory results dated 10/29/18 for the tests ordered. There were no laboratory test results for the following Monday (11/5/18). A Visit Summary from infectious disease dated 11/6/18 noted the reason for the visit was infection requiring IV (intravenous) therapy. Under Plan comments 2. Read: "Needs his labs done weekly and faxed to our office. Draw labs tomorrow if they have not been done this week yet. 3. F/u (follow-up) on 11/26/18. IV orders read: "Cefepime infuse 2GM IV every 12 hours. There were laboratory results on the record dated 11/7/18 that showed an increase in the resident ' s creatinine from 2.1 on 10/29/18 to 3.2 on 11/7/18. A lab test for creatinine is used to determine kidney function.<br><br>There was a physician ' s progress note dated 11/8/18 by the facility ' s physician that noted the resident was seen this morning for abnormal lab values. BUN (Blood Urea Nitrogen) and Creatinine elevated. No nausea or vomiting. The Plan revealed the following: "Acute Kidney Injury on Chronic Renal Insufficiency - Cr (Creatinine) 2.1 now to 3. Ordered IVF (intravenous fluids) NS (Normal Saline) times 2 liters. Repeat labs in AM tomorrow. Fax labs to RID (name of infectious disease practice) as well."<br><br>There was a Medication/Lab Order sheet dated 11/8/18 from infectious disease for Cefepime | F 658 | Labs will be added to the Residents master lab log on admission, readmission and with order changes. Daily lab draw sheet will be reviewed for completeness (lab drawn, lab resulted, physician notification of results) within twenty-four hours of scheduled draw. Labs noted not to be resulted will be identified with physician notification and lab draw rescheduled per physician order.<br>The DHS, Clinical Competency Coordinator and / or Nurse Managers educate the Licensed Nurses regarding transcribing admission / readmission orders correctly to include fluid restrictions / supplements. The Director of Nursing, Assistant Director of Nursing and/or Nurse Managers will review all admissions / readmissions within twenty-four hours to validate the physician orders have been carried out appropriately.<br><br>MONITORING PROCESS<br><br>The Director of Nursing, Assistant Director of Nursing and/or Nurse Managers will monitor the Lab Process for completeness (residents master lab log developed, lab placed on daily draw sheet, lab drawn, lab resulted, physician notification of results) within twenty-four hours of scheduled draw, weekly for four weeks then monthly thereafter.<br>The Director of Nursing will track, trend and analyze the data collected from the lab process review and report their findings to the quality assurance / performance committee monthly until three consecutive months of compliance | |

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| F 658 | Continued From page 2<br>infuse 1GM IV every 12 hours with a start date of 11/8/18 and to continue weekly labs as ordered and fax the results to the office. Review of the Medication Administration Record revealed the new reduced dose of Cefepime was carried out by the facility.<br><br>On 12/12/18 at 3:25 PM an interview was conducted with a nurse practitioner with the infectious disease practice that followed the resident. The Nurse Practitioner stated she saw the resident on 11/6/18 and his lab work had not been done on 11/5/18 as ordered but were done on 11/7/18 with an increase in his creatinine. The Nurse Practitioner stated she could not say there was any harm to the resident but would have decreased his dose of antibiotic 2 days earlier if she had the lab results on 11/6/18. The Nurse Practitioner further stated the resident ' s creatinine went up again the next blood draw and then started coming back down.<br><br>On 12/12/18 at 4:12 PM the Director of Nursing (DON) stated in an interview the labs were usually noted on the Medication Administration Record for the day the lab was to be drawn and the lab was not noted on the MAR for 11/5/18. The DON further stated she was unable to determine why the labs were not drawn on 11/5/18 but they were drawn on 11/7/18. The DON stated she would need to evaluate the process to determine where the break down occurred.<br><br>2. Resident #1 was admitted to the facility on 10/8/18 and had a diagnosis on nontraumatic intracerebral hemorrhage with acute encephalopathy, systolic heart failure and | F 658 | is sustained then quarterly thereafter.<br>The Director of Nursing, Assistant Director of Nursing and/or Nurse Managers will monitor the transcribing admission / readmission orders correctly to include fluid restrictions / supplements weekly for four weeks then monthly thereafter.<br>The Director of Nursing will track, trend and analyze the data collected from the admission / readmission transcription of physician order process review and report their findings to the quality assurance / performance committee monthly until three consecutive months of compliance is sustained then quarterly thereafter.<br><br>Date of Compliance is 12/24/18 | |

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| F 658 | Continued From page 3 | F 658 | | |

generalized weakness. Encephalopathy is a general term that means brain disease and the major symptom is an altered mental state that can have numerous causes.

Review of the hospital discharge summary dated 10/8/18 under Discharge Instructions read on the bottom of page 3: "Discharge Nutrition Therapy: General" and continued on the top of page 4 and read: "Fluid restriction 1500 ml (milliliters). No added sodium. Supplement of choice 2 times daily."

Review of the clinical record revealed no information on the Medication Administration Record, or the physician ' s orders for fluid restrictions or nutritional supplements. The admission nurse ' s note did not address the diet order, fluid restrictions or the nutritional supplements. Review of a diet order sheet dated 10/8/18 for Resident #1 noted the resident was on a regular diet with regular texture and was signed by Nurse #2. There was no information on the slip for fluid restrictions or supplements for the resident. Review of a Nutritional Screening and Assessment Form dated 10/8/18 revealed this was an initial assessment and signed by the certified dietary manager. The note revealed the resident was on a regular diet. The note did not reveal any information regarding fluid restrictions or nutritional supplements.

On 12/12/18 at 2:35 PM an interview was conducted with Nurse #3 who was the admissions nurse at the time the resident was admitted to the facility. The Nurse stated she would often get the orders prior to the resident ' s arrival to the facility and the resident would arrive after she had left for the day. The Nurse stated

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| F 658 | Continued From page 4<br>this resident arrived at 6:15 PM on 10/8/18 after she had left for the day.<br><br>On 12/12/18 at 3:33 PM an interview was conducted with Nurse #2 who admitted the resident upon arrival at the facility on 10/8/18 at 6:15 PM. Nurse #2 stated the admissions nurse (Nurse #3) wrote the medications ordered for the resident on the physician ' s order sheet but did not fill in the diet. Nurse #2 stated she did not see the order for fluid restrictions and no added sodium or the nutritional supplements on the following page or she would have written this information on the diet slip that was sent to the dietary department. The Nurse stated: "It looks like we all missed it."<br><br>On 12/12/18 at 4:14 PM the Director of Nursing reviewed the clinical record for Resident #1 and stated the nurse probably did not see the orders for nutritional supplements and fluid restrictions. | F 658 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident | F 842 | | 12/24/18 |

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| F 842 | Continued From page 5 | F 842 | | |

that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-

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| F 842 | Continued From page 6<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to maintain accurate clinical records for 1 of 3 residents reviewed (Resident #1).<br><br>The findings included:<br><br>Resident #1 was admitted to the facility on 10/8/18 and discharged from the facility on 10/12/18. The resident had a diagnosis of nontraumatic intracerebral hemorrhage with acute encephalopathy, atrial fibrillation, heart failure and coronary artery disease. Encephalopathy is a general term that means brain disease with the major symptom being altered mental state and has many causes.<br><br>Review of the October 2018 Medication Administration Record (MAR) for Resident #1 revealed the resident received the following medications by mouth on the morning of 10/13/18: Lanoxin 125 micrograms, Lactobaccilus 1 packet, Nystatin 5 milliliters swish and spit, Spironolactone 25 mg (milligrams), Valsartan 40mg, Vancomycin 2.5 milliliters and Metoprolol 100mg. The dispensing of the medications was indicated by the initials of Nurse #1. There was no | F 842 | IMMEDIATE CORRECTIVE ACTION<br><br>Resident #1 was discharged from the facility on 10/12/18.<br><br>METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED<br>The Director of Nursing, Assistant Director of Nursing and/or Nurse Management will review all residents discharged in the past 30 days to ensure medications have not be signed out post discharge time.<br><br>SYSTEMIC CHANGES<br><br>The Director of Nursing, Assistant Director of Nursing and/or Nurse Management is educating the Licensed Nurses regarding facility policy and procedure for documenting on the resident□s medication administration record. Medications are removed from the medication cart, validated with the medication administration record, a dot is | |

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| F 842 | Continued From page 7<br>documentation on the back of the MAR.<br><br>On 12/11/18 at 3:38 PM, Nurse #1 stated in an interview that during her medication pass on the morning of 10/13/18 the medications for Resident #1 were still on the medication cart and when she got to the resident ' s room, she pulled the resident ' s medications and went in to give the medications and the resident was not in the room and she remembered the resident had been discharged the day before. The Nurse stated if a resident ' s medications were not given, it was her practice to initial all the meds and then go back and circle the medications to indicate they were not given. The Nurse further stated she must have been interrupted during this time and forgot to go back and circle her initials to indicate the medications were not given.<br><br>On 12/12/18 at 4:14 PM the Director of Nursing (DON) stated in an interview had she seen the medications documented on the MAR she would have the nurse fill out a medication error form and notify the pharmacy so the resident would not be charged for the medications. The DON stated when a medication was not given, the nurse ' s initials should be circled and the reason the medications were not given documented on the back of the MAR. | F 842 | placed on each box for the medications being delivered, medication is delivered to the resident, nurse places their initials in the box for each medication. If a medication is not given the nurse will circle the medication and place an explanation as to why the medication was not given on the back of the medication administration record.<br><br>MONITORING PROCESS<br><br>The Director of Nursing, Assistant Director of Nursing and/or Nurse Managers will monitor the Medication Administration Record for compliance of nurses weekly for four weeks then monthly thereafter. The Director of Nursing will track, trend and analyze the data collected from the Medication Administration Review process and report their findings to the quality assurance / performance committee monthly until three consecutive months of compliance is sustained then quarterly thereafter.<br><br>Date of Compliance 12/24/2018 | |