PRINTED: 05/14/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTII	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345009	B. WING		C 04/12/2018	
	ROVIDER OR SUPPLIER S AT WHITAKER GLEN-	MAYVIEW	•	STREET ADDRESS, CITY, STATE, ZIP CODE 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 000	INITIAL COMMENTS	3	F 00	00		
F 600 SS=G	conduct a complaint and exited on 4/9/18 obtained on 4/10/18, Therefore, the exit days are cited investigation survey same time as the recompliance. Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the neglect, misappropri	om Abuse, Neglect, and right to be free from abuse, ation of resident property,	F 6	00	4/19/18	
	includes but is not lir corporal punishment any physical or chen treat the resident's m §483.12(a) The facili §483.12(a)(1) Not us physical abuse, corp involuntary seclusion This REQUIREMEN by: Based on record revistaff interviews, for o sampled residents the neglect. The residen hours and forty-five means the same same same same same same same sam	ty must- se verbal, mental, sexual, or oral punishment, or i; T is not met as evidenced view, resident interviews, and one (Resident # 1) out of five se facility failed to prevent t experienced pain for three		This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does not constitute admission or agreement by		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

04/20/2018 **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.

PRINTED: 05/14/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345009	B. WING		C 04/12/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/12/2010		
				513 EAST WHITAKER MILL ROAD			
THE OAK	S AT WHITAKER GLEN-	MAYVIEW		RALEIGH, NC 27608			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)			
F 600	Continued From pag	ne 1	F 600				
. 000	Continued From pag		1 000				
	1 Poviou of Posido	nt # 1's closed record		provider of the truth of items alleged conclusions set forth for the alleged	וכ		
		it was admitted to the facility		deficiencies. The plan of correction is			
		M and transferred back to the		prepared and/or executed solely beca			
		ay at 10:50 PM. The resident		it is required by the provision of the st			
	did not return to the			and federal law. It also demonstrates			
		•		good faith and desire to continue to			
	Review of hospital re	ecords, which were located		improve the quality of care and service	es to		
	on the resident's faci	ility record, revealed the		our residents.			
	_	Prior to undergoing left total					
		gery on 2/12/18, the resident		Process that lead to the deficiency			
		own and she was cognitively					
		he resident underwent a		Resident # 1 was admitted to the faci			
	-	urgery after sustaining a fall		6:45PM and did not receive the reque	ested		
		femur fracture (the bone		pain medication until 10:30pm. The	:		
		components of the hip 16/18 the resident was		Charge Nurse failed to communicate timely manner with the on-call pharma			
		hospital to the facility for		and on call physician. We also identi			
	rehabilitation.	nospital to the facility for		a communication system failure that	lica		
	Toriasintation.			compounded the situation which was	the		
	According to the 3/10	6/18 hospital discharge		turnaround time taken between the or			
	summary the resider			pharmacy and the on-call physician			
	following pain medic	ations:		service while attempting to obtain			
	Oxycontin 20 mg (m	illigrams) every twelve hours		clarification orders for this resident.			
	with meals (a sustair	ned release medication)					
	, ,	nmediate release 1 to 2					
	tablets every four to	six hours as needed for pain.		Process for implementing a plan of			
				correction for specific deficiency			
		d record revealed signed		On 4/11/2019 the Olivinal Comments			
	1 -	en sent from the hospital to		On 4/11/2018 the Clinical Competence	•		
		8 for both the Oxycontin and er the hospital discharge		Coordinator / Nurse Managers began educating the Licensed Nurses regard			
		otions were in the resident's		timeliness of medication first dose wh			
	closed record file.	Justice World III and residentes		admitted and notification to physician			
	2.3000.00010.1110.			pharmacy when a medication is not			
	Review of the reside	ent's admission facility orders		available in the Cubex system for time	ely		
		20 mg (milligrams) twice per		delivery / code to Cubex. This educa			
	-	verified as an order on		has been added to the new hire/rehire			
		done Immediate Release 5		License Nurse orientation. The Trans	ition		

PRINTED: 05/14/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245000	B. WING			С	
NAME OF B	201/1252 02 01/221/52	345009	B. WING	OTDEET ADDRESS OFFI OTATE TO SOO	•	4/12/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
THE OAK	S AT WHITAKER GLEN-	MAYVIEW		513 EAST WHITAKER MILL ROAD			
0,	, , , , , , , , , , , , , , , , , , ,			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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CTION SHOULD BE COI O THE APPROPRIATE		
F 600	Continued From pag	e 2	F 60	00			
	mg was also verified with one change made by the facility physician. The resident was to receive one to two tablets every four hours as needed instead of one to tablets every four to six hours as needed. Review of the resident's March, 2018 MAR (medication administration record) revealed the resident was not documented as receiving any pain medication. Review of nursing notes revealed Nurse # 1 documented the following information on 3/16/18 at 6:45 PM. The resident was admitted and was alert and oriented. The resident complained of left hip pain. The resident was "instructed on process of obtaining meds." The resident's medications were verified with a facility physician. Following the nursing entry of 3/16/18 at 6:45 PM, the next nursing entry was made on 3/16/18 at 10:15 PM. Nurse # 1 noted within the entry that she was on the phone with the pharmacy when the resident's family member requested to speak to her about the resident's pain medication. The nurse noted the family member stated, "someone told me your pharmacy is closed." The nurse noted she explained the process of obtaining medications after hours to the family member. Following the nursing entry of 3/16/18 at 10:15 PM, the next nursing entry was at 10:30 PM. The note read, "Meds obtained and taken to resident. At this time (family member) states she has called 911 to transport resident back to hospital." The last nursing entry was made on 3/16/18 at 10:50 PM. It read, "Resident taken to hospital via			Nurse will obtain the Hospital Discharge summary. The Transition Nurse will review the physician discharge orders for accuracy and forward the orders to the facility. The charge nurse validates the orders with the physician then faxes the physician orders to pharmacy, the charge nurse will pull and administer the initial doses from the Cubex system that houses medications within the facility. When a narcotic is ordered the charge nurse notifies the pharmacy for an access code for the Cubex to obtain the narcotic. The charge nurse contacts the pharmacy for medications not available in the Cubex for the pharmacy for timely delivery of the medications. All medications ordered will be given timely unless ordered to be held by the attending physician.			
				Monitoring to ensure effective POC The Director of Health Service Managers/ Department Mana utilization the Admission Med Review form to verify the time medication administration with twenty-four hours of all new a for at least five days for two wnew admissions weekly for the then 5 new admissions monthmonths, then 5 new admission for the next 3 quarters. The A and/or Director of Health Service and trend the Admission Review form and present the the Quality Assurance and Peters 1.	es or Nurse gers are ication eliness of nin dmissions veeks, then 5 ree weeks, nly for three ns quarterly Administrator vices will n Medication analysis at		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345009	B. WING			1	C / 12/2018
NAME OF PI	ROVIDER OR SUPPLIER		_	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	12/2010
THE OAK	S AT WHITAKER GLEN-N	IAVVIEW		5′	13 EAST WHITAKER MILL ROAD		
THE OAK	S AT WHITAKER GLEN-N	IAI VIEW		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	EFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 600	Continued From page	3	F	600			
	0.04040.40.50	or for the control of the control of			Improvement Committee meeting.		
	back-up medications Oxycodone 5 mg imm	ne facility provided a list of they maintain in the facility. nediate release was on the was on the list. Oxycontin list.			Title of person responsible for implementing the POC The Administrator and Director of Heal		
	for Resident # 1. According record, on 3/16/18 at she gave two 10 mg (20 mg) and one Oxydrelease pill to Resider record, this was 3 hou	ded a controlled drug record ording to the controlled drug 10:30 PM Nurse # 1 signed Dxycontin pills (for a total of codone 5 mg immediate at # 1. According to the curs and forty five minutes dent had complained of			Services are responsible for implemen the plan of correction.	ling	
	PM via phone. The rewas also present via sinterview. The resider Prior to her transfer to receiving intravenous because of her pains discharge date to the for the ambulance. The "rough ride" for her. We facility and was move bed, it "was very pain medication immediate pharmacy was closed tried to move to position and the pain grew every out. She stated her members stepped out help during all of this. responsible party, whe 4/10/18 at 12:20 PM,	I. The resident stated she on something beneath her, en worse and caused her to er responsible party t in the hall to try to get her According to the resident's o was also interviewed on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245000	D WING			С	
NAME OF P	ROVIDER OR SUPPLIER	345009	B. WING _	STREET ADDRESS, CITY, STATE, Z	IP CODE	04/12/2018	
	S AT WHITAKER GLEN-I	MAYVIEW		513 EAST WHITAKER MILL ROAL 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 T DEFICIE	ACTION SHOULD BE FO THE APPROPRIA	DATE	
F 600	on 3/16/18. The respichecked with the nurshad to process ordershad an influx of new inparty stated the resid decided to call 911 at any pain medication. Interview with the DC 4/9/18 at 12:35 PM rearesident arrives afte utilizes their back- up prescriptions, which insent to the pharmacy calls and gives authoremove the narcotics storage for the medicifacility). A facility pharmacist in 2:15 PM. The pharmacy when a resident arrive nurses are to fax new pharmacy and call the back- up pharmacy comparts are to fax new pharmacy and call the back- up pharmacy comparts are to fax new pharmacy service. Anotification from the comparts are to the nurse. An authorization code access the narcotics back-up pharmacist in that matches the order the physician directly authorization code to	consible party repeatedly se and was told that they se and also that the facility residents. The responsible ent's pain was such that they fiter hours of not receiving ON (Director of Nursing) on evealed the following. When er 5 PM then the facility pharmacy. Narcotic must match the orders, are . The facility pharmacy then rization access to a nurse to from the facility Cubex (the ations maintained at the was interviewed on 4/9/18 at acist reported the following. We after five PM, then orders to the regular the back- up pharmacy. The an login to the regular and view the new orders. It is placed by the facility the pharmacist then receives appearator service and calls to a back- up pharmacist gives to nurses so they can from the Cubex system. The needs either a prescription ters, or they need to talk to in order to give the the nurse. If the narcotics then the back-up pharmacist	F6	500			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345009	B. WING				C / 12/2018	
NAME OF P	ROVIDER OR SUPPLIER		1	STREE	T ADDRESS, CITY, STATE, ZIP CODE	04	/12/2016	
TO UNE OF TH	TO VIDER OR OUT FEILER				AST WHITAKER MILL ROAD			
THE OAK	S AT WHITAKER GLE	EN-MAYVIEW			IGH, NC 27608			
				KALE	IIGH, NC 27808		1	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	ON SHOULD BE IE APPROPRIATE		
F 600	Continued From p	page 5	F 6	800				
	· ·	pharmacist reviewed their						
		ent # 1 and reported the						
		ir pharmacy records. The first						
	•	y Nurse # 1 to the operator						
		8 at 9:23 PM. According to the						
		was requesting authorization						
		ycodone, and another						
	prescribed medica	ation as soon as possible. The						
	•	t returned the call to the facility						
		B PM and noted the following in						
		log. The orders were being						
		ntin dosage did not match what						
		, and the nurse gave the						
		nysician's number so the						
		speak to the physician directly. ation about the Cxycodone 5						
		ease at 9:38 PM in the call						
	_	8 at 9:50 PM faxed						
		e received by the on call						
		. On 3/16/18 at 10:20 PM a						
	·	on was given by the physician to						
		r the Oxycontin and Oxycodone.						
	On 3/16/18 at 10:	30 PM the pharmacist called						
	and gave Nurse #	t 1 the authorization code to						
	access the pain m	nedications in the Cubex.						
		erviewed on 4/9/18 at 3:20 PM.						
		d the following. When the						
		t the facility she had not had her						
		ose of Oxycontin and the						
		ain. The nurse had to verify the						
		ew physician, fax them to the						
	•	tain authorization to access the						
		to give the pain medication. not remember the specifics of						
		ctors which delayed her in						
		rmacy until 9:23 PM. According						
		ough she could not recall the						
		vening, it had not seemed to her						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345009	B. WING _			C 04/12/2018	
	ROVIDER OR SUPPLIER S AT WHITAKER GLEN-I	MAYVIEW	•	STREET ADDRESS, CITY, STATE, ZIP COD 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	the pharmacy. The nobtained authorization she then took the med 10:30 PM. By that time called 911 because the severe pain. She were pills of Oxycontin 10 dose) and she also go immediate release simulatined release an Soon after the medical arrived and transport hospital. Review of EMS reconsinformation. EMS arrived and transport hospital. Review of EMS reconsinformation. EMS arrived and transport hospital. Review of EMS reconsinformation. EMS arrived and transport hospital. The intravenous access for they administered To resident was transfer EMS crew noted the during pt (patient) considered the during pt (patient) considered and personally go get need anything possible with the resident getting pto the administrator, its services should work facility to have and acceptable services.	9:23 PM before she called urse reported that when she in for the pain medication, dication to the resident at the, the family had already the resident was having that ahead and gave the two ing (to equal the 20 mg ave her 5 mg of Oxycodone ince the Oxycontin was doubt the the that the resident needed relief. The ation administration, EMS are the facility on 3/16/18 and the facility on 3/16/18 are sident was found lying in her (patient) crying and in the medication, and noted aradol and Fentanyl. The red back to the hospital. The resident's pain "was reduced"	F 6				

PRINTED: 05/14/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345009	B. WING _		C 04/12/2018
	ROVIDER OR SUPPLIER S AT WHITAKER GLEN	-MAYVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 697 F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Ma The facility must en provided to resident consistent with profithe comprehensive and the residents' g This REQUIREMEN by: Based on record restaff interviews, for sampled resident act the resident experies	nagement. sure that pain management is is who require such services, essional standards of practice, person-centered care plan, oals and preferences. IT is not met as evidenced eview, resident interviews, and one (Resident # 1) of one dmitted to the facility in pain, enced pain for three hours and efore pain medication was	F 6	97	facility at equested ne ate in a
	revealed the resider on 3/16/18 at 6:45 F hospital that same of did not return to the Review of hospital ron the resident's fact following information hip replacement sur had resided on her intact. On 3/11/18 second orthopedics and a periprosthetic fractured around the replacement.) On 3 discharged from the rehabilitation.	ent # 1's closed record int was admitted to the facility PM and transferred back to the day at 10:50 PM. The resident facility. records, which were located cility record, revealed the in. Prior to undergoing left total regery on 2/12/18, the resident rown and she was cognitively the resident underwent a surgery after sustaining a fall is femur fracture (the bone is components of the hip in 16/18 the resident was is hospital to the facility for		and on call physician. We also idea communication system failure the compounded the situation which we turnaround time taken between the pharmacy and the on-call physicial service while attempting to obtain clarification orders for this resident Process for implementing a plan of correction for specific deficiency. On 4/11/2018 the Clinical Compet Coordinator / Nurse Managers be educating the Licensed Nurses retimeliness of medication first dose admitted and notification to physic pharmacy when a medication is not available in the Cubex system for delivery / code to Cubex. This education has also been added to the new hire/rehire License Nurse orientation.	nat was the le on-call an at. of tency gan garding e when cian and ot timely ucation ion. The

PRINTED: 05/14/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345009	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	0.0000	 	STREET ADDRESS, CITY, STATE, ZIP CODE		4/12/2018	
TO UNIC OF T	TO VIDER OR GOLF EIER			513 EAST WHITAKER MILL ROAD			
THE OAK	S AT WHITAKER GLEN-	MAYVIEW		RALEIGH, NC 27608			
(V4) ID	QLIMMADV QT	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	PECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE	
F 697	Continued From page	e 8	F 69	97			
	with meals (a sustain Oxycodone 5 mg imitablets every four to sustain Oxycodone 5 mg imitablets every four to sustain oxycodone 3 mg imitablets every four to sustain oxycodone as performed oxycodone as performed oxycodone oxycontinuous oxycodone oxycontinuous oxycodone oxycod	ations: ligrams) every twelve hours ed release medication) mediate release 1 to 2 six hours as needed for pain. record revealed signed en sent from the hospital to a for both the Oxycontin and er the hospital discharge tions were in the resident's on mg (milligrams) twice per rerified as an order on one Immediate Release 5 with one change made by The resident was to receive ery four hours as needed		Discharge summary. The Tran Nurse will review the physiciar orders for accuracy and forward orders to the facility. The charge validates the orders with the pithen faxes the physician order pharmacy, the charge nurse wadminister the initial doses from Cubex system that houses me within the facility. When a narrowdered the charge nurse notification of the cubix to obtain the narcotic. The nurse contacts the pharmacy for medications not available in the pharmacy for timely delivery of medications. All medications of be given timely unless ordered by the attending physician.	n discharge rd the ge nurse hysician s to vill pull and m the edications cotic is fies the for the ne charge for call f the ordered will		
	instead of one to tabl needed.	ets every four to six hours as		Monitoring to ensure effectiver POC	ness of		
	(medication administration (medication administration) resident was not door pain medication.	nt's March, 2018 MAR ration record) revealed the umented as receiving any		The Director of Health Service Managers/ Department Manag utilization the Admission Media Review form to verify the timel	gers are cation liness of		
	documented the follo at 6:45 PM. The resi alert and oriented. Th hip pain. The residen of obtaining meds." T were verified with a fa			medication administration with twenty-four hours of all new act for at least five days for two we new admissions weekly for thr then 5 new admissions monthl months, then 5 new admission for the next 3 quarters. The Act and/or Director of Nursing will	in dmissions eeks, then 5 ee weeks, ly for three is quarterly dministrator track and		
	the next nursing entry	entry of 3/16/18 at 6:45 PM, was made on 3/16/18 at noted within the entry that		trend the Admission Medicatio form and present the analysis Quality Assurance and Perform	at the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345009	B. WING			1	C / 12/2018	
NAME OF P	ROVIDER OR SUPPLIER	0.0000	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	04	/12/2016	
	S AT WHITAKER GLEN-I	MAYVIEW		51	3 EAST WHITAKER MILL ROAD ALEIGH, NC 27608			
	OUR MAR BY OF	TATEMENT OF DEFICIENCIES		- 107	<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 697	Continued From page	e 9	F 6	597				
		e with the pharmacy when			Improvement Committee meeting.			
	-	member requested to speak lent's pain medication. The			Title of person responsible for			
		ly member stated, "someone cy is closed." The nurse			implementing the POC			
	, ,	the process of obtaining			The Administrator and Director of Heal	th		
		urs to the family member.			Services are responsible for implemen the plan of correction.			
		entry of 3/16/18 at 10:15						
	-	entry was at 10:30 PM. The						
	note read, "Meds obtained and taken to resident. At this time (family member) states she has							
		rt resident back to hospital."						
	The last nursing entr	y was made on 3/16/18 at						
	10:50 PM. It read, "R EMS (Emergency Me	esident taken to hospital via edical Services)."						
		he facility provided a list of						
		they maintain in the facility.						
	, ,	nediate release was on the was on the list. Oxycontin						
	20 mg was not on the							
		ded a controlled drug record						
		ording to the controlled drug						
		10:30 PM Nurse # 1 signed Oxycontin pills (for a total of						
		codone 5 mg immediate						
	, ,	nt # 1. According to the						
		urs and forty five minutes						
	from the time the res pain.	ident had complained of						
	Resident # 1 was inte	erviewed on 4/10/18 at 12:20						
		esident's responsible party						
		speaker phone during the						
		nt reported the following. o the facility she had been						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345009	B. WING			C)4/12/2018	
	ROVIDER OR SUPPLIER	-MAYVIEW		STREET ADDRESS, CITY, STATE, ZIP COI 513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608		14,12,2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 697	because of her pain discharge date to the for the ambulance. "rough ride" for her. facility and was move bed, it "was very pare medication immediate pharmacy was close tried to move to pose and the pain grew endication immediate to move to pose and the pain grew endication immediate to move to pose and the pain grew endication and the process order that the pain medication and pain medication. Interview with the Day 18 at 12:35 PM a resident arrives and utilizes their back- uprescriptions, which sent to the pharmacials and gives authoremove the narcotic storage for the medicality). A facility pharmacist 2:15 PM. The pharmacist 2:15 PM. The pharmacist 2:15 PM. The pharmacial storage for the medical pharmacist 2:15 PM. The pharmac	is morphine in the hospital severity. On her 3/16/18 e facility there was a long wait. The ride to the facility was a When she arrived at the yed from the stretcher to the inful." She asked for pain ately and was told the ed. The resident stated she ition something beneath her, wen worse and caused her to her responsible party but in the hall to try to get her as. According to the resident's who was also interviewed on and the hospital at 3 PM ponsible party repeatedly but and was told that they are and was told that they are and also that the facility or residents. The responsible dent's pain was such that they after hours of not receiving	F 69				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD	NG		,	C
		345009	B. WING				12/2018
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE OAK	C AT MUUTAKED OLEM	NA ANAZIJENAZ		51	13 EAST WHITAKER MILL ROAD		
THE OAK	S AT WHITAKER GLEN	-MAY VIEW		R	ALEIGH, NC 27608		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	pharmacy and call thack-up pharmacy records The initial call, which nurse, goes to an opharmacy service. In the speak to the nurse, an authorization code access the narcotic back-up pharmacist that matches the ordination code that matches the physician directly service on 3/16/18 arecord, Nurse # 1 which for Oxycontin, Oxyconscribed medication call pharmacist ron 3/16/18 at 9:38 Fithe pharmacy call lof faxed, the Oxycontin was in the Cubex, apharmacist could spontation that matches the physician could spontation that matches the physician that the physicia	w orders to the regular he back- up pharmacy. The can login to the regular and view the new orders. h is placed by the facility perator for their back-up A pharmacist then receives operator service and calls to A back- up pharmacist gives de to nurses so they can serom the Cubex system. The needs either a prescription ders, or they need to talk to by in order to give the to the nurse. If the narcotics at then the back-up pharmacist will pharmacist to fill the harmacist reviewed their thank and reported the pharmacy records. The first Nurse # 1 to the operator at 9:23 PM. According to the as requesting authorization odone, and another on as soon as possible. The eturned the call to the facility PM and noted the following in the pharmacy records were being and dosage did not match what and the nurse gave the sician's number so the peak to the physician directly. In about the Cxycodone 5 as at 9:38 PM in the call	F	697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	· ,	(X3) DATE SURVEY COMPLETED	
		345009	B. WING _			C 04/12/2018	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO. 513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608		4/12/2016	
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 697	and gave Nurse # 1 access the pain med Nurse # 1 was interv Nurse # 1 reported the resident arrived at the evening 20 mg dose resident was in pain. Orders with the new pharmacy, and obtain narcotics in order to The nurse could not the evening or factor talking to the pharmato the nurse, althoug specifics of the even that it was as late as the pharmacy. The nobtained authorization she then took the medicalled 911 because the severe pain. She we pills of Oxycontin 10 dose) and she also gimmediate release and Soon after the medical arrived and transport hospital. Review of EMS reconinformation. EMS arrived.	e 12 PM the pharmacist called the authorization code to ications in the Cubex. iewed on 4/9/18 at 3:20 PM. The following. When the efacility she had not had her of Oxycontin and the The nurse had to verify the ohysician, fax them to the en authorization to access the give the pain medication. The remember the specifics of so which delayed her in acy until 9:23 PM. According the she could not recall the ing, it had not seemed to her 9:23 PM before she called urse reported that when she on for the pain medication, edication to the resident at the entering the family had already the resident was having the her 5 mg of Oxycodone ance the Oxycontin was done the Oxycontin was done the oxycontin was done the resident to the entering the facility on 3/16/18 and the facility on 3/16	Fé	97			
	bed. They noted "pt. obvious pain." The E	esident was found lying in her (patient) crying and in MS crew established or medication, and noted					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345009	B. WING			С		
NAME OF PI	ROVIDER OR SUPPLIER	343009	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	04/	12/2018	
THE OAK	S AT WHITAKER GLEN-N	MAYVIEW			13 EAST WHITAKER MILL ROAD PALEIGH, NC 27608			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 697	resident was transfer EMS crew noted the during pt (patient) con Interview with the fac at 11:30 AM revealed family after 9 PM on 3 personally go get need anything possible with the resident getting pto the administrator, the services should work facility to have and act as soon as possible spain. Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b) §483.45 Pharmacy Strucs Pharmacy Strucs and biologicals them under an agree §483.70(g). The facility must providing and biologicals them under an agree §483.70(g). The facility personnel to administ permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical service that assure the accurdispensing, and admibiologicals) to meet the service CS483.45(b) Service CS48	radol and Fentanyl. The red back to the hospital. The resident's pain "was reduced ntact." fility administrator on 4/12/18 he was contacted by the 3/16/18. He offered to ded medications and do nin his control to expedite ain medications. According he facility's pharmaceutical in a way that allowed the dminister pain medications to that residents were not in dedures/Pharmacist/Records (1)-(3) ervices ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed		755			4/19/18	

PRINTED: 05/14/2018 FORM APPROVED OMB NO. 0938-0391

	OVIDER OR SUPPLIER	345009	D MAINO			_	
	OVIDER OR SUPPLIER	0.0000	345009 B. WING			C 04/12/2018	
	VIDER OR OUT FIER			STREET ADDRESS, CITY, STATE, ZIP CODE		12/2018	
THE OAKS				513 EAST WHITAKER MILL ROAD			
THE OAKS AT WHITAKER GLEN-MAYVIEW		IAYVIEW		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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 755	Continued From page	: 14	F 7	55			
á	§483.45(b)(1) Provide aspects of the provision the facility.	es consultation on all on of pharmacy services in					
r		shes a system of records of n of all controlled drugs in able an accurate					
i - t	order and that an acco s maintained and per This REQUIREMENT by:	is not met as evidenced					
)) 1	staff interviews the fac Residents #2, and #	ew, resident interviews, and cility failed to assure two 3) of three newly admitted heduled medications. The		Process that lead to the deficient The charge nurse assigned to #2 was new to the facility and condensated the process of calling backup pharmacy and/or the transfer intervention substitution protocommunications.	Resident did not ng the nerapeutic		
6 1 1 1	admitted to the facility resident had diagnose follicular lymphoma, a oneumonia, degenera respiratory failure, refl			Resident #3, their charge nurse the pharmacy for the medication however, the pharmacy did not medication as they thought the was coming from a different so Compounding this situation, the did not follow through to ensure medications where received from pharmacy and/or that a therape	e did call on; t send the medication ource. e nurses e		
i		ed the resident's brief tatus score, dated 4/4/18, d the resident was		intervention form was obtained pharmacy with a substitute me ordered/received and administration	from the dication		
r r	March, 2018 MAR (m	orders and the resident's edication administration following orders and MAR		Process for implementing a pla correction for specific deficience On 4/11/2018 the Clinical Com Coordinator / Nurse Managers	petency		

PRINTED: 05/14/2018 FORM APPROVED OMB NO. 0938-0391

OLIVILIY	OT OIL MEDIO/ IILE &	WEDIO/ ND OLIVIOLO				OIVID IT	3. 0000 000 1
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
							С
		345009	B. WING			04	/12/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	S AT WHITAKER GLEN-	MAYVIEW			13 EAST WHITAKER MILL ROAD ALEIGH, NC 27608		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 755	Continued From page	e 15	F	755			
	There was an order for	or Lantus Insulin 20 Units			educating the Licensed Nurses regard	ing	
	Subcutaneous every	hour of sleep. The Lantus			the timeliness of medications being give	en en	
	Insulin was schedule	d on the MAR for 9 PM. The			when residents are admitted, notification	on	
		de the 9 PM doses for			to physician and pharmacy when a		
		There was no blood sugar			medication is not available in the Cube	X	
		n the MAR. On 3/30/18 the			system for timely delivery from the		
	_	r readings ranged from 92 to			back-up pharmacy, obtaining a		
	174.				Therapeutic Interchange for medication when appropriate and the process of	15	
	There was an order fo	or Asacol HD 800 milligrams			obtaining codes for dispensing from th	e	
	(a delayed release m				Cubex. This education has also been	•	
		ems) to be given three times			added to the new hire/rehire License		
		Juled on the MAR for 9 AM, 1			Nurse orientation. The Transition Nurs	se	
	PM, and 5 PM. Nurs	e # 2's circled initials			will obtain the Hospital Discharge		
	appeared beside the	9 AM and 1 PM dose on			summary. The Transition Nurse will		
		circled initials appeared			review the physician discharge orders		
	beside the 4 PM dose	e on 3/30/18.			accuracy and forward the orders to the		
					facility. The charge nurse validates the		
		or one inhalation of Breo			orders with the physician then faxes th		
		ram/dose (an inhaler for sease) to be given every			physician orders to pharmacy, the cha nurse will pull and administer the initial		
		duled on the MAR for 9 AM.			doses from the Cubex system that hou		
		itials appeared on 3/30/18 by			medications within the facility. The cha		
	the 9 AM dose.	mais appeared on creer to by			nurse contacts the pharmacy for	.90	
					medications not available in the Cubex	for	
	There was an order for	or Questran 4 gram powder			the pharmacy to notify the on-call		
	packet to be given tw	· · ·			pharmacy for timely delivery of the		
		R for 9 AM and 9 PM. Nurse			medications or to provide a therapeution		
	-	ppeared on 3/30/18 by the 9			intervention substitution. All medicatio	ns	
		s circled initials appeared by			ordered will be given timely unless		
	the 9 PM dose.				ordered to be held by the attending physician.		
	There was an order for	or two sprays of Flonase 50			, , , , , ,		
		n to be administered in each					
	_	as scheduled on the MAR			Monitoring to ensure effectiveness of		
		circled initials appeared on			POC		
	3/30/18 by the 9 AM						
		or Omeprazole 20 mg every			The Director of Health Services or Nur	se	
	morning. It was scheen	duled on the MAR for 6 AM.			Managers/ Department Managers are		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345009	B. WING			С	
	201/1050 00 01/100/150	345009	B. WING _		TDEET ADDRESS SITV STATE TIP SODE	04/	12/2018
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS	S AT WHITAKER GLEN-N	MAYVIEW			13 EAST WHITAKER MILL ROAD		
				R	RALEIGH, NC 27608		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	F 755 Continued From page 16		F 7	755			
	The MAR was blank o				utilization the Admission Medication		
	THO WILL WAS SIGNAC	511 57 557 16 dt 6 7 uvi.			Review form to verify the timeliness of		
	There was an order for	or Neurontin 900 mg three			medication administration within		
		scheduled on the MAR for 6			twenty-four hours of all new admission	s	
		/I. The MAR was blank			for at least five days for two weeks, the		
	beside the dose on 3/	/30/18 at 6 AM.			new admissions weekly for three week	S,	
					then 5 new admissions monthly for three	э е	
		was interviewed on 4/10/18			months, then 5 new admissions quarte	•	
	at 9:45 AM. The pharmacist reported the				for the next 3 quarters. The Administra		
	following. The facility				and/or Director of Nursing will track and		
		ex system which can be			trend the Admission Medication Review	٧	
	signed out to residents. When the medications				form and present the analysis at the		
	_	ne pharmacy receives a			Quality Assurance and Performance		
	record of this. Prior to				Improvement Committee meeting.		
	-	wed what medications had the Cubex for Resident # 2			Title of person responsible for		
	and what medications				implementing the POC		
	pharmacy. The pharm				Implementing the Foo		
		physician orders sheets on			The Administrator and Director of Heal	th	
		There is a cut off time at 5			Services are responsible for implement		
		cy makes one delivery per			the plan of correction.	J	
		narmacist stated the nurses			·		
	should have called th	e back- up pharmacy for					
	medications which we	ere not in the Cubex. The					
		ord the facility contacted the					
		he Breo Ellipta inhaler,					
		I are not in the facility's					
		ne orders for these three					
		ocessed on 3/30/18, and					
		ons were first delivered to the					
		3:23 AM. Therefore, these					
		re not available when the					
		itials indicating they were There was also no Lantus					
	_	back- up medication. The					
	-	ack-up Insulin kit in the					
		Levemir Insulin. According					
	_	ere is an approved process					
		en the facility and pharmacy.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345009 B. WING				C 04/12/2018	
	ROVIDER OR SUPPLIER	1 1111		STREET ADDRESS, CITY, STATE, ZIP CO 513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608	•	4/12/2016	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 755	The process allows to and utilized instead of physician's approval pharmacist there wa process had occurred that the Lantus Insultivation that the Lantus Insultivation and interest that was a documentation the numedications for Residual and interest that was the number of the Insultivation and interest the facility. The number of the Insultivation in the Insul	the Levemir to be exchanged of the Lantus if there is a to do so. According to the son odocumentation this don 3/29/18 and 3/30/18 or in was sent to the facility at 3:23 AM. Flonase and cility's Cubex. There was no urses removed these dent # 2 when she was or on 3/30/18. The first time to the pharmacy to the facility was M. Neurontin is in the re was evidence there were removed at the following 1 PM; 3/30/18 at 9:25 AM; PM. There was no record a removed from the Cubex by who was responsible for 1/18 at 6 AM when the MAR time it was sent by the 31/18 at 3:23 AM. Provided a list of nurses who ent # 2 on 3/29/18 and Nurse # 5 had been the Resident # 2 on 3/29/18. iewed on 4/10/18 at 7:05 PM. he following. She was new to not familiar with the process	F 7	55			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ı	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345009	B. WING	B. WING			C / 12/2018
	ROVIDER OR SUPPLIER			513 E	ET ADDRESS, CITY, STATE, ZIP CODE AST WHITAKER MILL ROAD EIGH, NC 27608	1 04/	12/2016
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 755	4/11/18 at 12:14 PM. # 4 was responsible medications on 3/30/the Neurontin were be evidence they were reduced they was the reduced to stated it was her star she administered. The aware she was to go medications were not sometimes the Cube medications were the actually in the Cubex Nurse # 2 was interved. Nurse # 2 report her initials for the Brec Questran, and the Asteria medications were not pharmacy and they was there. She did not 3/30/18 because she in the Cubex, and it is pharmacy. Nurse # 3 was interved the circled initials for meant she did not give could not recall if she had given Insulin she and she was not aware reduced to the reduc	dated the list of nurses on According to the list, Nurse for the resident's 6 AM '18 when the Prilosec and blank, and there had been no removed from the Cubex. iewed on 4/11/18 at 1:06 PM. remember the details of the n administration. The nurse indard to sign for medications ine nurse stated she was to the Cubex when t available. The nurse stated it available. The nurse stated it available is the was conce it was accessed.	F	755			
	Lantus. Resident # 2 was init	ially interviewed on 4/9/18 at					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345009	B. WING _			C 04/12/2018
	ROVIDER OR SUPPLIER	-MAYVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608		04/12/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 755	received all of her madmitted when they 12:32 PM the resident again. The resident missed medications gotten her Insulin fo was first admitted. The while to get her medications gotten her Insulin for was first admitted. The while to get her medicate in the second in th	ent reported she had not redications when she was first were due. On 4/11/18 at nt was interviewed via phone verified Insulin was one of the and reported she had not reaccuple of days when she the resident stated it took a fications. Idministrator on 4/12/18 at the was his expectation that the duled medications. In note, the administrator stated the osed to fax the exchange cility so that the nurses could a land dosage orders from the exchange information from the exchange informa	F 7	55		

A. BUILDING A. BUILDING A. BUILDING B. WING NAME OF PROVIDER OR SUPPLIER THE OAKS AT WHITAKER GLEN-MAYVIEW STREET ADDRESS, CITY, STATE, ZIP CODE 513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	C /12/2018
NAME OF PROVIDER OR SUPPLIER THE OAKS AT WHITAKER GLEN-MAYVIEW (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608 ID PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
THE OAKS AT WHITAKER GLEN-MAYVIEW 513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608 (X4) ID PROVIDER'S PLAN OF CORRECTION	COMPLETION
THE OAKS AT WHITAKER GLEN-MAYVIEW (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	COMPLETION
(X1)18	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	1
F 755 Continued From page 20 3/24/18-6 AM dose-Nurse # 8's initials were circled 3/24/18-10 PM dose-Nurse # 6's initials were circled 3/25/18-6 AM dose-Nurse # 9's initials were circled 3/25/18-6 AM dose-Nurse # 6's initials were circled 3/25/18-10 PM dose-Nurse # 6's initials were circled 3/25/18-10 PM dose-Nurse # 6's initials were circled 3/26/18-10 PM dose-Nurse # 9's initials were circled 3/26/18-10 PM dose-Nurse # 9's initials were circled 3/26/18-10 PM dose-Nurse # 9's initials were circled 3/26/18-10 PM dose-Nurse # 6's initials were circled 3/27/18-2 PM Murse # 10's initials were circled 3/27/18-2 PM Nurse # 10's initials were circled The back of the MAR did not have documentation related to why the Inderal was not given by the nurses. Record review revealed between the dates of 3/23/18 and 3/27/18 the highest documented systolic blood pressure was 137. The highest documented diastolic blood pressure was 87. Interview with a facility pharmacist on 4/9/18 at 2:15 PM revealed the Inderal was first filled and sent to the facility on 3/27/18, and the medication was not in the facility's Cubex medications (the medications stored at the facility). The pharmacist stated prior to 3/27/18, pharmacy records showed the resident's medications were being supplied by another source. According to the pharmacist there must have been confusion	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY DMPLETED
		345009	345009 B. WING			C 04/12/2018
	NAME OF PROVIDER OR SUPPLIER THE OAKS AT WHITAKER GLEN-MAYVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608		04/12/2010
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	regarding what led to Nurse # 6 was interval. The nurse repordates she circled he had not given the Inwas not available. Odate of 3/23/18, it was facility pharmacy was medications. The organishment of the days it was unaway that there had been to call the back-up per the back-up service number and instruct not heard from them stated there had been would not call within	id not contain notations	F 7	55		
	AM. According to the meant that the medinurse stated if the medinurse would have give According to staffing 4/9/18 at 5:17 PM by	viewed on 4/10/18 at 11:25 e nurse her circled initials cation was not given. The redication had been there, en it. information provided on y the administrator, Nurse # 7 medications on 3/24/18 at 6				
	interviewed on 4/10/ Nurse # 7 it was her she gave a medicati not recall the specifi	vas blank. Nurse # 7 was 18 at 10:23 PM. According to standard of practice to sign if on. Although the nurse could cs of why Resident # 3's ed as administered by her,				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245000	B. WING			С	
		345009				04/	12/2018
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS	S AT WHITAKER GLEN-N	MAYVIEW			513 EAST WHITAKER MILL ROAD		
	-			F	RALEIGH, NC 27608		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE	
F 755	the nurse stated there had to call the pharma admitted residents' m. According to staffing it 4/9/18 at 5:17 PM by 11 and Nurse # 5 wer medications on 3/27/2 was blank. Interview to at 9:12 PM revealed in that date, and Nurse amedications to Reside Nurse # 9 was intervie PM. Nurse # 9 reported because the medication rurse reported she cathan one time, and the delivered.	e were times when nurses acy several times for newly edications. Information provided on the administrator, Nurse # re responsible for 18 at 6 AM when the MAR with Nurse # 11 on 4/10/18 nurses switched carts for # 9 had been giving 6 AM eent # 3 on 3/27/18. Rewed on 4/10/18 at 10:54 ed she circled her initials on was not available. The alled the pharmacy more e medication was not	F	755			
F 760 SS=D	AM. The nurse report while he was on duty 2 PM dose was circle him when it arrived the Interview with the adri 11:30 AM revealed it residents would not maccording to the admipharmacy, in conjuncipharmacy, was to prohour basis. Residents are Free of CFR(s): 483.45(f)(2) The facility must ensured the condition of the condition	ministrator on 4/12/18 at was his expectation that hiss scheduled medications. inistrator, the facility's tion with their back-up ovide medications on a 24 f Significant Med Errors	F	760			4/19/18

PRINTED: 05/14/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345009 B. W			C 04/12/2018	
	ROVIDER OR SUPPLIER	MAYVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608	, 02.20.0	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE	JLD BE COMPLETION	
F 760	Continued From pag	e 23	F 76	60		
	medication errors. This REQUIREMEN' by: Based on record revistaff interviews the fall sulin as ordered for sampled residents were viewed. The findings included Record review reveal admitted to the facility resident had a diagn. Record review reveal interview for mental swas 15. This indicate cognitively intact. Review of admission March, 2018 MAR (record) revealed the documentation. There was an order Subcutaneous every Insulin was schedule MAR was blank besi 3/29/18 and 3/30/18 reading for 3/29/18 or esident's blood sugal 174. A facility pharmacist at 9:45 AM. The pha following. There is no facility's back- up metals and supplementations.	T is not met as evidenced view, resident interview, and acility failed to administer r one (Resident # 2) of three hose medications were d: aled Resident # 2 was by on 3/29/18 at 6 PM. The osis of diabetes. aled the resident's brief status score, dated 4/4/18, and the resident was a orders and the resident's medication administration following orders and MAR for Lantus Insulin 20 Units and on the MAR for 9 PM. The de the 9 PM doses for a There was no blood sugar on the MAR. On 3/30/18 the ar readings ranged from 92 to was interviewed on 4/10/18 rmacist reported the contacts and the resident's contact and the resident's and the resi		Process that lead to the deficiency. The charge nurse assigned to Res #2 was new to the facility and did runderstand the process of calling to backup pharmacy and/or the thera intervention substitution protocol. Compounding this situation, the nudid not follow through to ensure medications where received from to pharmacy and/or that a therapeutic intervention form was obtained from pharmacy with a substitute medical ordered/received and administered. Process for implementing a plan of correction for specific deficiency. On 4/11/2018 the Clinical Competer Coordinator / Nurse Managers begoed educating the Licensed Nurses regothe timeliness of medications being when residents are admitted, notifit to physician and pharmacy when a medication is not available in the Cosystem for timely delivery from the back-up pharmacy, obtaining a Therapeutic Interchange for medic when appropriate and the process obtaining codes for dispensing from Cubex. This education has also be added to the new hire/rehire Licens Nurse orientation. The Transition Nurse will obtain the Hospital Discharge summary. The Transition Nurse will serve to the residence of the process.	ident not he peutic urses pack-up m the tion d. f ency gan garding g given cation cation cubex ations of m the see lurse	
	following. There is no facility's back- up me the facility. The facil	Lantus Insulin in the		· ·	lers for	

PRINTED: 05/14/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			71. 501251	_		(
		345009	B. WING			04/12/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	S AT WHITAKER GLEN-N	AAVVIEW		513 EAST WHITAKER MILL ROAD			
THE OAK	SAI WHITAKER GLEN-II	MAI VIEVV		R	ALEIGH, NC 27608		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
F 760	approved process to facility and pharmacy with orders for Lantus Levemir to be exchanthe Lantus if there is so. According to the process of the Lantus Insulin was seen and a se	the pharmacist, there is an be followed between the when a resident is admitted in the good and utilized instead of a physician's approval to do charmacist there was no rocess had occurred on The first time the resident's ent to the facility was on Therefore it had not been ration when the MAR was ue on 3/29/18 and 3/30/18. Provided a list of nurses who are # 2 on 3/29/18 and Nurse # 5 had been the Resident # 2 on 3/29/18. Event of the facility was new to not familiar with the process	F	760	facility. The charge nurse validates the orders with the physician then faxes the physician orders to pharmacy, the char nurse will pull and administer the initial doses from the Cubex system that hou medications within the facility. The charnurse contacts the pharmacy for medications not available in the Cubex the pharmacy to notify the on-call pharmacy for timely delivery of the medications or to provide a therapeutic intervention substitution. All medication ordered will be given timely unless ordered to be held by the attending physician. Monitoring to ensure effectiveness of POC The Director of Health Services or Nurs Managers/ Department Managers are utilization the Admission Medication Review form to verify the timeliness of medication administration within twenty-four hours of all new admissions for at least five days for two weeks, the new admissions weekly for three weeks then 5 new admissions monthly for three months, then 5 new admissions quarter for the next 3 quarters. The Administration and/or Director of Nursing will track and trend the Admission Medication Review form and present the analysis at the Quality Assurance and Performance Improvement Committee meeting. Title of person responsible for	e ge ses rge for s se se se rly attor d	
		cility for an exchange of			implementing the POC		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345009	B. WING _			l	C 40/0040		
NAME OF D		343003	1 2: *******				04/12/2018		
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE				
THE OAK	S AT WHITAKER GLEN-N	IAYVIEW		513 EAST WHITAKER MILL ROAD					
07	, , , , , , , , , , , , , , , , , , ,			R/	ALEIGH, 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			BE COMPLETION			
F 760			F 7	760	The Administrator and Director of Health Services are responsible for implement the plan of correction.				