STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____ NOV 29 2012	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD PO BOX 3427 BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431	White Oak of Burlington labels drugs and biologicals in accordance with currently accepted professional principles and includes appropriate accessory and cautionary instructions and the expiration dates, when applicable. The Pneumo-vac vial opened 8/22/12 found in the refrigerator on B Wing medication room was discarded on 10/3/12 when found. The Advair diskus found on B Wing medication cart that was dated 8/29/12 and had been opened and removed from the moisture protective foil was discarded on 10/5/12 when found. The glucometer control agent found on B Wing medication cart with expiration date of 6/30/12 was discarded when found on 10/3/12. The Medication rooms and medication carts have been inventoried to assure no expired biologicals are stored. This inventory was completed by Nursing Administration, including the DON, Staff Development Coordinator (SDC), Unit Coordinators, and Nurse	11/1/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Catherine Meredith, LNHA | TITLE: ADMINISTRATOR | (X6) DATE: 10/25/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD PO BOX 3427 BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 1 Based on observations, interviews and record reviews the facility failed to remove expired medications and supplies from 2 of 13 medication storage areas (B Wing medication room and medication cart). The findings include: On 10/03/2012 at 10:40 a.m. an observation was made of the facility's B Wing medication room with staff member # 1. In the refrigerator in a plastic zip lock bag an opened single dose vial of Pneumo-vax for injection (lot # 1071AA, manufacturer's expiration date - 20 MAR 2013) was observed. The vial was observed with the protective cap removed and having fluid still in the bottle. The vial also had an open date written in permanent marker on the label of 08/22/2012. An interview was conducted with staff member #1 concerning the Pneumo-Vax vial. Staff member #1 indicated the vial was a one use/dose vial, the safety cap had been removed, the open date written on the vial was 08/22/2012 (42 days ago), and there was fluid left in the vial. Staff member #1 also indicated the vial should have been discarded due to the vial having the protective cap removed, the time since the open date, and it being a one dose vial. On 10/03/2012 at 1:15 p.m. an observation was made of the facility's B Wing Back Hall medication cart with staff member # 2. In the back of the top drawer an Advair diskus inhaler (Lot # 2ZP3448 and manufacturer's expiration date - 12/2012) was observed to be opened (taken out of the package) and being used. The date, 08/29/2012, was written in permanent marker on the inhaler label indicating it was	F 431	Supervisors. This inventory was completed on 10/19/12. The routinely scheduled licensed nursing staff have received re-education on checking medication rooms and medication carts daily for expired items by the DON and SDC. This re-education will be completed by 11/1/12. PRN nursing staff will receive this education on their next scheduled work day. Newly hired licensed staff receive this education during their specific job orientation by the SDC. To assist in prevention of expired controls, the Central Supply Clerk has been educated on the control test procedure by the Staff Development Coordinator and DON. This employee will check controls weekly on each machine to verify high and normal readings. She will be responsible for tracking the expiration date of controls used for glucose testing and reorder as necessary to assure compliance with expiration dates of all glucose testing controls.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD PO BOX 3427 BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 2 removed from the moisture protective foil package and put into use 35 day previously. An interview with staff member #2 was conducted concerning the expiration of the inhaler. Staff member # 2 indicated the inhaler was only good for 30 days once it was removed from the package and it was the facility procedure to put the date on the inhaler to know when it would expire (30 days later). A review of the manufacturer's (GlaxoSmithKline) prescribing information for the Advair Diskus read in part in paragraph 16 - The device should be discarded 1 month after removal from the moisture - protective foil overwrap pouch. Also observed in the B Wing Back Hall's medication cart on 10/03/2012 at 1:15 p.m. in the top right drawer, in a plastic basket was a box/bottle containing a control agent fluid (Lot# OL2A22 manufacturer's expiration date 06/30/12) used to check the Hi/Low level control of the Accu-check meter which was observed co-located in the same basket with the control agent. During interview with staff member #2 she indicated the control agent was used to verify if the Accu-check meter was working properly by giving a high or low reading. Staff member #2 also indicated the control agent had expired 95 days ago and could not say why it was still in the medication cart. An interview with the facility's DON was conducted on 10/04/2012 at 5:50 p.m. The DON was asked what her expectations were for ensuring expired medications/supplies were not available for use/administration to residents. The DON indicated her expectations to be that each nurse checks his or her medication room/cart	F 431	Nursing Administration will inventory each medication room and medication cart weekly times four (4) weeks, then monthly times two (2) months using an item check list. The Pharmacy Consultants will inventory medication rooms and medication carts monthly during their routine visits. Identified trends will be discussed with the QI Committee monthly for recommendations, as needed.. The DON will review data weekly for (8) weeks. The DON is responsible for ongoing compliance to F431.	

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	345301	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD PO BOX 3427 BURLINGTON, NC 27217

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F 431	Continued From page 3 daily and if an expired medication or supply is found it is to be removed so it can not be used.	F 431		11/1/12
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	White Oak of Burlington has an established infection control program, which is maintained to provide a safe, sanitary, and comfortable environment and helps prevent the development and transmission of disease and infection. Resident # 134 is no longer a resident of White Oak of Burlington. No other resident in the facility is currently on isolation precautions. Acceptable, CDC approved, signage is available and will be used, when isolation precautions are ordered. The licensed nursing staff were re-educated on following isolation precautions and on educating other staff and families of isolation precautions, when ordered, by the DON/SDC and completed by 11/1/12. Newly hired licensed nursing staff receive this education during their licensed nursing orientation by the SDC.	

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	345301	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD PO BOX 3427 BURLINGTON, NC 27217

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F 441	Continued From page 4 infection. This REQUIREMENT is not met as evidenced by: Based on review of the facility's infection control policy and procedure, observation, and staff interviews, the facility failed to post the appropriate Center for Disease Control (CDC) approved isolation sign outside the resident's door for one of one observed room, with an isolation sign on the door. The facility also failed to maintain contact precautions for one of one resident (Resident #134) noted to be on Contact Isolation. Findings include: Review of the facility's Infection Control Policy dated 8/30/2012 found in part: Signage may be placed on the resident's door as appropriate, i.e., "RESPIRATORY PRECAUTIONS - See nurse prior to entering (resident) room." "CONTACT PRECAUTIONS - See nurse before entering (resident) room." The facility's Infection Control Guidelines dated 1/15/2010 indicated in review that Methicillin Resistant Staphylococcus Aureus (MRSA) was primarily spread through colonization carried on hands of healthcare workers. The guideline included that individual nursing policies and procedures emphasized the use of universal/standard precautions and specifically wearing/changing of gloves as appropriate. Per the Statewide Program for Infection Control and Epidemiology (SPICE) the use of isolation	F 441	Other staff, including unlicensed nursing staff and other department staff were re-educated on following isolation precautions by the DON/SDC/ Department Manager and completed by 11/1/12. PRN staff will receive this education on the next scheduled work day by the SDC/ Department Manager. Newly hired staff receive this education during their job orientation by the SDC/ Department Manager. Infection control rounds will be completed weekly times (4) weeks, bi-weekly times (8) weeks and monthly times (2) months to assure ongoing compliance to F 441. The trends will be discussed with the QI Committee monthly for recommendations, as needed. The DON will review data weekly for (8) weeks. The DON will be responsible for compliance with F 441.	

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	345301	A. BUILDING _____ B. WING _____	C 10/04/2012

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F 441	Continued From page 5 signage has been a standard recommendation by the CDC as a tool for communicating the procedures that healthcare workers (HCW) and family or visitors should follow to prevent cross-transmission. Physician orders dated 9/26/2012 indicated that Resident #134 was on Contact Isolation for MRSA diagnosis of pneumonia. Observations were made on 10/1/2012 at 11:15 am and 12:39 pm, on 10/2/2012 at 10:45 am, on 10/3/2012 at 8:30 am, and on 10/4/2012 at 9:05am and 4:45 pm of a sign on Resident #134's door that read "all staff and visitors must see nurse at nursing station before entering room." There was no information regarding the reason for seeing the nurse or procedures to be followed. On 10/1/2012 at 12:56 a clear plastic chest was observed outside Resident #134's door containing Personal Protection Equipment (PPE). The PPE included gloves, masks, and gowns. NA#1 entered the room without putting on any PPE carrying a lunch tray for Resident #134. NA #1 was then observed feeding Resident #134 without gloves or any other PPE on. On 10/3/2012 NA #1 stated in an interview that the sign on the door of Resident #134's room meant that before entering the room one needed to wash their hands and after care wash them thoroughly before leaving the room. The NA stated that when Resident #134 first came back to the facility they had to wear a mask and gown. A nurse told him that he now only had to wash his hands as the resident had been on antibiotics long enough to make the resident	F 441		

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	345301	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD PO BOX 3427 BURLINGTON, NC 27217

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F 441	Continued From page 6	F 441		

non-contagious. Asked who the nurse was he said he was not sure.

Nurse #1 stated in an interview on 10/3/2012 at 2:08 pm that the sign on Resident #134's door was for respiratory MRSA. Nurse #1 indicated that anytime you were working with Resident #134 you should wear a mask and gloves. She specified that all staff including NAs should be wearing a mask and gloves when in the room until the physician lifted the isolation. Nurse #1 also said that Resident #134 was receiving antibiotics for the MRSA at Dialysis and they would notify the facility when the antibiotics were completed.

At 9:00 am on 10/4/2012 the Unit Nurse Manager (UM) was asked what the sign on Resident #134's door meant. The UM revealed that one should wear a mask and gloves before entering the room as the resident had respiratory MRSA.

NA #1 was observed on 10/4/2012 at 9:05 am taking the breakfast tray into Resident #134's room and feeding Resident #134 wearing no PPE.

In an interview on 10/4/2012 at 6:15 pm the Staff Development (SD) Nurse, who was also the Infection Control Nurse, stated that staff was educated to use gloves and appropriate PPE for isolation. She signified that for respiratory MRSA staff should wear a mask and gloves and if working with sputum should also wear a gown. She indicated that NAs should be wearing a mask and gloves when entering the room. The SD nurse also said that the isolation remained in effect until the sputum was tested for colonization

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	345301	A. BUILDING _____ B. WING _____	C 10/04/2012

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F 441	Continued From page 7 and the physician wrote an order ending the isolation. There was no documentation to indicate that a sputum specimen and been obtained and sent for testing. The administrator stated in an interview on 10/4/2012 at 7:00 pm that he was unaware that the signage used on Resident #134's door was not acceptable for isolation and was unaware of the SPICE recommendations. He also indicated that he expected staff to wear gloves and a mask when entering Resident #134 ' s room.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ NOV 20 2012	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - BURLINGTON	323 BALDWIN ROAD PO BOX 3427 CONSTRUCTION SECTION BURLINGTON, NC 27217

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. Building one and two are Type III construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By documentation on 10/30/12 the fire alarm system was non-compliant, specific findings include; the last Fire Alarm Control Panel (FACP) inspection was conducted on 9/22/11. The system shall be properly maintained in accordance with NFPA 70 and 72, Standard for the Inspection, Testing which includes annual certification for the fire alarm system.	K 052	**K052**: On 10/31/12, Toma Fire Protection Equipment, Inc., completed the Annual Fire Alarm System Test and Inspection Report, which indicated that the fire alarm system was functioning properly, including the Fire Alarm Control Panel (FACP). The LNHA will round monthly with the Director of maintenance to inspect all life safety requirements to assure ongoing compliance, including documentation of FACP. Inclusion of life safety compliance documentation, including timely testing of the fire alarm system, will be part of our ongoing monthly QI Committee, beginning 11/27/12. The LNHA will be responsible for monitoring to assure ongoing compliance.	10/31/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matthew Reamik, LNHA	Administrator	11-16-12

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CRW

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345301	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By documentation on 10/30/12 the facility sprinkler system was non-compliant, specific findings include; the quarterly inspections were not in accordance with NFPA 25 - Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems (1999 edition).	K 062	**K062:** United Sprinkler Co., Inc., who had completed the Quarterly Inspection and Test of the facility automatic sprinkler system on 10/26/12 but who had failed to properly leave documentation with the facility to demonstrate compliance with NFPA 25-Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, faxed the completed form to the facility on 11/5/12. The LNHA will round with the Director of Maintenance monthly to inspect all life safety requirements to assure ongoing compliance, including compliance with NFPA 25. Inclusion of life safety compliance, including automatic sprinkler system compliance with NFPA 25, will be part of our ongoing monthly QI Committee, beginning 11/27/12. The LNHA will monitor to assure on-going compliance.	11/5/12
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 10/30/12 at approximately noon the following Heating, Ventilating, and Air Conditioning system (HVAC) was non-compliant, specific findings include; smoke damper near room 210 did not function with fire alarm activation.	K 067		

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	345301	A. BUILDING 02 - BUILDING 02 B. WING _____	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS There were no Life Safety Code Deficiencies noted at time of survey.	K 000	KO67 : Toma Fire protection Equipment, Inc., completed an inspection of all facility smoke dampers, including the improperly functioning one cited near Room 210. All of the facility smoke dampers are being tested and repaired, as indicated, to ensure proper functioning with fire alarm activation. The LNHA will round with the Director of Maintenance monthly to inspect all life safety requirements to assure ongoing compliance, including HVAC compliance, specifically proper functioning of all smoke dampers with fie alarm activation. Inclusion of life safety compliance, including assuring proper smoke damper closure with fire alarm activation, will be part of our ongoing monthly QI Committee, beginning 11/27/12. The LNHA will be responsible for assuring on-going compliance.	11/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nathan Nesmith, LNHA	Administrator	11-16-12

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DRS