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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
E 000	Initial Comments An unannounced Recertification survey was conducted 4/15/19 through 4/18/19. The facility was in compliance with requirement CFR 483.73 Emergency Preeparedness. Event ID# Z5UW11.	E 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 561		5/16/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/13/2019

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 561	Continued From page 1 Based on record review, staff interviews, resident and family interviews, the facility failed to offer and provide showers as scheduled for 1 of 2 residents (Resident #79) reviewed for choices. Findings included: Resident #79 was admitted to the facility on 3/29/19 with diagnoses that included cerebral infarction, generalized muscle weakness, and aphasia. Review of resident #79's Admission MDS (Minimum Data Set) dated 4/5/19 revealed he was assessed as being moderately cognitively impaired, able to understand others, and as being totally dependent on staff for his personal hygiene and bathing activities. Review of the shower book on 4/17/19 at 3:00pm for Resident # 79's hall revealed a sheet with room numbers and the day of the week as well as the shift that the resident room numbers were scheduled to receive showers. The shower book was noted to have dividers so that each room had its own section for documentation. When reviewing the shower book, it was noted that resident # 79's room number had a tab with the room number listed but there was no documentation in the section. Further review of the entire notebook revealed no documentation in the shower book with his name or room number. This review was verified by two different people on 4/17/19. The shower book was reviewed again on 4/18/19 and it was noted to have a sheet of paper behind the tab for Resident #79's room. The sheet of paper was a preprinted form with a drawing of a	F 561	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. IMMEDIATE CORRECTIVE ACTION On 04/19/2019 a shower was provided to Resident # 79 per their request. The shower schedule was provided to resident # 79. METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED The Director of Nursing and Nursing Management interviewed residents to ensure the residents where knowledgeable regarding their shower schedules. SYSTEMIC CHANGES On 4/18/2019 the Unit Manager reviewed the process (shower schedule for residents) with the Interim Administrator and MDS Director that identified the step put into place to ensure showers are made known to the patients and that the showers are given.	

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F 561	Continued From page 2 body and a place for narrative documentation if written. The sheet included documentation that read: "completed and total bed bath head to toe." The sheet was dated 4/16/19. During an interview with the resident and his wife on 4/15/19 at 3:38 pm, the wife stated Resident #79 had only received bed baths since his admission on 3/29/19. She further stated she didn't know he had a choice in what type of bath he could receive. She further stated it would be nice for him to get a complete shower or whirlpool bath. An interview was conducted with NA #3 on 4/17/19 a 2:10pm. NA #3 stated that she works with Resident #79 frequently and that his shower days are Monday's and Thursday's each week on first shift. She further stated when showers are given, the nursing assistants are supposed to document in the Shower Book kept at the nursing station. Additionally, she stated any skin problems noted during the shower or if the resident refused the shower would be documented on the resident's sheet. During an interview with the Unit Manager at 10:32 on 4/18/19 revealed that the shower sheets are completed and placed in the shower book anytime a shower is refused. She added the nurse has to be notified and signs the sheet noting the refusal. The unit manager reviewed the shower book and didn't see a sheet to indicate that he had received or refused a shower. She stated he should have been offered a shower on 3/29/19, 4/2/19, 4/5/19, 4/9/19, 4/12/19 and 4/16/19. Additionally, she added she had no documentation to say Resident #79 had or had not had a shower. She stated she will	F 561	Moving forward Clinical Leadership will place signs indicating the shower days for each patient in their room so upon admission each patient is aware of the day and shift shower are to be provided. In addition, shower sheets are placed in a shower book and signed by the charge nurse verifying showers were given. Shower signs are posted in the patient□s room with the days of the week and shift showers are to be received, throughout the facility. Nurse Managers will validate showers are given daily for 7 days, weekly for 4 weeks then monthly thereafter for residents. MONITORING PROCESS The Director of Health Services will track and trend the shower data and report the analysis to the Quality Assurance and Performance Improvement Committee monthly until three month of continued compliance is maintained then quarterly thereafter.	

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F 561	Continued From page 3 follow up with the nursing assistants assigned on the above listed days. An interview was conducted with nurse consultant in the absence of the administrator and director of nursing on 4/18/19 at 12:40pm. During the interview she stated she looked to see if she could find if Resident #79 had been offered a shower since his admission and she could not find anything that would indicate the resident had been offered or received a shower.	F 561		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		5/16/19

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F 640	Continued From page 4 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to transmit an annual MDS assessment within the required time frame for 1 of 3 residents (Resident #2) reviewed for MDS completion and submission activities. Findings included: Resident #2 was originally admitted to the facility on 8/20/15 with diagnoses that included repeated falls, hypertension and generalized muscle weakness. Review of Resident #2's most recent completed	F 640	IMMEDIATE CORRECTIVE ACTION On 4/18/2019 the assessment for resident # 2 was closed and submitted. METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED On 04/18/2019 the Case Mix Director reviewed Residents assessments for the past six months to validate no other assessment was late. SYSTEMIC CHANGES The Case Mix Director will continue to	

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F 640	Continued From page 5 MDS (Minimum Data Set) was coded as a quarterly assessment with an ARD (Assessment Reference Date) of 12/8/18 revealed resident #2 had impaired cognition and clear speech. A review of the most recent MDS dated 3/9/19 and coded as an annual assessment, revealed the assessment was open, and had not been closed and transmitted. During an interview with the MDS nurse on 4/18/19 at 10:47 am, she stated the assessment had been left open in error. She indicated she would close the assessment and transmit the assessment today (4/18/19). She further stated she will mark the assessment as a late assessment.	F 640	submit all assessments daily and review the resident Minimum Data Set (MDS) scheduler to ensure that all assessment have been locked and transmitted. The Case Mix Director and/or Director of Health Services will track and trend the transmission of MDS□s daily for 30 days then weekly for four weeks then month thereafter to validate the transmission of the scheduled MDS□s. MONITORING PROCESS The Case Mix Director will analysis of the MDS transmission review to the Quality Assurance and Performance Committee meeting quarterly until three consecutive months of compliance is maintained then quarterly thereafter.	
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F 655		5/16/19

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F 655	Continued From page 6 (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to complete and implement a baseline care plan in conjunction with the interdisciplinary team and failed to conduct a care plan meeting with the resident and/or resident representative for 4 of 7 sampled new admission residents (Residents #135, 139, 142 and 79). Findings included: 1.Resident #135 was readmitted on 4/5/19 with diagnoses including pleural effusion and atrial fibrillation, chronic ischemic heart disease and	F 655	IMMEDIATE CORRECTIVE ACTION Resident # 135, 139, 142 and 79 baseline care plans were completed on 04/18/2019. Social Services Director/Senior Care Partner/Nurse Manager scheduled and completed the Post-Admission Care meetings for Resident # 135, 139, 142 and 79. METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE	

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F 655 Continued From page 7

retention of urine. The most recent completed minimum data set (MDS) assessment was the discharge assessment dated 3/22/19 in which cognitive status was not assessed. Resident required extensive assistance with bed mobility, transfers, dressing, eating, toileting and personal hygiene.
Review of the baseline care plan revealed the care plan was signed as completed on 4/5/19. The Post Admission Care Conference/Care Plan meeting Date was blank. On the baseline care plan there was a preprinted area that read in part: Baseline Care Plan and Admission Physician order forms: and a box to check if reviewed with the resident and resident representative, a box to check if a copy of the baseline care plan was given to the resident and the resident representative to sign. None of the boxes were checked and there was no resident or resident representative signature on the blank space provided. Additionally, there was no documentation included on the form in the areas for people in attendance to list their names, the department, or their signatures. The care plan summary was not completed nor was there documentation a care plan meeting occurred with the resident or a resident representative.

An interview, conducted with Nurse Navigator on 4/17/19 11:02 AM revealed she was responsible for contacting residents ' families to set up care plan meetings. Nurse Navigator stated the care plan meeting for Resident #135 was not held and the meeting should have been done when she was out sick week of 4/9/19-4/11/19. The nurse navigator further stated there have been lots of admissions and it has been difficult keeping up with scheduling the care plan conferences.

F 655

AFFECTED
The Social Services Director, Nurse Navigator and/or Nurse Manager reviewed residents admitted within the past fourteen days to validate the baseline care plan was started and/or completed. The Nurse Management team will review new admission charts daily to validate the baseline care plan has been started. PAC meeting will be set either at the time of admission by the admission nurse if family is present and/or by the discharge planner.
PAC meetings/conferences will be scheduled for 72 hours after admission, per family availability.

SYSTEMIC CHANGES
The Nurse Management team will review new admission charts daily for seven days, then weekly thereafter to validate the baseline care plan has been started and completed.

The Admissions Director, Nurse Navigator, Social Services Director and/or Nurse Manager will schedule the Post-Admission Care meetings/conference with resident and/or responsible upon admission. The Post-Admission Care meetings will be scheduled for 72 hours after admission or as resident and/or family is available.

The Interdisciplinary Team will review the baseline care plan with the Resident and/or Resident�s Responsible Party and a signed copy will be provided to the Resident and/or Responsible Party at the

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F 655	Continued From page 8 An interview, conducted with the Unit Manager on 4/18/19 at 9:14 AM revealed she reviewed the baseline care plan for Resident #135 dated 4/5/19. The Unit Manager stated that since there were no signatures or a date of the conference documented on the care plan, she could not say if the care plan had been reviewed with the resident or his family. She stated that after she reviews the care plan, the nurse navigator sets up the care plan meeting, goes over the care plan with the resident and/or resident representative, gets their signature and provides the resident and resident representative a copy of the care plan. In the absence of a Director of Nursing and the Administrator, an interview was conducted with the nurse consultant on 4/18/19 at 1:30 PM. The nurse consultant stated the baseline care plan problem had been identified at the beginning of April and the Interdisciplinary Team has put a plan into place to ensure compliance. 2. Resident # 139 was admitted 3/1/19 with diagnoses including disruption of a surgical wound and Parkinson ' s disease. The admission minimum data set assessment (MDS) dated 4/1/19 revealed the resident was cognitively intact but required extensive assistance with transfers, toileting and personal hygiene. Resident was totally dependent for dressing. Review of the baseline care plan revealed the care plan was signed as completed on 3/1/19. The Post Admission Care Conference/Care Plan meeting Date was blank. On the baseline care plan there was a preprinted area that read in part: Baseline Care Plan and Admission Physician order forms: and a box to check if reviewed with the resident and resident representative, a box to	F 655	meeting. MONITORING PROCESS The Director of Nursing Services and/or Case Mix Director will review the tracking and trending obtained from the chart reviews for the baseline care plan completion and provide the analysis to the Quality Assurance and Performance Improvement Committee monthly until three consecutive months of compliance is maintained then quarterly thereafter.	

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F 655	Continued From page 9	F 655		

check if a copy of the baseline care plan was given to the resident and the resident representative to sign. None of the boxes were checked and there was no resident or resident representative signature on the blank space provided. Additionally, there was no documentation included on the form in the areas for people in attendance to list their names, the department, or their signatures. The care plan summary was not completed nor was there documentation a care plan meeting occurred with the resident or a resident representative.
On 4/15/19 at 3:20 PM, an interview was conducted with the resident and his wife. The wife stated the facility has not had a care plan meeting since Resident #139 ' s admission on 3/1/19. She further stated she wanted to be included in a care plan conference.

An interview, conducted with the Nurse Navigator on 4/17/19 11:02 AM revealed she was responsible for contacting residents ' families to set up care plan meetings. Nurse Navigator stated there has been no care plan meeting but stated she has talked with the resident ' s wife several times but unable to provide dates and times of discussions about a care plan meeting. The nurse navigator further stated there have been lots of admissions and it has been difficult keeping up with scheduling the care plan conferences.

In the absence of a Director of Nursing and the Administrator, an interview was conducted with the nurse consultant on 4/18/19 at 1:30 PM. The nurse consultant stated the baseline care plan problem had been identified at the beginning of April and the Interdisciplinary Team has put a plan into place to ensure compliance.

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F 655	Continued From page 10 3. Resident #142 was admitted on 4/1/19 with diagnoses including colon cancer with colostomy and dementia with behavioral disturbances. The admission minimum data set assessment (MDS) dated 4/12/19 revealed resident ' s short-term and long-term memory was cognitively impaired. Resident required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene. The baseline care plan was incomplete for dietary needs, therapies, social services, and colostomy care. Review of the baseline care plan revealed the care plan was signed as completed on 4/1/19. The Post Admission Care Conference/Care Plan meeting Date was blank. On the baseline care plan there was a preprinted area that read in part: Baseline Care Plan and Admission Physician order forms: and a box to check if reviewed with the resident and resident representative, a box to check if a copy of the baseline care plan was given to the resident and the resident representative to sign. None of the boxes were checked and there was no resident or resident representative signature on the blank space provided. Additionally, there was no documentation included on the form in the areas for people in attendance to list their names, the department, or their signatures. The care plan summary was not completed nor was there documentation a care plan meeting occurred with the resident or a resident representative. An interview, conducted with Nurse Navigator on 4/17/19 11:02 AM revealed she was responsible for contacting residents ' families to set up care plan meetings. The care plan meeting for Resident #142 was not held nor has the resident nor representative received a summary of the care plan. The Nurse Navigator further stated	F 655		

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there have been lots of admissions and it has been difficult keeping up with scheduling the care plan conferences.

An interview, conducted with the Unit Manager on 4/18/19 at 9:14 AM revealed she reviewed the baseline care plan for Resident #142. The Unit Manager stated that since there were no signatures or a date of the conference documented on the care plan, she could not say if the care plan had been reviewed with the resident or his family. She stated that after she reviews the care plan, the Nurse Navigator sets up the care plan meeting, goes over the care plan with the resident and/or resident representative, gets their signature and provides the resident and resident representative a copy of the care plan.

In the absence of a Director of Nursing and the Administrator, an interview was conducted with the Nurse Consultant on 4/18/19 at 1:30 PM. The nurse consultant stated the baseline care plan problem had been identified at the beginning of April and the Interdisciplinary Team has put a plan into place to ensure compliance.
4. Resident # 79 was admitted to the facility on 3/29/19 with diagnoses including cerebral infarction, muscle weakness and aphasia.

Review of Resident #79's admission minimum data set assessment (MDS) dated 4/5/19 revealed he had been assessed as being moderately cognitively impaired, as able to understand others and as being totally dependant on staff for his ADLs (Activities of Daily Living).

Review of the baseline care plan revealed the care plan was signed as completed on 3/29/19. The Post Admission Care Conference/Care Plan

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

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F 655	Continued From page 12	F 655		

meeting Date was left blank. On the baseline care plan there was a preprinted area that read in part: Baseline Care Plan and Admission Physician order forms: and a box to check if reviewed with resident and resident representative, a box to check if a copy of the baseline care plan was given to the resident and the resident representative and a space for the resident or the resident representative to sign. None of the boxes were checked and there was no resident or resident representative signature on the blank space provided. Additionally, there was no documentation included on the form in the areas for people in attendance to list their names, the department, or their signatures. The care plan summary was not completed nor was there documentation a care plan meeting occurred with the resident or a resident representative.

On 4/15/19 at 3:52 PM, an interview was conducted with the resident and his wife. The wife stated the facility has not had a care plan meeting that she was aware of since Resident #79's admission on 3/29/19. She further stated she would like to be included in a care plan conference.

On 4/18/19 at 10:32AM, the Unit Manager reviewed the baseline care plan. She stated she completed the care plan upon admission. When asked specifically if the baseline care plan had been reviewed with the resident or his family, she stated since there were not signatures or a date of the conference listed on the care plan the she could not say if it had or had not been reviewed with the resident or his family. She explained that once she completes the care plan, the nurse navigator sets up a care plan meeting, goes over the care plan with the resident and/or resident

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F 655	Continued From page 13 representative, gets their signature and provides the resident and resident representative a copy of the care plan. The Nurse Navigator was not available for interview on 4/18/19. During an interview with the social worker on 4/18/19 at 10:25 AM, she reviewed the baseline care plan. She confirmed the baseline care plan for the resident did not have signatures that are typically on the care plan and stated it may have been missed. In the absence of the Director of Nursing and the administrator, an interview was conducted with the nurse consultant on 4/18/19 at 12:29pm. The nurse consultant stated the baseline care plan problem had been identified at the beginning of April and have put a plan in place with the IDT (Inter Disciplinary Team) to ensure compliance.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		5/16/19

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F 657	Continued From page 14 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to revise and update a care plan related to falls for 1 of 16 sampled residents (Resident#15). Findings included: Resident #15 was readmitted to the facility on 9/25/18 with diagnoses that included Dementia, Hypertension and Diabetes Mellitus. Review of resident's most recent comprehensive MDS (Minimum Data Set) coded as an admission assessment with an ARD (Assessment Reference Date) of 10/2/18 revealed the resident was cognitively impaired. He had been assessed as needing with extensive assistance with his ADLs (Activities of Daily Living) except for eating. The assessment had documentation of resident being at risk for falling but had not experienced any falls since admission. His balance during transfers and walking was assessed as not steady, only able to stabilize with human assistance.	F 657	IMMEDIATE CORRECTIVE ACTION The Interdisciplinary Team updated Resident # 15 Care Plan on 04/18/2019. Moving forward, all falls will be recorded and updated on the care plan within 24 hours by the clinical team. METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED On 04/18/2019, Clinical Leadership reviewed resident□s baseline care plans and/or comprehensive care plans on each station to ensure all baseline care plans/comprehensive care plans are updated with any new changes in condition and new intervention are put into place. SYSTEMIC CHANGES During morning clinical rounds, nursing management and/or interdisciplinary team will review all incidents / falls within the	

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Continued From page 15

A review of Resident #15's active care plan revealed a care plan in place for being at risk for falls related to impaired balance, frequent incontinence of bladder and bowel and use of psychotropic medication.

The onset date of the problem on the fall care plan was 10/5/18. The goal listed for the problem on the fall care plan read n part: will have decreased number of falls through next review.

The fall care plan had a date listed under the problem (handwritten) of 10/23/18 and a statement to continue POC (Plan of Care) times 90 days. The care plan had an additional entry handwritten under the listed problem with a date of 1/22/19 and a statement to continue POC times 90 days. The care plan had been updated with each fall and interventions were added as appropriate. However; the goal remained the same even though he did not meet the goal written.

During a review of the resident's medical record, there was no documentation that the resident had experienced a fall between his most recent assessment dated 10/2/18 and the care plan problem onset date of 10/5/18.
Further review of the medical record revealed resident #15 experienced a fall on 10/9/18, 11/8/18, 11/30/18, 12/22/18, and 1/11/19.

During an interview with the MDS nurse on 4/17/19 at 3:47 pm, she stated that the care plan goal listed on the fall care plan should not have been continued. She further stated it should have been revised since Resident #15 continued to fall and did not meet the goal of having

F 657

past 24 hours to ensure the baseline/comprehensive care plan was updated and/or update the care plan with intervention(s) as necessary.

The nurse management team and/or interdisciplinary team will continuously update care plan and validate start/completion of the baseline care plan within 24 hours of admission.
The nurse management team and/or interdisciplinary team reviews for any change in status, medication, and falls/occurrences as indicated, and continue to revise and update interventions for the patient needs as appropriate to continually meet goals set for patients.

MONITORING PROCESS
The Director of Nursing Services and/or Case Mix Director will review the tracking and trending obtained from the chart reviews for the baseline care plan completion and provide the analysis to the Quality Assurance and Performance Improvement Committee monthly until three consecutive months of compliance is maintained then quarterly thereafter.

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F 657	Continued From page 16 decreased number of falls with the last two care plan reviews. Additionally, she added she would revise to care plan to include a reasonable goal for his falls.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Base on observations, interviews and record reviews, the facility failed to provide proper positioning for 1 of 2 sampled residents reviewed for falls (Resident #138). Findings included: Resident #138 was admitted on 8/22/13 with diagnoses including chronic pain syndrome, chronic kidney disease, abnormal posture and repeated falls. Review of the annual minimum data set assessment (MDS) dated 1/22/19 revealed the resident required extensive assistance with bed mobility, transfers, dressing, eating, toileting, and personal hygiene. On 4/15/19, observations were made at 1:20 PM and 4:20 PM of the resident sitting in a wheelchair, at the dining room table in a common area, slumped over to the right side. Multiple staff walked by the resident during the observations.	F 684	IMMEDIATE CORRECTIVE ACTION The Occupational Therapist evaluated resident # 138 on 4/17/2019. On 4/18/2019, Occupational Therapy provided in-service to staff about positioning of resident # 138 in their wheelchair. METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED The Director of Nursing and Nurse Managers visualized all residents in wheelchairs on 4/18/2019 to identify any other residents who may be leaning in their chairs. 0 of 50 residents were identified and referred to therapy for positioning. SYSTEMIC CHANGES	5/16/19

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F 684	Continued From page 17 On 4/16/19 at 9:00 AM observations were made at 9:00 AM, 9:45 AM and 10:20 AM of the resident sitting in a wheelchair, at the dining room table in the common area, slumped over to the right side. At 9:45 AM, a nurse aide offered resident sips of water while resident was sitting in the wheelchair slumped over. The NA did not attempt to reposition the resident. At 10:20 AM, another resident got a folded sheet from the laundry cart, doubled the sheet and placed it under resident ' s right arm while telling the resident she wanted to help her sit up straighter. Review of resident ' s care plan revealed the following events with revisions to resident ' s care plan: On 11/16/18 the resident slid off her chair to the floor. A Dycen was added to the wheelchair. On 1/1/19 resident fell. Physical therapy evaluated for posture. On 1/12/19 resident attempted to stand unassisted and fell. Staff were to offer naps in the afternoon. On 1/16/19 resident fell with injury. Staff were to place resident by the table and offer activities. On 2/11/19 resident fell after dinner. Staff were to assist resident to bed right after dinner. Incident reports for falls, dated 11/15/18, 12/31/18 and 2/11/19 were reviewed. On 11/18/19, resident was found on the floor in her room with the wheelchair behind her. A Dycen was added to her wheelchair to prevent sliding. On 12/31/18, resident was pushing back from the table in the dining room and fell out of her wheelchair. A referral for physical therapy to evaluate for positioning was made. On 2/11/19 the resident fell attempting to get out of the wheelchair unassisted. Care planned to assist resident to bed right after dinner.	F 684	On 04/18/2019, the Clinical Competency Coordinator educated the Nursing staff regarding proper positioning of residents while they are in their chairs to assist in positioning and prevention of skin integrity concerns. The Clinical Competency Coordinator also educated staff to observe residents for the need of rest periods throughout the day. The Director of Nursing and/or Clinical Competency Coordinator will observe residents in chairs for proper positioning daily for 7 days, then weekly for four weeks, then monthly thereafter. The Director of Nursing and /or Clinical Competency Coordinator will track and trend the data of the positioning observation and compare the resident not positioned appropriately to validate a therapy referral has been completed. MONITORING PROCESS The Director of Nursing Services will present the analysis of the resident positioning/therapy referral to the Quality Assurance Performance Improvement Committee monthly until three consecutive months of compliance is maintained then quarterly thereafter.	

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F 684	Continued From page 18 An interview, conducted with the RN Case Mix Director (CMD) on 4/17/19 at 10:15 AM, revealed the resident has had multiple falls. RN CMD stated she had not noticed the resident slumped over in her wheelchair. She stated that during the last comprehensive assessment on 1/22/19, resident was not assessed to have altered positioning while in the wheelchair. An interview, conducted with the Occupational Therapist (OT) on 4/18/19 at 10:38 AM, revealed that staff made a referral on Resident #135 on 4/17/19 for leaning. The OT evaluation was completed the same day and revealed the right armrest on the wheelchair was tilted. OT adjusted the armrest. Bilateral elevating leg rests were added to the wheelchair. OT recommended to staff that resident be assisted back to bed late in the afternoon. Leg rests should be used on the wheelchair at all times. When resident demonstrates fatigue, she needs to go to bed. OT stated she conducted an in-service for staff specific to the resident and correct positioning for her. In the absence of a Director of Nursing and the Administrator, an interview was conducted with the nurse consultant on 4/18/19 at 1:30 PM. The nurse consultant stated staff should have addressed the resident ' s positioning when observed.	F 684		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:	F 732		5/16/19

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F 732	Continued From page 19 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to post the Daily Nursing Hours that reflected the census and staffing numbers for 2 of 4 days reviewed for sufficient staffing.	F 732	IMMEDIATE CORRECTIVE ACTION Clinical Leadership corrected any Nursing Staffing Postings to accurately reflect physical clinical care provided in the facility.	

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F 732	Continued From page 20 Findings included: It was observed on 4/15/19 that the posting for the Daily Nursing Hours was in the hallway of station 2 bulletin board. The census was 104 with each nursing numbers and hours for each shift were posted. An observation for the next two days on 4/16/19 and 4/17/19 were not posted. The posted daily nursing hours were as the same sheet dated 4/15/19. Further observation of the plastic sheet protector, there was only one sheet posted and there were no other sheets behind the daily nursing hours. On 4/18/19 at 11 AM the Daily Nursing Hours Form was checked and there was a new one posted with the correct date. An interview with the Director of Nursing (DON) and the NA Scheduler was conducted on 4/18/19 at 11:07 AM. The DON stated that the NA Scheduler was the one responsible for posting and changing the daily nursing hours. The DON also stated that she was the other back up for making sure the daily posting was in place. The NA scheduler stated that she was called back to work from vacation and she thought that the posting was changed daily. Interview with the Regional Nurse Consultant was conducted on 4/18/19 at 1:20 PM. She stated that the Daily Nursing Hours Form should be posted daily that reflects the census and staffing of the facility.	F 732	METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED Clinical Leadership began reviewing the clinical daily staffing hours each morning to ensure the correct staffing numbers are posted for the current day. SYSTEMIC CHANGES Clinical Leadership and/or the nurse scheduler, will ensure that the daily nursing hours and census is posted to reflect the current day. The Director of Health Services will track and trend the daily staff postings daily for seven days, then weekly for four weeks, then monthly thereafter to validate accuracy. MONITORING PROCESS The Director of Health Services will present the analysis of the daily nursing hours posting to the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained, then quarterly thereafter.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		5/16/19

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§483.45(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-

§483.45(d)(1) In excessive dose (including duplicate drug therapy); or

§483.45(d)(2) For excessive duration; or

§483.45(d)(3) Without adequate monitoring; or

§483.45(d)(4) Without adequate indications for its use; or

§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, Physician interview and record review, the facility failed to monitor and follow up the digoxin level as ordered by the Physician for 1 of 5 residents (Resident #25) reviewed for unnecessary medication.

Findings included:

Resident #25 was admitted in the facility on 2/14/19 with a diagnosis of Atrial Fibrillation and Hypertension.

Record review revealed the resident was on digoxin 0.125mg every day since admission. The discharged orders from the hospital included

F 757

IMMEDIATE CORRECTIVE ACTION
The Physician discontinued identified labs for resident # 25 on 04/16/2019.

METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED
On 04/18/2019, the Director of Health Services/Nurse Managers and Licensed Nurses reviewed physician orders within the past 30 days for diagnostic orders to ensure all labs were drawn, resulted and physician had reviewed.

Systemic Changes

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F 757	Continued From page 22 digoxin 0.125mg. The physician ordered a laboratory test on 4/3/19 for CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel), Digoxin level, Valproic Acid level and TSH (Thyroid-Stimulating Hormone). The laboratory result was received by the facility on 4/5/19 with no result of the Digoxin level. Interview with the RN #2 was conducted on 4/17/19 at 2:52 PM. She stated that the night nurses were the ones responsible for making sure the laboratory test was done. She also stated that she can't find the digoxin result in the chart. Interview with the Physician was conducted on 4/18/19 at 12:21 PM. The Physician stated that the facility was expected to follow his orders as written. He further stated that the Digoxin level test was not done, and he didn't know where the breakdown was. An interview with the Director of Nursing (DON) was conducted on 4/18/19 at 12:25 PM. The DON stated the night shift nurses were the ones to make sure the request was filled, and the requisition form she reviewed was marked for all including Digoxin level, but the test was not done in the laboratory. She stated that the receiving nurse should have compared the requisition and the result to check all the laboratory tests requested were done. Interview with the Regional Nurse Consultant was conducted on 4/18/19 at 1:47 PM. She stated that she expected the nurses would check and compare the laboratory testing results with the	F 757	The Clinical Competency Coordinator began educating the Licensed Nurses on 04/18/2019 related to ordering and resulting laboratory blood work. This included ordering, completing requisition sheet, placing lab on daily lab log, resulting lab on daily lab log and verifying all labs were completed daily per the daily lab log. Labs results are checked for accuracy before Physician notification and placing the lab results in the Physician Communication Book. Notification to Physician and Laboratory of any labs not returned in an appropriate timeframe for labs drawn. The Director of Nursing/Nurse Managers will review the daily lab log for tracking and trending of daily lab orders have been resulted and discrepancies have been reported to the diagnostic laboratory company and physician if applicable. MONITORING PROCESS The Director of Nursing Services will present the analysis of the diagnostic laboratory review to the Quality Assurance Performance Improvement Committee monthly until three consecutive months of compliance is maintained then quarterly thereafter.	

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 757	Continued From page 23 Physician orders to make sure the order was completed.	F 757		