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 01/31/2022

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 An unannounced recertification survey was conducted in conjunction with a complaint and Focused Infection Control survey on 1/24/22 through 1/31/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RQY311.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted in conjunction with a complaint and Focused Infection Control survey on 1/24/22 through 1/31/22. Ten (10) of the 47 complaint allegations were substantiated. Event ID # RQY311.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		2/27/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/24/2022

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 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff, and resident interviews the facility failed to knock and/or announce entry before entering a resident ' s room which made the resident feel bad. This was evident for 1 of 3 observations of Resident #76. Findings included: Resident #67 was admitted to the facility on 06/24/2021 with diagnoses that included cerebral infarction. Review of a minimum data set (MDS) assessment dated 12/03/21 identified that Resident #76 ' s cognitive status was intact. During an interview with Resident #76 on 01/25/22 at 11:43 am a housekeeping staff	F 550	Housekeeping #1 and NA #5 was in serviced on 1/28/2022 by Director of Health Service for knocking on the door and announcing self before entering. Resident #76 was notified on 1/28/22 about staff education on knocking on door and/or announcing self before entering resident□s room. All residents have the potential to be affected with deficiencies. Director of Health Services (DHS) and nurses on the floor did audits on 10 resident rooms which was completed on January 28, 2022. All partners were noted to knock and announce themselves before entering room.	

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F 550	Continued From page 2 member (HS #1) was observed to walk into the resident ' s room without knocking and / or announcing himself. HS #1 staff member walked in the room, placed two trash cans down by the bed side table and walked out of the room. During this same interview a second observation was observed of a nursing assistant (NA #5) who walked into Resident #76 ' s room without knocking or announcing themselves. NA #5 placed a bed sheet on Resident #76 bed side table and walked out of the room. HS #1 and NA #5 did not address the resident upon entering the room but did upon exiting the room. The resident indicated this happened all the time and it made her feel bad. An interview with NA #5 at 11:56 am, on 01/25/22, NA #5 stated she knocked on the door, but it was a soft knock. NA #5 stated she knew someone was in the room with the resident because staff told them outside of the door. An interview was conducted with HS #1 on 01/26/22 at 11:42 am. HS #1 indicated he knocked on Resident #76 ' s door before he placed the trash cans in her room. HS #1 stated he always knocked on resident's doors when he cleaned their rooms. On 01/28/22 at 11:30 am an interview was conducted with the Director of Nursing who stated that all staff were required to knock and or announce themselves before entering a residents' room. On 01/31/22 at 10:00 am an interview was conducted with the Administrator, He indicated that all staff were required to announce themselves and knock before going into any	F 550	All facility staff were in serviced on 1/28/22 and 2/22/22 by Director of Health Services and Clinical Competency Coordinator on knocking on doors and/or announce before entering resident□s room. Any staff member that was not in serviced will be in serviced prior to start of next scheduled shift. This education has been added to the general orientation of all newly hired staff. Weekly audits by Director of Health Services, Clinical Competency Coordinator, and/or Unit Manager was started on 2/22/22 which will include 10 observations weekly on staff knocking on door and/or announce before entering rooms for four weeks, then 10 observation per month for 4 months then quarterly thereafter until compliance achieved. The Director of Health Services will track, trend and analysis the knocking on door audits tools monthly and will present the analysis of the audit to the Administrator during the monthly Quality Assurance and Performance Improvement Committee meeting. Audit tools will be reviewed monthly times three (3) months by DHS and/or designee and during the monthly Quality Assurance and Performance Improvement Committee meeting. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance.	

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F 550	Continued From page 3 resident's room. The Administrator stated he would follow up with all staff about knocking on resident ' s doors.	F 550	Date of Compliance will be 2/27/2022	
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed	F 636		2/27/22

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F 636	Continued From page 4 on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete an admission minimum data set assessment (Resident #4), a significant change minimum data set assessment (Resident #12) and 2 annual minimum data set assessments (Resident #13 and Resident #15) within the required time frames. This was evident for 4 of 40 minimum data set assessments reviewed. Findings Included:	F 636	The plan of correction for the specific deficiency: Resident #4 will have an Admission Assessment completed on 2/24/2022 by the Case Mix Director. Resident #12 had a Significant Change Assessment completed on 2/1/2022. Resident #13 had an Annual Assessment completed on 1/27/2022. Resident #15 had an Annual Assessment completed on 2/4/2022. Resident #195 had an Admission Assessment completed on 2/4/2022. Processes that led to deficiency	

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F 636	Continued From page 5 1.Resident #13 was admitted to the facility on 5/3/19 and diagnoses included cerebral vascular accident. Review of the minimum data set (MDS) for Resident #13 revealed he had an annual MDS with an assessment reference date of 11/27/21 that had been completed on 1/28/22. The previous completed annual MDS was on 12/7/20. An interview on 1/28/22 at 1:06 pm with the MDS Nurse revealed the annual MDS dated 1/28/22 for Resident #13 was completed late. An interview on 1/31/22 1:55 pm with the Administrator revealed the facility had identified they were behind on completing MDS assessments and they were in the process of getting them caught up. 2.Resident #12 was admitted to the facility on 5/27/21 and diagnoses included renal failure and diabetes. Review of the MDS ' s for Resident #12 revealed he had a significant change MDS with an assessment reference date of 11/3/21 that was not completed. An interview on 1/28/22 at 1:06 pm with the MDS Nurse revealed the significant change MDS for Resident #12 should have been completed by the assessment reference date and was late. An interview on 1/31/22 1:55 pm with the Administrator revealed the facility had identified they were behind on completing MDS assessments and they were in the process of getting them caught up.	F 636	cited attributed to change in MDS and shift in administrative nursing duties. The facility will identify other residents having the potential to be affected by the same deficient practice by: An audit conducted by the Case Mix Director of 100% of all current residents to ensure an admission, significant change or annual was completed within 14 days per RAI guidelines. This audit was completed on 2/23/2022. Twenty-two residents were noted as affected by comprehensive assessments not completed timely. Focus will be on completing current comprehensive assessments timely, and completing 1 late comprehensive assessment per week until late assessment log is complete beginning 2/25/2022. Systemic changes made to ensure this deficient practice will not occur: Education was provided to the Case Mix Director re: timely completion of the MDS on 2/22/2022. Case Mix Director and IDT were educated on RAI guidelines by Regional Clinical Reimbursement Consultant on completing Admission, Significant Change and Annual Assessments within 14 days per RAI guidelines starting 1/31/2022- 2/27/2022. This education will be provided to newly hired IDT members and those newly providing remote assistance to the center. Obtain assistance from other Case Mix Directors/Case Mix Coordinators in the region as needed. An audit tool was created utilizing the Assessment Due	

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F 636	Continued From page 6	F 636		

3.Resident #4 was admitted on 2/28/18 and diagnoses included coronary heart disease and Alzheimer ' s Disease.

Review of the MDS ' s for Resident #4 revealed she had an admission assessment with an assessment reference date of 12/13/21 that was not completed.

An interview on 1/28/22 at 1:06 pm with the MDS nurse revealed the admission assessment dated 12/13/21 should have been completed within 14 days of admission and it was late.

An interview on 1/31/22 1:55 pm with the Administrator revealed the facility had identified they were behind on completing MDS assessments and they were in the process of getting them caught up.

4.Resident #15 was admitted to the facility 9/25/20 and diagnoses included coronary artery disease and Alzheimer ' s Disease.

Review of the MDS ' s for Resident #15 revealed an annual assessment with an assessment reference date of 11/10/21 was not completed. The last completed comprehensive assessment was a significant change dated 11/9/20.

An interview on 1/28/22 at 1:06 pm with the MDS nurse revealed the annual assessment dated 11/10/21 for Resident #15 had not been completed and was late.

An interview on 1/31/22 1:55 pm with the Administrator revealed the facility had identified they were behind on completing MDS

Report to monitor residents scheduled for an Admission, Significant Change (weight loss) and Annual assessment.

How will the corrective action be monitored to ensure that solutions are sustained: The Case Mix Director will review the audit tool weekly x4, twice a month x 4 and monthly x 4. A list of all completed assessments will be given to the Administrator daily by the Case Mix Director and kept in a binder in the MDS office. The Case Mix Director will provide tracking and trending tools to the QAPI committee. The Administrator or designee will review the POC in the monthly QAPI meeting for 3 months or until compliance is achieved. Changes will be made to the plan by the committee as indicated to include, but not limited to, further education and or immediate corrective action.

Date of Compliance: 2/27/2022

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F 636	Continued From page 7	F 636		

assessments and they were in the process of getting them caught up.

5. Resident #195 admitted to the facility on 12/23/21 and had a history of dementia, blindness, and COVID-19.

Resident # 195 ' s admission minimum data set (MDS) had an assessment initiated with a reference date of 12/25/21 that had not been completed. The completion date should have been 1/5/22.

On 1/28/22 at 11:39 AM an interview was conducted with MDS Coordinator, and it was indicated Resident # 195 ' s admission MDS should have been completed on 1/5/22. She indicated they were behind with the MDS and was in the process of getting caught up. The MDS Coordinator indicated she was the only MDS nurse for the facility right now and had been "pulled into different roles in the facility". She indicated they had created a system to get the assessments caught up. She also indicated she was out with COVID-19 last week prior to the survey.

On 1/28/22 at 11:51 AM an interview was conducted with the facility Administrator, and it was indicated under the current circumstances, due to the COVID outbreak in the facility they were behind in completing the MDS assessments. He indicated the facility had received help from the corporate office and was working to get the assessments caught up. Administrator stated, "the rules say they should be done timely; however, they did the best they could due to the circumstances at hand".

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F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed complete quarterly minimum data set (MDS) assessments within the required time. This was evident for 2 of 40 MDS assessments reviewed (Resident #14 and Resident #4). Findings Included: 1.Resident #14 was admitted 8/30/21 and diagnoses included cerebral vascular accident. Review of the minimum data set (MDS) for Resident #14 revealed a quarterly assessment with an assessment reference date of 12/3/21 that was not completed. An interview on 1/28/22 at 1:06 pm with the MDS Nurse revealed the quarterly assessment dated 12/3/21 for Resident #14 had not been completed and was late. An interview on 1/31/22 1:55 pm with the Administrator revealed the facility had identified they were behind on completing MDS assessments and they were in the process of getting them caught up. 2.Resident #4 was admitted on 2/28/18 and diagnoses included coronary heart disease and Alzheimer ' s Disease.	F 638	The plan of correction for the specific deficiency: Resident #14 had a quarterly completed on 2/17/2022 and Resident #4 had a quarterly completed on 2/4/2022. Processes that led to deficiency cited attributed to change in MDS and shift in administrative nursing duties. The facility will identify other residents having the potential to be affected by the same deficient practice by: An audit conducted by the Case Mix Director of a 100% of all current residents to ensure a quarterly was completed within 14 days per RAI guidelines. This audit was completed on 2/23/2022. Fifteen residents were noted as affected by quarterly assessments not completed at least every 3 months. Focus will be on completing current quarterly assessments timely, and completing 3 late assessments per week until late assessment log is complete beginning 2/25/2022. Systemic changes made to ensure this deficient practice will not occur: Education was provided to the Case Mix Director re: timely completion of the MDS on 2/22/2022. Case Mix Director and IDT were educated on RAI guidelines by	2/27/22

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F 638	Continued From page 9 Review of the MDS ' s for Resident #4 revealed a quarterly assessment with an assessment reference date of 11/2/21 that was not completed. An interview on 1/28/22 at 1:06 pm with the MDS Nurse revealed the quarterly assessment dated 11/2/21 for Resident #4 had not been completed and was late. An interview on 1/31/22 1:55 pm with the Administrator revealed the facility had identified they were behind on completing MDS assessments and they were in the process of getting them caught up.	F 638	Regional Clinical Reimbursement Consultant on completing Quarterly Assessments within 14 days per RAI guidelines starting on 1/31/2022 through 2/27/2022. This education will be provided to newly hired IDT members and those newly providing remote assistance to the center. Obtain assistance from other Case Mix Directors/Case Mix Coordinators in the region as needed. An audit tool was created utilizing the Assessment Due Report to monitor residents scheduled for a Quarterly Assessment. How will the corrective action be monitored to ensure that solutions are sustained: The Case Mix Director will review the audit tool weekly x 4, twice a month x4 and monthly x 4. A list of all completed assessments will be given to the Administrator daily by the Case Mix Director and kept in a binder in the MDS office. The Case Mix Director will provide tracking and trending tools to the QAPI committee. The Administrator or designee will review the POC in the monthly QAPI meeting for 3 months or until compliance is achieved. Changes will be made to the plan by the committee as indicated to include, but not limited to, further education and or immediate corrective action. Date of Compliance: 2/27/2022	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4)	F 640		2/27/22

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F 640	Continued From page 10 §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. §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.	F 640		

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F 640	Continued From page 11 (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 complete discharge minimum data set (MDS) assessments for 2 of 40 MDS assessments reviewed (Resident #12 and Resident #4). Based on record review and staff interview the facility failed to submit quarterly Minimum Data Set (MDS) assessments for 1 of 40 MDS assessments reviewed (Resident #17). Findings Included: 1.Resident #12 was admitted to the facility on 5/27/21 and diagnoses included renal failure and diabetes. Review of the MDS ' s for Resident #12 revealed a discharge assessment dated 11/24/21 that was not completed. An interview on 1/28/22 at 1:06 pm with the MDS Nurse revealed the discharge assessment dated 11/24/21 for Resident #12 had not been completed and was late. An interview on 1/31/22 1:55 pm with the Administrator revealed the facility had identified they were behind on completing MDS assessments and they were in the process of	F 640	The plan of correction for the specific deficiency: Resident #12 had a Discharge Assessment completed on 2/1/2022 and was accepted on 2/2/2022. Resident #4 had a Discharge Assessment completed on 2/22/2022 and accepted on 2/25/2022. Resident #17 had a Quarterly Assessment completed on 1/28/2022 and accepted on 2/2/2022. Processes that led to deficiency cited attributed to change in MDS and shift in administrative nursing duties. The facility will identify other residents having the potential to be affected by the same deficient practice by: Resident MDS Assessments Due Report pulled beginning with date of 11/1/2021 thru 2/23/2022 from Matrix. Will continue plan that is in place, which started December 2021, for completion of delinquent assessments. As assessments are completed they will be transmitted to the QIES system for acceptance. Obtain assistance from other Case Mix Directors/Case Mix Coordinators/Clinical Reimbursement Coordinators as needed. Transmit twice a week.	

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F 640	Continued From page 12 getting them caught up. 2.Resident #4 was admitted on 2/28/18 and diagnoses included coronary heart disease and Alzheimer ' s Disease. Review of the MDS ' s for Resident #4 revealed a discharge assessment dated 12/6/21 that was not completed. An interview on 1/28/22 at 1:06 pm with the MDS Nurse revealed the discharge assessment dated 12/6/21 for Resident #4 had not been completed and was late. An interview on 1/31/22 1:55 pm with the Administrator revealed the facility had identified they were behind on completing MDS assessments and they were in the process of getting them caught up. 3. Resident #17 was admitted to the facility on 10/9/2020. Her cumulative diagnosis included type 2 diabetes, occlusion carotid artery, and dysphagia. Review of the quarterly MDS for Resident #17 on 1/26/2022 revealed an assessment was started on 12/6/2021. The assessment showed as "in process" which indicated the MDS had not been transmitted to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System. An interview conducted on 1/28/2022 at 11:44 A.M. with the MDS Nurse revealed the quarterly MDS dated 12/6/2022 had not been completed and transmitted by the required date of 12/20/2022. The MDS Nurse stated she had fallen behind on completing resident MDSs.	F 640	Systemic changes made to ensure that the deficient practice will not occur: Education was provided to the Case Mix Director re: the regulation for timely transmission of MDS assessments on 2/22/2022. This education will be provided to newly hired Case Mix Directors. Case Mix Director will pull the Resident MDS Assessments Due Report weekly to ensure timely completion of MDS assessments beginning on 2/23/2022 and utilize this report as an audit to ensure all assessments were completed and transmitted with acceptance from QIES system. Keep a manual calendar of assessments due in the MDS office. Transmit twice a week. How will the corrective action be monitored to ensure that solutions are sustained: The Case Mix Director will provide tracking and trending tools to the QAPI committee. The Administrator or designee will review the POC in the monthly QAPI meeting for 3 months or until compliance is achieved. Changes will be made to the plan by the committee as indicated to include, but not limited to, further education and or immediate corrective action. Date of Compliance: 2/27/2022	

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F 640	Continued From page 13 An interview conducted on 1/28/2022 at 11:51 A.M. with the Administrator revealed resident's MDSs should be completed in a timely manner. The Administrator stated he was aware the MDS Nurse had fallen behind.	F 640		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment related to Pain (Resident #10) and Activities of Daily Living (Resident #10, Resident #70, and Resident #57) for 3 of 23 residents reviewed for MDS accuracy. The findings included: 1-a. Resident #10 was admitted to the facility on 3/19/21 with a cumulative diagnoses which included pain in her right leg and restless leg syndrome. Review of the resident ' s electronic medical record (EMR) revealed her most recent Minimum Data Set (MDS) was a quarterly assessment dated 11/23/21. The MDS indicated Resident #10 had the ability to make herself understood and to understand others with clear comprehension. She was assessed to have intact cognitive skills for daily decision making. The MDS included a section entitled, "Pain Assessment Interview." This section indicated Resident #10 reported	F 641	The plan of correction for the specific deficiency: Resident #10 had a Quarterly Assessment modified to correct ADLs and Pain Assessment on 2/22/22. Resident #70 had a Quarterly Assessment modified to correct ADLs on 2/22/22. Resident #57 had a Quarterly Assessment modified to correct ADLs on 2/22/22. Processes that led to deficiency cited attributed to assistance from other Case Mix Directors/Case Mix Coordinators assisting remotely due to changes in MDS and shift in administrative nursing duties. The facility will identify other residents having the potential to be affected by the same deficient practice by: The Case Mix Director pulled a Daily Census Report on 2/23/22 and audited the last admission, quarterly or annual completed for coding of ADLs and pain assessment. Assessments with incorrect coding of ADLs or pain assessment will be modified. 9 residents were noted as	2/27/22

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F 641

Continued From page 14

having pain or hurting within the last 5 days. However, answers to the follow-up questions for the pain assessment were documented with a dash (-) only. No information was provided for the follow-up questions related to the resident ' s frequency of pain, effect of the pain on her function, or the intensity of the pain.

An interview was conducted on 1/27/22 at 10:10 AM with the facility ' s MDS Coordinator. During the interview, the MDS Coordinator reviewed Resident #10 ' s quarterly MDS dated 11/23/21. When asked what her thoughts were with regards to the Pain Assessment Interview, she reported the rest of the pain assessment section needed to be completed to address the frequency and level of the resident ' s pain. She confirmed the follow-up interview questions on pain were not documented as completed. The MDS Coordinator reported off-site staff had helped the facility with the completion of MDS assessments.

An interview was conducted on 1/27/22 at 12:50 PM with the facility ' s Director of Nursing (DON). When asked, the DON reported she would expect the MDS assessments to be coded correctly. She also stated the follow-up questions on the Pain Assessment Interview should not have been answered with dashes. The DON reported if there was a question on the severity or frequency of the resident ' s pain, the person completing the MDS off-site could have called the facility to obtain this information, as needed.

1-b. Resident #10 was admitted to the facility on 3/19/21 with a cumulative diagnoses which included generalized muscle weakness and difficulty in walking.

F 641

affected by incorrect coding of ADLs and 15 residents were noted affected by incorrect coding of pain assessments.

Systemic changes made to ensure this deficient practice will not occur: Case Mix Directors/Case Mix Coordinators/Clinical Reimbursement Consultants assisting remotely will be educated on RAI guidelines for coding of ADLs and pain assessments and the need to seek clarification from the facility Case Mix Director regarding accurate assessment of the resident, by Regional Clinical Reimbursement Consultant. Facility CMD/CMC will provide clarification to partners assisting with assessments remotely by obtaining information for ADLs and resident interviews as needed. The Case Mix Director or designee will monitor ADLs and pain assessments of finalized MDSs that were remotely completed prior to transmitting. Monitor for need for correction. Re educate partners as needed for proper coding of ADLs and pain assessment as needed.

How will the corrective action be monitored to ensure that solutions are sustained: The Case Mix Director will review 100% of remotely completed assessments prior to batching for need for correction. The Case Mix Director will document the assessments audited on a log, indicating compliance or lack of compliance with accuracy of the assessments in the areas of ADLs and pain assessment. The Administrator will monitor the compliance of this POC in the

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F 641	Continued From page 15 Review of the resident ' s electronic medical record (EMR) revealed her most recent Minimum Data Set (MDS) was a quarterly assessment dated 11/23/21. The MDS included a section related to her functional status. This section indicated Resident #10 required supervision with bed mobility and transfers. Walking in the room/corridor and locomotion on/off the unit were reported as not occurring during the 7-day look back period. This section also documented dressing, eating, toileting, and personal hygiene only occurred one to two times during the 7-day look back period. An interview was conducted on 1/27/22 at 10:10 AM with the facility ' s MDS Coordinator. During the interview, the MDS Coordinator reviewed Resident #10 ' s quarterly MDS dated 11/23/21. When asked what her thoughts were with regards to the assessment ' s documentation of Resident #10 ' s functional status, the MDS Coordinator stated the section was, "inaccurate and Section G (the section related to functional status) needs to be modified." She reported off-site staff had assisted the facility with the completion of MDS assessments and this one had been coded incorrectly. An interview was conducted on 1/27/22 at 12:50 PM with the facility ' s Director of Nursing (DON). When asked, the DON reported she would expect the MDS assessments to be coded correctly. The DON stated re-education needed to be conducted on coding for residents ' functional status. She reported off-site staff should contact the facility to obtain this information, as needed. 2. Resident #70 was admitted to the facility on 8/4/21 with re-admission to the facility from a	F 641	monthly QAPI meeting for 3 months to ensure we have achieved appropriate corrective action. Changes will be made to the plan by the committee as indicated to include, but not limited to, further education and or immediate corrective action. Date of Compliance: 2/27/22	

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F 641	Continued From page 16	F 641		

hospital on 9/3/21. His cumulative diagnoses included fibromyalgia (a condition which may cause widespread pain), cognitive communication deficit, and a history of cerebral infarction (stroke).

Review of the resident ' s electronic medical record (EMR) revealed his most recent Minimum Data Set (MDS) was a quarterly assessment dated 11/6/21. The MDS included a section related to his functional status. The following Activities of Daily Living (ADLs) were documented as only occurring one to two times during the 7-day look back period: bed mobility, transfers, walking in the room/corridor, locomotion on/off the unit, dressing, eating, toileting, and personal hygiene.

An interview was conducted on 1/27/22 at 10:10 AM with the facility ' s MDS Coordinator. During the interview, the MDS Coordinator reviewed Resident #70 ' s quarterly MDS dated 11/23/21. When asked what her thoughts were with regards to the assessment ' s documentation of Resident #70 ' s functional status, the MDS Coordinator stated the section was, "inaccurate and Section G (related to functional status) needs to be modified." She reported off-site staff had assisted the facility with the completion of MDS assessments and this one had been coded incorrectly.

An interview was conducted on 1/27/22 at 12:50 PM with the facility ' s Director of Nursing (DON). When asked, the DON reported she would expect the MDS assessments to be coded correctly. The DON stated re-education needed to be conducted on coding residents ' functional status. She reported off-site staff should contact

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F 641	Continued From page 17 the facility to obtain this information, as needed. 3. Resident #57 was admitted to the facility 4/1/20 and diagnoses included lupus, chronic pain and neuromuscular dysfunction of bladder. A quarterly MDS dated 11/3/21 for Resident #57 identified dressing, eating, toilet use, and personal hygiene had not occurred during the 7-day lookback period. An interview on 1/28/22 at 1:06 pm with the MDS Nurse revealed a staff member who had assisted the facility with MDS completion had coded the 11/3/21 MDS for Resident #57 incorrectly. She stated the resident had received ADL (activities of daily living) care during the look-back period and the MDS should have reflected that care. An interview on 1/31/22 at 1:55 pm with the Administrator revealed he expected the MDS assessment to be coded correctly.	F 641		
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.	F 657		2/27/22

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F 657	Continued From page 18 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of 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 record review and staff interview the facility failed to update a care plan to reflect development of a pressure ulcer. This was evident for 1 of 3 residents reviewed for pressure ulcers (Resident #57). Findings Included: Resident #57 was admitted to the facility 4/1/20 and diagnoses included lupus, chronic pain and neuromuscular dysfunction of bladder. Review of wound documentation for Resident #57 from 10/8/21 through 12/30/21 revealed the resident had an unstageable pressure ulcer to her sacrum and her left ischium. The left ischium pressure ulcer was identified as healed 12/20/21. Review of a quarterly minimum data set (MDS) dated 11/3/21 for Resident #57 identified she had 2 unstageable pressure ulcers.	F 657	Resident #57 care plan was updated on 2/24/22 by the Case Mix Director for current pressure injuries. All residents have potential to be affected. Case Mix Director (CMD) completed 100% audit of all current residents with pressure injury to ensure care plan was updated. Audit was completed on 2/23/22. All Licensed nurses were in-serviced on 2/24/22 by Case Mix Director on how to update care plans when new pressure injury noted. Licensed Nurses not educated will be educated prior to their next scheduled shift or removed from the schedule. This education regarding updating care plans with any new pressure injury has been added to the general orientation of all newly hired Licensed Nurses.	

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F 657	Continued From page 19 A care plan for Resident #57 with a start date of 4/18/21 and a review date of 6/24/21 stated the resident was at risk for skin breakdown related to incontinence of bowel and bladder, preference to stay in bed, pain when moved and decreased mobility. An interview on 1/31/22 at 1:45 pm with the MDS Nurse revealed Resident #57 ' s skin care plan should have been updated to reflect her pressure ulcers when they developed on 10/8/21. An interview on 1/31/22 at 1:55 pm with the Administrator revealed he expected care plans to be updated as needed.	F 657	Case Mix Director will be complete care plan audits weekly x 4, bi-weekly x 4 and monthly moving forward. The Case Mix Director will track, trend and analysis the care plan audits monthly and will present the analysis of the audit to the Administrator during the monthly Quality Assurance and Performance Improvement Committee meeting. Audit tools will be reviewed monthly times three (3) months by CMD and/or designee and during the monthly Quality Assurance and Performance Improvement Committee meeting. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance. Date of Compliance: 2/27/22	
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: Based on observations, record review, and staff	F 684	The Director of Health Services educated	2/27/22

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F 684 Continued From page 20
interviews, the facility failed to follow physician's orders for the treatment of a non-pressure wound for 1 of 2 sampled residents (Resident #76).

The findings included:

Resident #76 was initially admitted to the facility on 4/30/2021 and had a reentry date of 9/1/2021. Her cumulative diagnoses included chronic venous hypertension with ulcer of right lower leg, type two diabetes, lymphedema, a non-pressure chronic (lasting longer than six months) ulcer on right lower leg, varicose veins on right lower leg, and peripheral vascular disease.

A review of a physician order dated 9/30/2021 revealed an order for a wound dressing change for a wound on the right lower leg. The order read moisten dressing prior to removal. Clean wound with wound cleanser. Apply silver alginate and ABD pad (abdominal pad are highly absorbent multilayer pads used where high absorbency is needed to manage heavy draining wounds), then wrap with gauze roll, change every other day, and as needed. Wrap the gauze roll from mid foot to just below the knee. Apply a compression stocking in the morning and remove at night.

A review of Resident #76's most recent care plan last revised on 9/21/2021 included an area of focus for an ulcer on right lower leg and Resident #76 was at risk for recurrent wound infection of cellulitis to right lower leg. The interventions included wound dressing changes per physician orders, skin assessment routinely, treatments as ordered, and monitor skin around the wound.

Resident #76's most recent Minimum Data Set (MDS) was a quarterly assessment dated

F 684

the Wound treatment nurse on February 22, 2022, on the requirement to follow physician orders with specific treatments dressings as ordered.

All residents have the potential to be affected. The Director of Health Service observed the Wound treatment Nurse completing dressings on 2/23/22 and all orders were followed as prescribed.

All Licensed nurses were in-serviced on 2/22/22 by the Director of Health Services on following physician ordered as prescribed, Licensed Nurses not educated will be educated prior to their next scheduled shift or removed from the schedule. This education regarding following physician wound orders has been added to the general orientation of all newly hired Licensed Nurses.

Director of Health Service, Clinical Competency Coordinator and/or Unit manager will complete 5 wound observations per week for four weeks, then 5 wound observation per month for 4 months then quarterly thereafter.

Wound observation tools will be tracked, trended and analyzed, the Director of Health Services will present the analysis of the wound review to the Quality Assurance and Performance Improvement Committee meeting monthly until three months of sustained compliance is maintained then quarterly thereafter. Any issues or trends identified will be addressed by the Quality

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F 684	Continued From page 21 12/3/2021. The MDS revealed the resident was cognitively intact. Resident #76 required extensive assistance to complete bed mobility, transfers, dressing, and toileting. There were no behaviors or rejection of care reported by staff. Resident #76 was assessed as having no pressure ulcers and one venous ulcer on admission. An observation was conducted on 1/27/2022 at 2:01 P.M. of a wound treatment dressing change. The Wound Treatment Nurse reviewed the physician wound dressing order. The Wound Treatment Nurse gathered silver alginate, scissors, two syringes with 10 milliliters of normal saline, tape and wound cleaner sprayed onto 4x4 inch gauze. The compression stocking and old bandage were removed and discarded into the trash. The silver alginate dressing was moistened with two syringes of normal saline and discarded. The wound was cleaned with the wound cleanser-soaked gauze. Silver alginate was applied and rolled gauze was wrapped around resident's leg. Tape was applied to the end of the rolled gauze and taped to the rolled gauze wrapped around her leg. A new compression stocking was cut and applied on top of the rolled gauze. An interview was conducted on 1/27/2022 at 2:20 P.M. with the Wound Treatment Nurse revealed per the wound order an ABD pad should have been applied on top of the silver alginate, prior to Resident #76's leg being wrapped with the gauze wrap. During the interview the Wound Treatment Nurse stated when she opened the wound cart drawer to gather supplies, she grabbed a small tray to carry the items and forgot to grab the ABD pad.	F 684	Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance. Date of compliance 2/27/2022	

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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
F 684	Continued From page 22 An interview was conducted on 1/28/2022 at 12:13 P.M. with the Wound Nurse Practitioner (NP) revealed the ABD pad was ordered per Resident #76's request. During the interview the Wound NP stated having the primary dressing of silver alginate was more important than the absorbent layers on top of the primary dressing. The NP stated the wound goal for Resident #76 was to keep the wound from getting worse, therefore the ABD pad not being applied had no negative outcome for Resident #76. An interview conducted on 1/28/2022 at 12:44 P.M. with the Director of Nursing revealed staff should follow the physician order when they completed wound care.	F 684		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		2/27/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 23 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to discard 3 containers of expired cottage cheese and failed to ensure opened food items were sealed, labeled and dated. This was evident for 1 of 1 kitchen observation. Findings Included: An observation of the kitchen on 1/24/22 at 1:00 pm was conducted with Cook #1. The following areas were identified: 1. In the walk-in cooler there were 3 - 5-pound (lb.) containers of cottage cheese that had expired. The containers had manufacturer use by dates of 12/12/21, 1/5/22 and 1/6/22. Cook #1 stated she was not sure if the residents had been served any of the cottage cheese and the cottage cheese needed to be thrown away. 2. In the walk-in freezer there was a sleeve of approximately 20 sausage patties and a sleeve of approximately 10 hamburger patties that were not labeled and dated. Cook #1 indicated these items should have been labeled with the date they were opened. 3. In the dry storage room, a 25 lb. box of food thickener was open and exposed to the air. Cook #1 stated the bag should have been re-sealed. An interview on 1/31/22 at 1:50 pm with the Administrator revealed he expected the expired cottage cheese to be discarded and opened food items should be sealed, labeled and dated.	F 812	On 1/24/2022 3 containers of cottage cheese were removed and discarded by Certified Dietary Manager due to being expired. No resident was served the expired item. Sausage and hamburger patties were throwed away and the thickened liquid powder was removed from cardboard box and placed in a container. On February 23, 2022, Dietary Manager and Dietary Aide did a complete audit on the kitchen and no items were noted to be expired or without labels or dates. On January 25, 2022, all dietary employees were in serviced by Certified Dietary Manager on pulling expired food, and labeling/dating all items when open. Dietary Manager/Dietary Aide to check shipments and do weekly audits to make sure no expired items are in the kitchen and to ensure all open items are labeled and dated. Audit was completed on 1/24/2022 and 2/23/2022. This education has been added to the general orientation of all newly hired staff. Dietary Manager and/or Dietary Aide will do weekly audits to make sure no items are expired in the kitchen, or all items are labeled and dated. The Dietary Manager will track, trend and analyze the dietary audit tools and present the analysis to the Quality Assurance and	

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F 812	Continued From page 24	F 812	Performance Improvement Committee meeting monthly until three months of sustained compliance is maintained. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance. Date of Compliance will be 2/27/2022	