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 02/05/2021

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
E 000	Initial Comments The survey team entered the facility on 02/02/21 to conduct an unannounced COVID-19 Focused Infection Control survey and a Complaint Investigation. The survey team was onsite 02/02/21 and 02/03/21. Additional information was obtained offsite on 02/04/21 and 02/05/21. Therefore, the exit date was 02/05/21. The facility was found in compliance with the requirement 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID#50II11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 02/02/21 to conduct an unannounced COVID-19 Focused Infection Control survey and a Complaint Investigation. The survey team was onsite 02/02/21 and 02/03/21. Additional information was obtained offsite on 02/04/21 and 02/05/21. Therefore, the exit date was 02/05/21. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID#50II11. 14 of the 14 complaint allegations were not substantiated.	F 000		
F 655 SS=D	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	F 655		3/5/21

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

Electronically Signed | 02/19/2021

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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.
(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:

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F 655	Continued From page 2 Based on record review and staff interviews the facility failed to develop and implement a baseline care plan within 48 hours of admission that included goals and interventions to provide effective pain management and person centered care for 1 of 1 sampled residents (Resident #3) admitted with medication orders for treatment of severe pain. Findings included: Resident #3 was admitted to the facility on 11/05/20 with diagnoses that included in part; psoas muscle abscess (collection of pus, or infection around the muscle located in the lower lumbar region of the spine, extending through the pelvis to the femur), MRSA (methicillin resistant staphylococcus aureus), deep vein thrombosis, and anemia. A review of the physician orders dated 11/05/20 revealed orders for Oxycodone 10mg (milligrams) administer one tablet by mouth every 4 hours as needed for severe pain. Gabapentin 300 mg administer one tablet three times a day for pain, and Lidocaine medicated patches, apply one patch daily for pain. Record review of the baseline care plan revealed there was no initial 48-hour baseline care plan implemented with measurable goals and interventions regarding pain management. An interview was conducted on 02/03/21 at 4:00 PM with the MDS (Minimum Data Set) nurse along with the Nurse Navigator. The MDS nurse stated the admitting nurse was responsible for completing the baseline care plan within 48 hours of admission and the MDS nurse completed the comprehensive care plan after completion of the comprehensive assessment. They both agreed	F 655	This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. 1. Resident #3 is no longer in the facility. 2. Base line care plans for new admissions in past 30 days have been audited for pain management. Pain management has been added to those care plans as indicated. Audit will be completed on 2/28/2021 by DON/ADON. New admission base line care plans will be audited to include pain management as indicated, by DON/ADON 5x/weekx4 weeks then weekly x4 weeks then monthly x3 months. 3. Licensed Nurses educated on base line care plans to include pain management by DON/ADON on 2/17/2021. Education will be incorporated in the orientation process. 4.The DON/ADON will report all findings to the Quality Assurance Quality Improvement committee monthly. Date of Compliance March 5, 2021	

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F 655	Continued From page 3 that pain management should have been included on the baseline care plan for Resident #3 due to his admitting diagnoses and his medication orders. In an interview with the Director of Nursing on 02/03/21 at 4:15 PM, she acknowledged that pain management was not included on Resident #3's baseline care plan and agreed that a care plan regarding pain management with measurable goals and interventions should have been included on the baseline care plan.	F 655		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (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. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident 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	F 842		3/5/21

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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-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 5 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Consultant Pharmacist and Physician interviews the facility failed to maintain an accurate Medication Administration Record (MAR) by not documenting the administration of a prescribed as needed controlled opioid medication (Oxycodone 10 milligrams) on the MAR after signing it out on the Controlled Drug Record for 1 of 1 sampled residents (Resident #3). Findings included: The facility policy titled; Medication Administration Guidelines revised 04/10/19 read in part; licensed personnel records the administration on the residents MAR at the time the medication is given. At the end of each medication pass, the person administering the medications reviews the electronic MAR to ascertain that all necessary doses were administered and all administered doses were documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. Resident #3 was admitted to the facility on 11/05/20 with diagnoses that included in part; psoas muscle abscess (collection of pus, or infection around the muscle located in lower lumbar region of the spine, extending through the pelvis to the femur), MRSA (methicillin resistant staphylococcus aureus), deep vein thrombosis, and anemia. The Minimum Data Set (MDS) admission assessment dated 11/07/20 documented	F 842	1. Resident #3 is no longer in the facility. 2. Current residents MAR□s and narcotic count sheets audited by DON/ADON for documentation of narcotic administration. Audit will be completed by 02/28/2021 MAR□s and narcotic count sheets will be audited 5x/week x4 weeks then weekly x4 weeks, then monthly x3 months by DON/ADON. 3. Licensed Nurses educated on proper documentation of narcotics on MAR and narcotic sheets by DON/ADON on 02/17/2021. Education will be incorporated in the orientation process. 4.The DON/ADON will report findings to the Quality Assurance Quality Improvement Committee monthly. Date of Compliance March 5, 2021	

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Resident #3 was cognitively intact. He required extensive two-person assistance with bed mobility and transfers, and extensive one-person assistance with walking, dressing, and personal hygiene. He received scheduled and as needed pain medications.

Record review revealed a physician's order dated 11/05/20 for Oxycodone 10 mgs (milligrams) administer one tablet by mouth every four hours as needed for severe pain.

Record review of the Controlled Drug Record declining inventory count revealed six doses of Oxycodone 10 mgs were signed out and removed from the inventory for Resident #3 on 11/06/20.

A review of the MAR revealed only four doses of Oxycodone 10 mgs were documented as administered to Resident #3 on 11/06/20 the administration times were 2:48 AM, 8:39 AM, 12:20 PM, and 10:02 PM.

Record review of the Controlled Drug Record declining inventory count revealed four doses of Oxycodone 10 mgs were signed out and removed from the inventory for Resident #3 on 11/07/20.

A review of the MAR revealed only three doses of Oxycodone 10 mgs were documented as administered to Resident #3 on 11/07/20 the administration times were 9:15 AM, 2:37 PM, and 11:43 AM.

Record review of the Controlled Drug Record declining inventory count revealed four doses of Oxycodone 10 mgs were signed out and removed from the inventory for Resident #3 on 11/08/20.

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A review of the MAR revealed only three doses of Oxycodone 10 mgs were documented as administered to Resident #3 on 11/08/20 the administration times were 5:05 AM, 11:42 AM, and 9:31 PM.

Record review of the Controlled Drug Record declining inventory count revealed five doses of Oxycodone 10 mgs were signed out and removed from the inventory for Resident #3 on 11/09/20.

A review of the MAR revealed only two doses of Oxycodone 10 mgs were documented as administered to Resident #3 on 11/09/20 the administration times were 5:13 AM, and 9:42 PM.

Record review of the Controlled Drug Record declining inventory count revealed six doses of Oxycodone 10 mgs were signed out and removed from the inventory for Resident #3 on 11/10/20.

A review of the MAR revealed only two doses of Oxycodone 10 mgs were documented as administered to Resident #3 on 11/10/20 the administration times were 1:46 AM, and 6:00 AM.

Record review of the Controlled Drug Record declining inventory count revealed four doses of Oxycodone 10 mgs were signed out and removed from the inventory for Resident #3 on 11/11/20.

A review of the MAR revealed only two doses of Oxycodone 10 mgs were documented as administered to Resident #3 on 11/11/20 the administration times were 9:30 AM, and 3:13 PM.

Record review of the Controlled Drug Record declining inventory count revealed four doses of Oxycodone 10 mgs were signed out and removed

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from the inventory for Resident #3 on 11/12/20.

A review of the MAR revealed only three doses of Oxycodone 10 mgs were documented as administered to Resident #3 on 11/12/20 the administration times were 9:34 AM, 2:17 PM, 10:42 PM.

Record review of the Controlled Drug Record declining inventory count revealed five doses of Oxycodone 10 mgs were signed out and removed from the inventory for Resident #3 on 11/13/20.

A review of the MAR revealed only three doses of Oxycodone 10 mgs were documented as administered to Resident #3 on 11/13/20 the administration times were 3:54 AM, 2:33 PM, 11:10 PM.

Record review of the Controlled Drug Record declining inventory count revealed five doses of Oxycodone 10 mgs were signed out and removed from the inventory for Resident #3 on 11/14/20.

A review of the MAR revealed only two doses of Oxycodone 10 mgs were documented as administered to Resident #3 on 11/14/20 the administration times were 5:54 AM, and 9:05 PM.

Record review of the Controlled Drug Record declining inventory count revealed five doses of Oxycodone 10 mgs were signed out and removed from the inventory for Resident #3 on 11/15/20.

A review of the MAR revealed only two doses of Oxycodone 10 mgs were documented as administered to Resident #3 on 11/15/20 the administration times were 2:32 AM and 9:20 PM.

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Record review of the Controlled Drug Record declining inventory count revealed five doses of Oxycodone 10 mgs were signed out and removed from the inventory for Resident #3 on 11/16/20.

A review of the MAR revealed only two doses of Oxycodone 10 mgs were documented as administered to Resident #3 on 11/16/20 the administration times were 2:16 AM and 10:14 PM.

Record review of the Controlled Drug Record declining inventory count revealed six doses of Oxycodone 10 mgs were signed out and removed from the inventory for Resident #3 on 11/17/20.

A review of the MAR revealed only four doses of Oxycodone 10 mgs were documented as administered to Resident #3 on 11/17/20 the administration times were 2:25 AM, 1:54 PM, 6:32 PM, 10:37 PM.

Record review of the Controlled Drug Record declining inventory count revealed five doses of Oxycodone 10 mgs were signed out and removed from the inventory for Resident #3 on 11/18/20.

A review of the MAR revealed only one dose of Oxycodone 10 mgs was documented as administered to Resident #3 on 11/18/20 the administration time was 8:57 PM.

Record review of the Controlled Drug Record declining inventory count revealed three doses of Oxycodone 10 mgs were signed out and removed from the inventory for Resident #3 on 11/19/20.

A review of the MAR revealed only one dose of Oxycodone 10 mgs was documented as

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administered to Resident #3 on 11/19/20 the administration time was 2:18 AM.

In an interview with the Director of Nursing (DON) on 02/03/21 at 11:00 AM, she reviewed the Controlled Drug Record for Resident #3 along with the MAR and agreed the Controlled Drug Record documentation when the Oxycodone was signed out by the nurse and the documentation on the MAR that the medication was administered did not reconcile.

Further review of the Controlled Drug Record of the Oxycodone 10 mg inventory count for Resident #3 revealed the nurse's signatures that signed out the medication on the dates that did not reconcile with the MAR were not legible.

In a follow up interview on 02/03/21 at 12:00 PM the DON provided the names of the nurses who signed out the Oxycodone 10 mgs as needed for Resident #3 and did not document the doses on the MAR. It included nurse #8, #1, #3, #9, and nurse #12.

An interview was conducted on 02/03/21 at 1:40 PM with Nurse #8. She stated she was the wound treatment nurse but did take call and may get called in to take a resident assignment at times. She reported that she was called in to work on the medication cart the day she signed out the Oxycodone for Resident #3. She stated she was sure she administered the pain medication if she signed it out on the Controlled Drug Record sheet, but she just forgot to complete the documentation on the MAR.

A phone interview was conducted on 02/03/21 at 3:00 PM with Nurse #1. She stated she worked at

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the facility for a year, but she did not recall Resident #3. She stated he would have been on the quarantine hall during his stay if he was a new admission. She reported that the rehab unit was a very busy unit and many of the residents were on IV (intravenous) antibiotics, some received wound treatments, and the nurses may have to complete the wound treatments or complete the admission process if that nurse was not available. She reported the rehab unit also had and heavy medication pass. She stated if she signed off Oxycodone, she would have administered it and just forgot to sign the MAR due to being busy and stated that was no excuse, but it was a busy assignment. She stated if a resident was on IV medications then that would require documentation every shift, and she always tried to document the pain assessment as well as when pain medications were administered in the resident's progress notes. She stated if a resident asked for pain medications and she was extremely busy she would look at the narcotic book (Controlled Drug Record) to see when it was last given and sign off the dose and then she would just forget to go to the MAR and document. She stated she knew for sure she would have administered the medication if she signed it out on the Controlled Drug Record sheet.

A phone interview was conducted on 02/04/21 at 9:24 AM with Nurse #3. She stated she did not recall Resident #3. She stated there were many residents that came in and out on the rehab hall combined with him being in the facility for only 14 days made it difficult for her to remember his care needs. She stated if a medication was not documented on the MAR after she administered the medication it would have been due to her being rushed and then just forgot to document it

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on the MAR. She stated that if she signed off the Oxycodone 10 mgs for Resident #3 on the Controlled Drug Record, then she did administer the medication to Resident #3 but just forgot to go back and document it on the MAR.

A phone interview was conducted on 02/04/21 at 10:16 AM with Nurse #9. She stated she worked at the facility for over a year and recalled Resident # 3's name but not all of his health needs. She reported that she did remember pain being an issue for him but didn't remember the cause of his pain. She stated although pain was an issue for him, she thought his pain medications were effective because she didn't remember him ever voicing to her that his pain was not controlled. She recalled that he was alert and oriented and could voice his needs. She stated if she signed off on the narcotic sheet (Controlled Drug Record) that she removed Oxycodone 10 mgs for Resident #3 but then didn't document it on the MAR then it was due to just being busy with her assignment and not remembering to sign the MAR. She reported that she knew she was supposed to sign off on the MAR once the medication was administered, and stated it was a terrible mistake but attested that if her name was on the Controlled Drug Record sheet then she did give the medication to the resident.

An attempt was made on 02/04/21 to call Nurse #12 who no longer worked at the facility. The phone number was invalid. The DON stated it was the only contact number they had record of.

In an interview on 02/03/21 at 3:50 PM, the DON explained that the nurses were required to sign out a controlled medication on the Controlled

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 02/05/2021

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
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Drug Record when it was removed from the inventory, then once the medication was given the nurse documents on the MAR that they administered the medication. During shift change a second nurse signed off on the Controlled Drug Record sheet with the off going nurse to reconcile the medication count, and stated pharmacy reviewed the Controlled Drug Record as well. The DON stated she expected the documentation on the MAR to match the documentation on the Controlled Drug Record Count Sheet.

An interview was conducted with the Administrator on 02/03/21 at 5:15 PM he stated he expected that all medications were accurately documented on the Medication Administration Record.

A phone interview was conducted on 02/04/21 at 11:00 AM with the facility physician (Physician #1). He reported he was not aware of any concerns regarding medication administration at the facility and stated none of the residents had voiced any concerns to him regarding not getting their medications.

During a phone interview with the facility Consultant Pharmacist on 02/04/21 at 11:54 AM he acknowledged Resident #3 had an order for Oxycodone 10 mgs to be administered as needed for severe pain during his stay at the facility. He stated the initial medication review was conducted by the Pharmacist on 11/07/20 to verify the medication orders, then a comprehensive medication review would be conducted within 30 days of admission however, Resident #3 was only in the facility for 14 days. He reported he was not aware of any concerns with medication administration at the facility.

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