DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			· /	SURVEY PLETED
		345009	B. WING			05/	/19/2016
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	S AT WHITAKER GLEN-M	IAYVIEW			13 EAST WHITAKER MILL ROAD RALEIGH, NC 27608		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 164 SS=D	PRIVACY/CONFIDEN	 PERSONAL NTIALITY OF RECORDS right to personal privacy and or her personal and clinical 	F	164			6/1/16
	medical treatment, wr communications, pers meetings of family an	sonal care, visits, and d resident groups, but this acility to provide a private					
	section, the resident r	a paragraph (e)(3) of this may approve or refuse the nd clinical records to any facility.					
	and clinical records d resident is transferred	o refuse release of personal oes not apply when the d to another health care elease is required by law.					
	contained in the resid the form or storage m release is required by	r transfer to another law; third party payment					
	by: Based on record revi resident and staff inte provide full visual priv treatments for 1 of 4 r The findings included	erview the facility failed to vacy while providing residents receiving care.	F		F164 This Plan of correction constitut a written allegation of compliance. Preparation and submission of this plan correction does not constitute an admission or agreement by the provide the truth of the facts alleged or the	n of	(X6) DATE

Electronically Signed

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.

05/26/2016

ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 345009 B. WING 05/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE OAKS AT WHITAKER GLEN-MAYVIEW STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			MEDICAID SERVICES	(X2) MI II TID	E CONSTRUCTION		B NO. 0938-03
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it made her feel uncomfortable when staff failedtherapists, those staff on PTO or FMLAto provide privacy.will be educated upon return.		-	-			••••	
to provide privacy. will be educated upon return.		her roommate getting	g care. Resident #22 stated		on 5/19-5/25/16	6 to nurses, aides,	
			mfortable when staff failed				
On 5/19/16 at 0.01 AM Nurse #1 /the nurse that		to provide privacy.			will be educated	d upon return.	
		On 5/18/16 at 0:01 A	M Nurso #1 (the surse that		Conoral oriente	tion for now nurse, side	
			coloto Event ID: BI12				

Facility ID: 923332

If continuation sheet Page 2 of 16

						0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		345009	B. WING		05/19	9/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	DDE	
THE OAK	S AT WHITAKER GLEN-I	MAYVIEW		513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIOI DATE
F 164	Continued From page	e 2	F 16	4		
	scan. She stated she	to Resident #128 on vas completing a bladder e " yanked and yanked " the buld not get it to close at the		therapy hires will include ec of privacy curtains to mainta privacy.		
	end of the bed. She stated she was aware that the privacy curtain should have been pulled around the resident while providing a treatment. During an interview on 5/19/16 at 9:29 AM the			DHS or designee will audit rooms daily for 7 days, ther two weeks, and then once r compliance with use of priv	weekly for monthly x 1 for	
	Assistant Director of expectation was to m	on 5/19/16 at 9:29 AM the Nursing stated that her naintain a patient ' s privacy ains before beginning a		when providing care. Compliance rounds will be randomly on a minimum of		
	procedure especially roommate.			by a member of the manage identify if privacy curtains a repairs or replacements	ement team to	
	Resident #22 stated were 2 privacy curtai	terview on 5/19/16 11:05 AM she did not know that there ns and was not aware there at the end of her roommate		ongoing for 7 days, then we weeks, then once monthly.		
	' s bed until 5/17/16. During an interview c			4.How facility plans to moni and incorporate into QAPI	tor, evaluate,	
		d it did bother her that staff ivacy curtain while she was		DHS or designee will audit rooms daily for 7 days, ther two weeks, and then once compliance with use of priv when providing care.	n weekly for monthly x 1 for	
				Compliance rounds will be randomly on a minimum of by a member of the manag- identify if privacy curtains a repairs or replacements for	3 rooms daily ement team to re in need of 7 days, then	
				Results of 7 day audit will b the QAPI committee on 5/3 determine if audits need to Complaince rounds checkli	e reported to 1/16 to continue.	

Event ID: RI1211

Facility ID: 923332

If continuation sheet Page 3 of 16

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/31/20 MAPPROVE D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345009	B. WING			05/	/19/2016
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
	S AT WHITAKER GLEN-I	MAYVIEW		51	3 EAST WHITAKER MILL ROAD		
			RALEIGH, NC 27608				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 164	Continued From pag	e 3	F	164	turned in to the administrator and reviewed for necessary follow up. Compliance rounds checklist will be shared during QAPI meetings to determine additional follow up if needed	d	
F 241 SS=E		AND RESPECT OF	F	241			5/25/16
	manner and in an en	note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.					
	by: Based on observation facility failed to ensure disposable tableware of 69 residents who re disposable dishes. During the meal obset 5/18/16 between 11:4 noted all desserts we disposable containers In an interview with th on 5/19/16 at 8:42 AF always served cake in containers. He indicate with plastic wrap as a and does not look ve During an interview w 5/19/16 at 12:48 PM came to the facility a using the disposable serve cake. She state management that it w	ne Certified Dietary Manager M he stated that they had n the disposable Styrofoam ted that when cake is served a cover it pulls the frosting off ry appealing to residents. with the Kitchen Manager on she stated that when she year ago the kitchen was Styrofoam containers to			F241 This Plan of correction constitute written allegation of compliance. Preparation and submission of this plan correction does not constitute an admission or agreement by the provide the truth of the facts alleged or the correctness of the conclusions set forth on this statement of deficiencies. The Plan of correction is prepared and submitted solely because of requirement under state and federal law 1. Address what corrective action will b accomplished for those residents found have been affected: No residents identified to be affected. No grievances have been received by residents or patients for use of sytrofoa clam shells which were used to protect the integrity of the desserts.	n of er of n nts e d to	

Facility ID: 923332

If continuation sheet Page 4 of 16

		ND HUMAN SERVICES MEDICAID SERVICES			FC	TED: 05/31/2016 DRM APPROVED NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) D.	ATE SURVEY DMPLETED
		345009	B. WING			05/19/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		
	S AT WHITAKER GLEN-I	ΜΔΥΛΙΕΜ		513 EAST WHITAKER MILL ROA	AD	
				RALEIGH, NC 27608		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 241	was pulled off it mess decorations. During an interview w 5/19/16 at 1:00 PM s aware of any residen receiving cake in disp indicated that resider	a plate and the plastic wrap sed up the frosting and with the Administrator on he stated that she was not t that complained about posable containers. She hts had complained that wrapped in plastic wrap it	F	 241 2. Address what correct accomplished for those have potential to be affer their potential to be affer their and oriented residents with poten Ten alert and oriented resident their dignity. 3. Address what measu place or systemic channel use of Styrofoam clam was stopped on 5/19/16. Use of Styrofoam clam was stopped on 5/25/16. Use of plates or bowls frimplemented on 5/20/11 Dietary staff educated resident of the use of start or shells for desserts on 5 Dietary staff on PTO or educated upon return. Dietary Manager or Destray line for 5 days, then week, then monthly x 1 shells are not used for or systrofoam products. 4. How facility plans to and incorporate into QA Dietary Manager or Destray Manager or Destray Manager or Destray plane for start of the s	e residents found to fected: ntial to be affected. residents were and all stated that lam shells did not ures will be put into ges made: shells for desserts 6. ed on 5/19 and for desserts was 6. not to use clam 5/19-5/24/16. FMLA will be signee will monitor n weekly for one to ensure clam desserts dietary staff will o when to use	
L	7/02 00) Previous Versions Ob	solete Event ID: PI1			-	about Dago E of 16

Facility ID: 923332

If continuation sheet Page 5 of 16

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	D: 05/31/2016 MAPPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345009	B. WING			05/	19/2016
NAME OF PF	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS	S AT WHITAKER GLEN-N	IAYVIEW			3 EAST WHITAKER MILL ROAD ALEIGH, NC 27608		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	{	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From page	e 5	F 2-	41	tray line for 5 days, then weekly for one week, then monthly x 1 to ensure clam shells are not used for desserts Results of audit will be presented to the QAPI committee on 5/31/16 and the committee will determine need for furth monitoring.)	
F 356 483.30(e) POSTED NURSE STAFFING		IURSE STAFFING	F 3	56			6/1/16
SS=C	The facility must post a daily basis: o Facility name. o The current date. o The total number ar by the following categ unlicensed nursing sta resident care per shift - Registered nurse - Licensed practic vocational nurses (as - Certified nurse a o Resident census.	aff directly responsible for :: es. al nurses or licensed defined under State law). ides.					
	specified above on a of each shift. Data m o Clear and readable o In a prominent place residents and visitors. The facility must, upo make nurse staffing d	e readily accessible to					
	The facility must main	tain the posted daily nurse					

Facility ID: 923332

If continuation sheet Page 6 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER THE OAKS AT WHITAKER GLEN-MAYVIEW (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608			PRINTED: 05/31/20 FORM APPROV OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 05/19/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	staffing data for a min required by State law, This REQUIREMENT by: Based on observation staff interviews, the fa staff posting the numb Nurses), LPNs (Licen NAs (Nursing Assistan to 3PM shift and failed 3PM to 11PM and the 3 days of the survey a posting 2 of 3 days of included: On 5/17/16 at 10:15A observed on a bulletin station on the 100 hal number of RNs, LPNs 7AM to 3PM shift. On 5/19/16 at 2:43PM posting on the bulletin dated 5/17/16. The po shift and the 11PM to information regarding or the number of hour NAs. An interview was cond Administrator and the on 5/19/16 at 2:43PM manager filled out the morning and evening supervisor filled out the The DON stated appar	imum of 18 months, or as whichever is greater. is not met as evidenced hs, document review and icility failed to include in the ber of RNs (Registered sed Practical Nurses) and hts) that worked on the 7AM d to post the staffing for the 11PM to 7AM shifts for 1 of and failed to post the staff the survey. The findings M the staff posting was h board near the nurse ' s 1. The posting did not list the s or NAs that worked on the 4 an observation of the staff h board revealed the posting posting for the 3PM-11PM 7AM shift revealed no the number of staff working s worked by RNs, LPNs or clucted with the Director of Nursing (DON) . The DON stated the unit staff posting for the shifts and the night he posting for the night shift. irrently the unit manager did ing on 5/18/16 or 5/19/16.	F	356	F356 This Plan of correction constitut written allegation of compliance. Preparation and submission of this pla correction does not constitute an admission or agreement by the provid the truth of the facts alleged or the correctness of the conclusions set for on this statement of deficiencies. The Plan of correction is prepared and submitted solely because of requirem under state and federal law 1. Address what corrective action will accomplished for those residents four have been affected: No residents were identified 2. Address what corrective action will accomplished for those with potential be affected: No residents were identified, but all w potential to be affected New staffing form developed to include number of hours and number of perso for each shift for RN, LPN, and NA. M staffing form implemented on 5/20/16.DHS or designee educated supervisors (5/19-5-24-16) on staffing hours posting requirement.	an of ler of th ents be to be to to ith e sns lew	

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	MENT OF HEALTH AN S FOR MEDICARE &					F	NTED: 05/31/20 ORM APPROVE <u>3 NO. 0938-03</u>
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		· /	PLE CONSTRUCTION		DATE SURVEY COMPLETED
		345009	1	B. WING			05/19/2016
NAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, 2	ZIP CODE	00/10/2010
	AT WHITAKER GLEN-M				513 EAST WHITAKER MILL ROA	AD	
THE OAK	AT WHITAKER GEEN-I				RALEIGH, NC 27608		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	' FULL	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE HENCY)	(X5) COMPLETIO DATE
F 356	Continued From page	e 7		F 35	56		
					 3. Address what meas place or systemic cham. New staffing form deven number of hours and number of a designee educa (5/15-5-24-16) on staffing requirement. General orientation for will include posting of s 4. How facility plans to and incorporate in QAF DHS or designee will cl ensure staffing hours is of each and number of daily for 12 days beginn weekly for two weeks, the Admin or designee will days, then weekly for two monthly to ensure staffing posted as part of comp checklist. Results of audits will be QAPI and committee w for additional monitoring check list will be completed as part of complete	ges made: loped to include umber of persons PN, and NA. New ted on 5/20/16. ated supervisors ng hours posting nurse supervisors taffing hours daily. monitor, evaluate, PI: heck daily to posted with hours each RN, LPN, NA hing 5/20/16, then then monthly. check daily for 12 wo weeks, then ing hours are liance rounds	
F 371 SS=F	483.35(i) FOOD PRC STORE/PREPARE/S			F 37	member of the manage ensure hours are poste findings reported in QA determine if additional a needed.	d daily and PI meeting to	6/1/16
SS=E	483.35(i) FOOD PRC STORE/PREPARE/S 7(02-99) Previous Versions Obs	ERVE - SANITARY	Event ID: RI1211			If continuatio	

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345009	B. WING			0	5/19/2016
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
				51	13 EAST WHITAKER MILL ROAD		
THE OAK	S AT WHITAKER GLEN-N	IAYVIEW		R	ALEIGH, NC 27608		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page	2 8	F	371			
	considered satisfacto authorities; and	sources approved or ry by Federal, State or local stribute and serve food ions					
	by: Based on observatio facility failed to maint and in a sanitary con- contamination by faili table shelf for one of The findings included A review of the Dietar Assignments issued S under Steam table: C Under shelf/ over she cleaned. During an observation five well steam table underside of the stea to be covered with da A second observation 5 ½ foot underside of observed to be cover particles. The 5 ½ fo the steam table was of drips 2 to 4 inches low In an interview with th	y Daily Cleaning September, 2001: listed lean/free of food debris. If cleaned. Glass/tray slides n on 5/18/16 at 11:47 AM the was observed. The 5 ½ foot m table shelf was observed rk dried food particles. n on 5/19/16 at 12:46 PM the the steam table shelf was ed with dark dried food ot tray line shelf attached to observed with dark dried			 F371 This plan of correction constitute a written allegation of compliance. Preparation and submission of this plan correction does not constitute an admission or agreement by the provide the truth of the fact alleged or the correctness of the conclusions set forth on this statement of deficiencies. The plan of correction is prepared and submitted solely because of requireme under state and federal law. 1. Address what corrective action will l accomplished for those residents identified: No residents were identified to be affect 2. Address what corrective action will l accomplished for those residents with potential: all residents with potential to be affected 	n of er of n nts be eted be	

Facility ID: 923332

	<u>OF DEFICIENCIES</u>			PLE CONSTRUCTION	OMB NO.	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	G	(X3) DATE SU COMPLE	
		345009	B. WING		05/19	9/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
THE OAK	S AT WHITAKER GLEN-	MAYVIEW		513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE
F 371	Continued From pag	e 9	F 37	1		
	 F 371 Continued From page 9 that she did not know when staff had last cleaned the shelf. Review of the Dietary Daily Cleaning Assignments dated May 2016 listed under Steam table: Clean/free of food debris. Under shelf/ over shelf cleaned. Glass/tray slides cleaned was initialed and checked yes as completed. 			 Steam table was immedia 5/19/2016 Dietary staff educated on procedure and cleaning ch through 5-24-16. 3. Address what measure place or systemic changes Steam table was immedia 5/19/2016 Dietary staff educated on procedure and cleaning ch through 5-24-16. General orientation of new will include education on checklist. CDM or designee will insp tables each day for 12 day 	proper cleaning necklist on 5-19 es will be put into s made: tely cleaned on proper cleaning necklist on 5-19 v Dietary staff cleaning	
				 4. How will facility will mor and incorporate into QAPI CDM or designee will insp tables each day for 12 day 	hly to ensure stables. Weekly esignee will to ensure checklist. hitor, evaluate, pect steam ys, then weekly	
				proper cleaning of steams for 4 weeks the CDM or do check cleaning schedules compliance with cleaning	stables. Weekly esignee will to ensure	

Event ID: RI1211

Facility ID: 923332

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345009	B. WING		05/19/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	
	S AT WHITAKER GLEN-N			513 EAST WHITAKER MILL ROAD	1
	SAI WIIIARER GEEN-I			RALEIGH, NC 27608	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 371	Continued From page	e 10	F 3	71	
F 441	483 65 INFECTION (CONTROL, PREVENT	F 4	Findings will be presente committee and will deterr further monitoring/auditin	mine the need for
SS=D	SPREAD, LINENS				
	Infection Control Prog safe, sanitary and con	blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on.			
	Program under which (1) Investigates, cont in the facility; (2) Decides what pro- should be applied to a	blish an Infection Control n it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective			
	prevent the spread of isolate the resident. (2) The facility must p communicable diseas from direct contact wi direct contact will tran (3) The facility must r	n Control Program ident needs isolation to f infection, the facility must prohibit employees with a se or infected skin lesions ith residents or their food, if namit the disease. equire staff to wash their ict resident contact for which cated by accepted			

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		345009	B. WING		05/19/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	05/19/2016
				513 EAST WHITAKER MILL ROAD	
THE OAK	S AT WHITAKER GLEN-I	MAYVIEW		RALEIGH, NC 27608	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 441	F 441 Continued From page 11 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.		F 44	1	
	by: Based on observation interviews, facility stat during wound care for to receive wound care to clean a glucose more sidents for 2 of 2 ref finger stick blood sug and #128). The findir 1. On 5/18/16 at 3PM and Nurse #3 was ob- care for the Resident room the NP and Nur The NP was observe sacral wound and pri- the nurse further inst dressing. The Nurse debriding agent into the applicators and pack with saline. The nurse	T is not met as evidenced ons, record review and staff aff failed to wash their hands or 1 of 4 residents observed e (Resident #25) and failed eter with bleach between esidents observed to have a gar check (Resident #150 ngs included: A a Nurse Practitioner (NP) oserved to provide wound t #25. Upon entering the rse #3 were wearing gloves. ed to clean the resident ' s or to leaving the room gave ructions regarding the was observed to place a the wound with cotton tipped ed the wound with gauze wet e was observed to place an round the outside of the		 F441 This plan of correction cons written allegation of compliance. Preparation and submission of this correction does not constitute an admission or agreement by the pro- the truth of the fact alleged or the correctness of the conclusions set on this statement of deficiencies. plan of correction is prepared and submitted solely because of requir under state and federal law Address what corrective action accomplished for those residents identified: Orders were obtained 5/19/16 on r #25 to monitor g-tube site for signs/symptoms of infection for 7 or 	s plan of ovider of forth The rements will be

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	IPLF	CONSTRUCTION	OMB NC	SURVEY
IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		345009	B. WING			05/	19/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	S AT WHITAKER GLEN-N	ΛΔΥ\/IFW/		51	13 EAST WHITAKER MILL ROAD		
				R	ALEIGH, NC 27608		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOU		JLD BE COMPLETI	
F 441	Continued From page	- 12	F 4	141			
		onto gauze pads and			hygiene technique by educator on		
	cleaned around the re tube insertion site. Th			5.20.16.			
	place gauze around t			Nurse practitioner and nurse #3 were			
	place. The Nurse was			educated immediately on 5/18/16 by			
	gloves, pick up the cl			facility educator on proper hand hygier	ne		
	the desk and exit the			technique with dressing changes. Nurs	se		
	observed to go to the			education on proper hand hygiene			
	the unused supplies of			technique with dressing changes			
	used a hand sanitizer			implemented on 5/18-5/24/16. Nurses			
	On 5/18/16 at 3:28 Pl			PTO or FMLA will be educated upon the	eir		
	interview she washed			return.			
	finished everything. T			DHS or designed will observe 2 dressin			
	probably should have dressing change on t			DHS or designee will observe 3 dressin changes daily for 12 days, then weekly			
	On 5/18/16 at 3:39 Pl			two weeks, then once monthly to ensur			
		rse should have washed her			compliance with hand hygiene techniqu		
	hands prior to cleanin	ng the gastric tube. The d once dressing supplies			with dressing changes.		
	were taken into the ro			3. Address what measures will be put i	into		
	been removed from th			place or systemic changes made :			
	2. The manufacturer			Nurse practitioner and nurse #3 were			
	meter used by the fac			educated immediately on 5/18/16 by			
	be disinfected with an agent approved by the EPA				facility educator on proper hand hygier		
	(Environmental Protection Agency) such as				technique with dressing changes. Nurs	se	
	bleach.				education on proper hand hygiene		
	On 5/19/16 at 11:18AM, Nurse #2 was observed				technique with dressing changes		
	to check a finger stick blood sugar on Resident #150. The Nurse was observed to open a small package and remove a pad and clean the				implemented on 5/18-5/24/16. Nurses		
					PTO or FMLA will be educated upon the return.	C 11	
		•					
	glucose meter and stated she was cleaning the glucose meter with alcohol. The Nurse was then				General nurse orientation will include		
	observed to enter the room of Resident #128 and				proper hand hygiene technique with		
	explain to the resident she needed to check her				dressing changes.		
	blood sugar. Prior to						
		nurse was asked how she			DHS or designee will observe 3 dressin		
	-	glucose meter between			changes daily for 12 days, then weekly		
		stated she cleaned the			two weeks, then once monthly to ensur		
	alucose meter with h	each wipes before and after	1		compliance with hand hygiene techniqu		1

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		ND HUMAN SERVICES			PRINTED: 05/31/2016 FORM APPROVED	
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) N		E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		345009	B. WING		05/19/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
THE OAKS AT WHITAKER GLEN-MAYVIEW						
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 441	On 5/19/16 at 11:26A conducted with the N the glucose meter sh bleach wipes. The Ac during the interview a	alcohol between residents	F 441	 with dressing changes. 4. How facility will monitor, evaluate incorporate into QAPI: Nurse practitioner and nurse #3 were educated immediately on 5/18/16 by facility educator on proper hand hygiene technique with dressing changes. Nu education on proper hand hygiene technique with dressing changes implemented on 5/18-5/24/16. Nurse PTO or FMLA will be educated upon return. DHS or designee will observe 3 dres changes daily for 12 days, then week two weeks, then once monthly to ensite compliance with hand hygiene techniwith dressing changes. Results of hand hygiene observation be reported to the QAPI committee of 5/31/2016 and will determine need for further observations. Address what corrective action with accomplished for those residents identified: Resident #150 and #128 were monitor for 48 hours for any sign/symptoms of the process of the proce	e iene urse es on their sing cly for sure ique es will n or libe ored	
				infection.2. Address what corrective action will accomplished for those residents with	ll be	
ORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: RI1211	I F	acility ID: 923332 If cont	inuation sheet Page 14 of	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/31/2016 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345009	B. WING			05	/19/2016
NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
THE OAK	S AT WHITAKER GLEN-N	IAYVIEW			13 EAST WHITAKER MILL ROAD		
				R	ALEIGH, NC 27608		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From page	× 14	Í -				
1 441	Continued From page 14		F	441	potential:		
					Charts reviewed and 9 residents recein glucose checks identified with potentian be affected.		
					Nurse #2 was reeducated on 5/19/16 use bleach wipes between patient use clean and disinfect glucometer.		
					Nurses were educated 5-19 through 5/24/16 on glucometer cleaning and disinfecting between residents using bleach wipes. Nurses on PTO or FMLA will be educa upon return to the facility.	ated	
					DHS or designee will check daily 3 to nurses who have residents receiving glucose checks to ensure glucometers are cleaned with bleach wipes betwee use for 12 days, then weekly for two weeks, then monthly on varying shifts	s en	
					3. Address what measures will be put place or systemic changes made :	t into	
					Nurses were educated 5-19 through 5/24/16 on glucometer cleaning and disinfecting between residents using bleach wipes. Nurses on PTO or FMLA will be educa upon return to the facility.	ated	
					DHS or designee will check daily 3 to nurses who have residents receiving glucose checks to ensure glucometers are cleaned with bleach wipes betwee	8	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/31/2016 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345009	B. WING		05/19/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
THE OAKS AT WHITAKER GLEN-MAYVIEW 513 EAST WHITAKER MILL RO			513 EAST WHITAKER MILL ROAD		
-				RALEIGH, NC 27608	I
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 441	Continued From page	a 15	F 44	1	
				use for 12 days, then weekly for t weeks, then monthly on varying s	
				General nurse orientation will incl education on cleaning and disinfor glucometers with bleach wipes be patients.	ecting
				4. How facility will monitor, evalu incorporate into QAPI:	ate, and
				Nurses were educated 5-19 throu 5/24/16 on glucometer cleaning a disinfecting between residents us bleach wipes. Nurses on PTO or FMLA will be e upon return to the facility.	ind
				DHS or designee will check daily nurses who have residents receiv glucose checks to ensure glucom are cleaned with bleach wipes be use for 12 days, then weekly for t weeks, then monthly on varying s	ving leters tween wo
				General nurse orientation will incleducation on cleaning and disinfuglucometers with bleach wipes be patients.	ecting
				Results of audit will be reported to QAPI committee on 5/31/16 and to committee will determine the nee additional monitoring.	the

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