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
	345462	A. BUILDING _____ B. WING _____	C 07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS OF BREVARD	300 MORRIS ROAD BREVARD, NC 28712

(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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews and documentation review the facility failed to follow physician orders to obtain orthostatic blood pressure sets for one (1) of three (3) sampled residents who had experienced falls (Resident #2). The findings are: Resident #2 was admitted to the facility on 4/22/11 and re-admitted on 7/3/11 with diagnoses that included a hip fracture and Alzheimer ' s disease among others. The most recent Minimum Data Set (MDS) dated 5/2/11 specified the resident had severely impaired cognitive function and had a history of falls. Resident #2's Care Area Assessments (CAAs) dated 5/4/11 specified a new fall care plan was started related to history of falls and unsteady gait. Resident #2's fall care plan updated 5/16/11 specified interventions to avoid a fall related injury included: -three (3) sets of orthostatic blood pressures Resident #2's medical record revealed a physician's order dated 5/16/11 for three sets of orthostatic blood pressures. Further review of the medical record revealed only one (1) documented set of orthostatic blood pressures on the	F 281	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. **F281** 8-5-11 1. Corrective Action: The resident affected no longer requires orthostatic blood pressure checks. 2. Others with Potential to be Affected: Residents with orders for orthostatic blood pressure checks have the potential to be affected. An audit was conducted and no current residents have orders for orthostatic blood pressure checks.	

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

Coclon Offoo Ph.D. NHA Administrator 7/29/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 Medication Administration Record (MAR) dated 5/20/11. On 7/19/11 at 1:10 p.m. licensed nurse (LN) #1 was interviewed and reported that when a physician order was written for orthostatic blood pressure the licensed nurse who received the order was responsible for transcribing the order onto the MAR. She stated that the orthostatic blood pressures would be initiated within 24 hours of receiving the order. On 7/19/11 at 1:20 p.m. the Director of Health Services (DHS) reviewed Resident #2's medical record and confirmed she was only able to locate one set of orthostatic blood pressures. The DHS was interviewed and reported orthostatic blood pressures could be documented anywhere in the medical record and after additional review of Resident #2's medical record only located one documented set of orthostatic blood pressures. The DHS also reported she would expect orthostatic blood pressures to be initiated the same day the order was written and was unable to explain why the only documented set of orthostatic blood pressures for Resident #2 was completed on 5/20/11. The DHS offered no explanation why the Resident's orthostatic blood pressures were not documented as having completed as ordered. On 7/19/11 at 1:30 p.m. the Assistant Director of Health Services (ADHS) was interviewed and reported she had obtained the physician's order for orthostatic blood pressure sets on Resident #2 after the resident fell while standing up. She also reported that the licensed nurse assigned to Resident #2 on 5/16/11 would have been	F 281	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. 3. Measures/Systemic Changes: Nurses will receive in-service and education on proper documentation of orthostatic blood pressure checks. 4. Monitoring: Monitoring to be completed through random scheduled audits by DHS/ADHS/Nurse-in-Charge. Any areas of non-compliance will be corrected at the time of discovery. The findings will be reported to the physician immediately and monthly to facility's performance improvement committee for patterns or trends and further interventions will be developed as necessary to ensure continued compliance. Audits will be conducted for a minimum of 90 days, followed by monthly audits until substantial compliance is achieved and maintained for an additional 90 days.	

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F 281	Continued From page 2 responsible for transcribing the order onto the MAR. She added the licensed nurse would have also been expected to report to the oncoming licensed nurse during shift report the order to obtain orthostatic blood pressure sets. She stated that ideally the order should have been initiated within 24 hours and performed on consecutive shifts or days. She was unable to explain why the resident had only one documented set of orthostatic blood pressures.	F 281	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide a safety alarm as a care planned fall intervention for one (1) of three (3) sampled residents who had experienced falls (Resident #1). The findings are: Resident #1 was admitted to the facility 1/3/06 with diagnoses including seizure disorder and debility. The latest Minimum Data Set (MDS) dated 6/6/11 indicated impaired cognition and dependence on staff assistance for all care including transfers, dressing, eating, and hygiene.	F 323	F323 1. Corrective Action: One resident was affected and the torso alarm was immediately put in place. 2. Others with Potential to be Affected: Residents with torso alarms have the potential to be affected. An audit was conducted to ensure residents with torso alarms have the alarms in place.	8-5-11

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F 323	Continued From page 3 A review of a care plan dated 3/25/11 revealed Resident #1 had a potential for falls that may cause injury related to a seizure disorder treated by medication which was refused at times. The goal of the care plan stated the approaches will minimize the risks for injuries due to impaired physical mobility and the possibility of seizure activity. Approaches dated 3/25/11 included medication as ordered by the physician and assist to move at own pace, do not rush. The care plan was noted updated on 7/11/11 due to a fall experienced on 7/10/11. Added approaches included a torso alarm when in bed, bed in low position, and mats on floor at bedside. A review of Resident #1's medical record revealed a nurse note dated 6/15/11 at 6:00 a.m. The note documentation included at 1:30 a.m., a nursing assistant reported Resident #1 demonstrated jerking motions and moving about in bed. The note continued medication as ordered by the physician was administered resulting in subsiding of jerking motions. An observation of Resident #1's room on 7/19/11 at 9:08 a.m. revealed the bed was in low position and mats were observed on the floor at the bedside. No torso alarm was observed. Resident #1 was not in the bed on this observation. An observation on 7/19/11 at 12:58 p.m. revealed Resident #1 was lying in the bed. The bed was observed in low position with mats on the floor at bedside. No torso alarm was observed. An interview with the Director of Health Services	F 323	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. 3. Measures/Systemic Changes: Staff will receive in-service and education on ensuring torso alarms are appropriately placed for patients with this intervention. Nurses will document torso alarm function and placement every shift for affected patients. 4. Monitoring: Monitoring to be completed through random scheduled audits by DHS/ADHS/Nurse-in-Charge. Any areas of non-compliance will be corrected at the time of discovery. The findings will be reported to the physician immediately and monthly to facility's performance improvement committee for patterns or trends and further interventions will be developed as necessary to ensure continued compliance. Audits will be conducted for a minimum of 90 days, followed by monthly audits until substantial compliance is achieved and maintained for an additional 90 days.	

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F 323	Continued From page 4 (DHS) on 7/19/11 at 10:30 a.m. revealed Resident #1 experienced a fall on 7/10/11. She stated this fall out of bed was unwitnessed and may have been contributed to seizure activity. She added this resident had no previous history of falls. An interview with Nursing Assistant (NA) #1 on 7/19/11 at 1:10 p.m. revealed to her knowledge, Resident #1 had not had a torso alarm. She stated the nursing assistant care guide located in each resident's room provided guidance for the resident's care. During this interview, NA #1 was unable to find torso alarm in Resident #1's nursing assistant care guide. NA #1 added this was the first time she has cared for Resident #1 since the resident experienced a fall on 7/10/11. An interview was conducted on 7/19/11 at 1:50 p.m. with the DHS and the Assistant Director of Health Services (ADHS). During the interview, the DHS and ADHS were unable to locate a torso alarm in Resident #1's bed or in the room. The DHS and ADHS were unable to find a torso alarm added to the nursing assistant care guide for Resident #1. The DHS stated it was the responsibility of the ADHS to ensure nursing assistant care guides where kept up to date. The DHS added she expected the torso alarm to be in place as care planned. An interview with Licensed Nurse (LN) #2 on 7/19/11 at 2:25 p.m. revealed she had cared for Resident #1 on this date. She added she had not seen a torso alarm in Resident #1's room. An interview with NA #2 on 7/19/11 at 2:40 p.m. revealed she had cared for Resident #1 on the	F 323		

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F 323	Continued From page 5 evening shift of 7/18/11. She stated she did not see a torso alarm in the resident's bed. NA #2 explained when a torso alarm is in place on a resident's bed, a beep is heard when the resident's weight contacts the mattress. She added when she assisted Resident #1 to bed after supper on 7/18/11, she did not hear that beep. NA #2 continued she was unaware Resident #2 was supposed to have a torso alarm while in bed.	F 323		