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 06/05/2014

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=E	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 observations, record review, resident and staff interview the facility failed to follow physician's orders for 4 of 13 residents reviewed for physician's orders (Residents #5, 11, 13 and 18). The findings included: 1. Resident #13 was admitted to the facility on 01/23/14 with diagnoses including diabetes mellitus. Review of the most recent care plan addressed Resident #13's risk for hypoglycemia or hyperglycemia and need for insulin. Interventions included: give medications as ordered, laboratory tests as ordered by the Physician, monitor blood sugars as ordered, and observe for signs and symptoms of hypoglycemia or hyperglycemia. Review of Resident #13's physician orders revealed an order dated 01/23/14 for finger stick blood sugar (FSBS) before each meal and at bedtime. The order also included parameters for sliding scale insulin units to be given based on the FSBS results and specified the Physician was to be notified if Resident #13's FSBS was greater than 400 milligrams per deciliter (mg/dL). Review of Resident #13's May 2014 Medication Administration Record (MAR) revealed Nurse #2	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 conclusion set forth on this statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F281 Corrective Action for those residents affected. " The attending physician for resident #13 and #18 were notified of the finger stick blood sugars (FSBS) per the parameters of the MD notification orders. " One on one education on following physician orders and documentation of notification of MD was completed with nurses #2, #3, #4, #6, and #8 by the Director of Health Services (DHS) and Clinical Competency Coordinator (CCC). " The daily blood pressures (BP) have been added to the medication administration record (MAR) for resident #11. " The daily oxygen (O2) saturation has been added to resident #5 MAR.	7/3/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/29/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 1 documented a FSBS of 420 mg/dL on 05/14/14 at 9:00 PM and a FSBS of 514 mg/dL on 05/16/14 at 9:00 PM. Review of Resident #13's May 2014 MAR revealed Nurse #6 documented FSBS results above 400 as follows: - 534 mg/dL on 05/19/14 at 9:00 PM - 455 mg/dL on 05/20/14 at 9:00 PM - 422 mg/dL on 05/21/14 at 9:00 PM - 407 mg/dL on 05/22/14 at 4:30 PM - 439 mg/dLon 05/24/14 at 4:30 PM - 421 mg/dLon 05/25/14 at 4:30 PM - 404 mg/dLon 05/25/14 at 9:00 PM - 446 mg/dL on 05/29/14 at 4:30 PM. Review of Resident #13's May 2014 MAR revealed Nurse #8 documented a FSBS of 446 mg/dL on 05/23/14 at 4:30 PM and a FSBS of 403 mg/dLon 05/26/14 at 4:30 PM. Review of Resident #13's June 2014 MAR revealed Nurse #6 documented a FSBS of 413 on 06/02/14 at 9:00 PM. Review of Resident #13's nurses notes for April 2014 through June 2014 revealed no documentation that the Physician was notified of any of the FSBS results that were above 400 mg/dL. During an interview on 06/04/14 at 3:50 PM Nurse #6 confirmed he recorded the FSBS on 06/02/14 at 9:00 PM on Resident #13's MAR and administered Novolog insulin 7 units, which was the dosage specified for a FSBS of 351 to 400 mg/dL. Nurse #6 stated he didn't notify the Physician as specified in the order and stated: "I guess I just overlooked it."	F 281	" One on one education will be completed with nurse #1 on physician□s order form reconciliation, obtaining, transcribing and documentation of Physician orders by the Director of Health Services (DHS) and Clinical Competency Coordinator (CCC). Corrective Action for Those with Potential to be affected. A 100% chart audit compared to current medication administration record was completed on 6/24/14 by the Director of Health Services and the Clinical Competency Coordinator of all current residents with Finger stick blood sugars for documentation of MD notification, residents with orders for daily or weekly blood pressure checks, and residents on oxygen with orders for oxygen saturation checked every shift. Systemic Changes to Prevent Deficient Practice. Education was begun on 6/19/2014 by the Director of Health Service and the Clinical Competency Coordinator on for the licensed nursing staff on facility policy " Physician orders to include o Obtaining physician orders o Reconciliation of orders with new orders and monthly o Transcription of orders o Documentation " Physician notification and documentation Education was added to new license nurse orientation and as an annual in-service.	

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THE OAKS OF BREVARD	300 MORRIS ROAD BREVARD, NC 28712

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F 281	Continued From page 2 An interview was conducted with the Director of Nursing (DON) on 06/05/14 at 3:40 PM. The DON stated she expected nurses to notify the Physician and document in the nurse's notes any time a resident's FSBS result was greater than the parameters specified in the Physician's orders. During an interview on 06/05/14 at 4:20 PM Nurse #8 confirmed she recorded the FSBS on 05/23/14 and 05/26/14 at 4:30 PM on Resident #13's MAR. She stated she administered Novolog insulin 7 units, which was the dosage specified for a FSBS of 351 to 400 mg/dL. She could offer no explanation for not notifying the Physician as specified in the order. Nurse #8 stated the nurses were expected to call the Physician when the FSBS was higher than the level specified in the order. During an interview on 06/05/14 at 4:30 PM Nurse #2 confirmed she recorded the FSBS on 05/14/14 at 9:00 PM on Resident #13's MAR. Nurse #2 stated she was orienting Nurse #6 on 05/16/14 and thought he documented the FSBS on 05/16/14 at 9:00 PM on Resident #13's MAR. Nurse #2 stated she didn't call the physician about the elevated FSBS on 05/14/14 at 9:00 PM because she had already called the physician about Resident #13's FSBS being elevated at 4:30 PM on 05/14/14 and had administered an extra dosage of insulin at that time. Nurse #2 stated the nurses were expected to call the Physician every time the FSBS was higher than the level specified in the order. During an interview on 06/05/14 at 5:02 PM Nurse #6 confirmed he recorded the FSBS	F 281	Director of Health Service, Clinical Competency Coordinator, Unit Managers and/or Week-end Supervisor conduct audits on finger stick blood sugars for physician notification daily x 2 weeks then biweekly x 2 weeks then weekly x 2 then monthly thereafter until compliance is maintained. Director of Health Service, Clinical Competency Coordinator, Unit Managers and/or Week-end Supervisor conduct audits of new orders compare to the medication administration sheets for transcription and documentation daily x 2 weeks then biweekly x 2 weeks then weekly x 2 then monthly thereafter until compliance is maintained. Director of Health Service, Clinical Competency Coordinator, Unit Managers and/or Week-end Supervisor conduct audits of medication administration sheets for documentation of daily/weekly blood pressure and pulse ox daily x 2 weeks then biweekly x 2 weeks then weekly x 2 then monthly thereafter until compliance is maintained. How will Corrective Action be monitored? Director of Health Service, Clinical Competency Coordinator, Unit Managers and/or Week-end Supervisor conduct audits on finger stick blood sugars for physician notification daily x 2 weeks then biweekly x 2 weeks then weekly x 2 then monthly thereafter until compliance is maintained. Findings will be trended by the Director of Health services and brought to the monthly quality assurance performance improvement meeting.	

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F 281	Continued From page 3 results on Resident #13's MAR on 05/19/14 - 05/21/14 at 9:00 PM, on 05/22/14 at 4:30 PM, on 05/24/14 at 4:30 PM, on 05/25/14 at 4:30 PM, on 05/25/14 at 9:00 PM and on 05/29/14 at 4:30 PM. He stated he recalled notifying the Physician once in May about Resident #13's elevated FSBS but couldn't recall the date. Nurse #6 stated the nurses were expected to call the Physician every time the FSBS was higher than the level specified in the order. The Physician was not available for interview during the investigation. 2. Resident #18 was admitted to the facility on 08/14/13 with diagnoses including diabetes mellitus. Review of a care plan dated 02/20/14 revealed Resident #18 was at risk for hypoglycemia related to the diagnosis of diabetes mellitus and received insulin. Interventions included: give medications as ordered, laboratory tests as ordered by the Physician, monitor blood sugars as ordered, and observe for signs and symptoms of hypoglycemia or hyperglycemia. Review of Resident #18's April 2014 Physician's orders revealed an order for finger stick blood sugar (FSBS) monitoring before each meal. The order also included parameters for sliding scale insulin to be administered based on the FSBS results and specified the Physician was to be notified if Resident #18's FSBS was greater than 400 mg/dL. Review of Resident #18's April 2014 Medication	F 281	Director of Health Service, Clinical Competency Coordinator, Unit Managers and/or Week-end Supervisor conduct audits of new orders compare to the medication administration sheets for transcription and documentation daily x 2 weeks then biweekly x 2 weeks then weekly x 2 then monthly thereafter until compliance is maintained. Findings will be trended by the Director of Health services and brought to the monthly quality assurance performance improvement meeting.	

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	345462	A. BUILDING _____ B. WING _____	C 06/05/2014

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F 281	Continued From page 4	F 281		

Administration Record (MAR) revealed Nurse #3 documented a FSBS of 433 mg/dL on 04/05/14 at 4:30 PM and Nurse #4 documented a FSBS of 423 mg/dL on 04/29/14 at 11:30 AM.

Review of Resident #18's May 2014 Physician's orders revealed an order for finger stick blood sugar (FSBS) monitoring before each meal. The order also included parameters for sliding scale insulin to be administered based on the FSBS results and specified the Physician was to be notified if Resident #18's FSBS was greater than 320 mg/dL.

Review of Resident #18's May 2014 Medication Administration Record (MAR) revealed Nurse #5 documented a FSBS of 352 mg/dL on 05/12/14 at 11:30 AM.

Review of nurse's notes from 04/05/14 through 05/12/14 revealed no documentation of notification of the Physician regarding Resident #18's FSBS results on 04/05/14, 04/29/14, or 05/12/14.

An interview was conducted with the Director of Nursing (DON) on 06/05/14 at 3:40 PM. The DON stated she expected nurses to notify the Physician and document in a nurse's note any time a residents FSBS result was greater than the parameters specified in the Physician's orders.

During an interview on 06/05/14 at 4:05 PM Nurse #5 confirmed he cared for Resident #18 on 05/12/14 and documented the FSBS of 352 mg/dL at 11:30 AM on the May 2014 MAR. Nurse #5 reviewed Resident #18's medical record and stated he should have documented her elevated FSBS result and notification of the Physician in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 281	Continued From page 5	F 281		

nurse's note on 05/12/14.

A telephone interview with Nurse #4 on 06/05/14 at 5:07 PM revealed she typically notified the Physician and documented in a nurse's note anytime a resident's FSBS result was greater than the parameters specified on the Physician's orders. Nurse #4 did not recall if she had notified the Physician regarding Resident #18's elevated FSBS or documented in a nurse's note on 04/29/13.

The Physician and Nurse #3 were not available for interview during the investigation.

3. Resident #11 was admitted to the facility on 01/24/14 with diagnoses including hypertension and coronary artery disease with a past myocardial infarction.

Review of a progress note dated 05/21/14 revealed the Physician examined Resident #11 due to a cough and congestion and also reviewed his vital signs to assess his hypertension. The Physician noted Resident #11's blood pressure (BP) was low normal when last checked. The plan was to stop one of his BP medications and monitor daily blood pressures.

Review of the medical record revealed a Physician's order written on 05/21/14 for daily BPs.

Review of Resident #11's May 2014 Medication Administration Record (MAR) revealed daily BPs were documented 05/21/14 through 05/31/14 and were within normal limits. Review of Resident #11's June 2014 MAR revealed no BPs were documented. Review of a vital sign sheet in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 6	F 281		

Resident #11's medical record revealed his vital signs were monitored on 06/01/14 and included a BP of 137/86.

During an interview on 06/04/14 at 2:40 PM Nurse #1 confirmed she had completed and signed off on the review of Resident #11's June 2014 MAR. Nurse #1 stated she would have checked Resident #11's June 2014 MAR against the May 2014 MAR and reviewed the medical record for all new orders written in May 2014. Nurse #1 further stated she should have transcribed the order for daily BPs on to Resident #11's June 2014 MAR and had just overlooked the order.

An interview was conducted with Director of Nursing (DON) on 06/05/14 at 5:44 PM. The DON stated she would have expected Nurse #1 to transcribe the order for daily BPs to Resident #11's June 2014 MAR when she completed the review and signed off on the June 2014 MAR. The DON further stated the new monthly MARs were reviewed for accuracy by two additional nurses before they were placed on the medication cart and could not explain how the order for Resident #11's daily BPs had been missed.

4. A record review revealed Resident #5 was admitted on 08/20/13 with diagnoses of chronic airway obstruction, history of cardio pulmonary disease (COPD), and dyspnea (shortness of breath).

A record review of Minimum Data Set (MDS) dated 03/18/14 revealed Resident #5 had diagnoses of shortness of breath (SOB) on

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	345462	A. BUILDING _____ B. WING _____	C 06/05/2014

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F 281	Continued From page 7	F 281		

exertion and SOB, trouble breathing when lying flat. The resident's cognitive status was intact.

A record review of Resident #5's care plan dated 06/01/14 revealed an identified problem of potential for respiratory complication related to oxygen use. The goal was that resident would be free from respiratory complication through next review period. Interventions for Resident #5 included: oxygen as ordered, auscultate lung sounds as needed (PRN), and monitor respiratory status.

A record review of physician ' s order dated 06/01/14 revealed oxygen 2 liters PRN for SOB or low oxygen saturation, monitor and record oxygen saturation each shift, oxygen via nasal cannula (device used to deliver supplemental oxygen), clean filters, and change supplies weekly or Saturdays.

A record review of Resident #5's medication administration record (MAR) and nurses notes revealed lack of documentation of oxygen saturation on 06/01/14 and 06/02/14 for all shifts. A review of the MAR revealed Resident #5's oxygen saturation was recorded as 94% on the night shift 06/03/14 and 92% on the day shift 06/04/14.

Observations of Resident #5 on 06/03/14 at 2:13 PM; 06/04/14 at 8:56 AM, 11:15 AM, and 12:55 PM revealed resident was not utilizing oxygen and was not experiencing signs of respiratory distress.

An interview was conducted with Resident #5 on 06/03/14 at 1:15 PM. Resident shared that she did not need to use her oxygen currently.

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	345462	A. BUILDING _____ B. WING _____	C 06/05/2014

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

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F 281	Continued From page 8 Resident indicated staff would provide oxygen if she felt SOB. An interview with Nurse #1 on 06/04/14 at 3:20 PM revealed that she wrote the physician's order on 06/01/14 and failed to transcribe the order to Resident #5's June 2014 MAR. Nurse #1 shared since she failed to transcribe the order, nursing staff did not know to obtain and record Resident #5's oxygen saturation. Nurse #1 revealed that on 06/03/14 the night nurse transcribed to the June 2014 MAR the order for obtaining and recording oxygen saturation on every shift. An interview with Nurse #2 on 06/04/14 at 3:36 PM revealed that she did not obtain and record Resident #5's oxygen saturation during the day shift on 06/01/14 and 06/02/14. Nurse #2 shared that she was unaware of an order to obtain and record oxygen saturation each shift for Resident #5. An interview with the Director of Nursing on 06/05/14 at 9:37 AM revealed that her expectation was for nursing staff to transcribe the physician order for Resident #5 onto the MAR so that nursing staff would be aware to obtain and record oxygen saturation for resident #5 as ordered by the physician.	F 281		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced	F 311		7/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE OAKS OF BREVARD	300 MORRIS ROAD BREVARD, NC 28712

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F 311	Continued From page 9 by: Based on record review and staff interviews the facility failed to implement restorative services to improve or maintain a residents ambulatory status for 1 of 1 sampled resident reviewed for restorative services (Resident #20). The findings included: Resident #20 was admitted to the facility with diagnoses including dementia, history of cardiovascular accident (CVA), and aphasia. An admission Minimum Data Set (MDS) dated 09/10/13 revealed Resident #20 had long and short-term memory problems and severely impaired cognitive skills for daily decision making. The admission MDS noted Resident #20 did not speak and responded adequately only to simple and direct questions or instructions. In addition, she required extensive assistance with walking in her room and limited assistance with walking in the corridor. A significant change MDS dated 03/12/14 revealed Resident #20 had long and short-term memory problems and moderately impaired cognitive skills for daily decision making. The significant change MDS noted walking in her room only occurred once or twice and walking in the corridor did not occur. A Care Area Assessment (CAA) Summary for activities of daily living function dated 12/11/13 revealed Resident #20 had a diagnoses of vascular dementia and recurrent strokes that left her with severe expressive aphasia. The CAA summary noted her needs were anticipated by staff. Review of a care plan dated 03/21/14 revealed Resident #20 had a self care deficit and required	F 311	F 311 Corrective Action for those residents affected. Resident #20 was added to restorative services on 6/5/14. Corrective Action for Those with Potential to be affected. A 100% chart audit was conducted by the Director of Health Service, Clinical Competency Coordinator on 6/24/14 for physical therapy referrals and physician orders related to restorative services. No other residents were found to be effected. Systemic Changes to Prevent Deficient Practice. One on one education was completed by the Director of Health Services and the Clinical Competency Coordinator on 6/5/2014 with the restorative nurse on obtaining, transcribing, noting and following through with the physician□s orders. Education of all licensed nursing staff started on June 06/19/2014 by the Clinical Competency Coordinator, Director of Health Services on obtaining, transcribing, noting and following through of physician□s orders. Education was added to the new licensed nursing orientation and the annual in service program. Daily audits of all new physical therapy referrals and physician□s orders for Restorative services conducted by the Director of Health Services/Clinical Competency Coordinator/Unit Manager/Weekend Coordinator x 4	

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F 311	Continued From page 10 extensive assistance with ADL and mobility. Interventions included rehab services as indicated and ordered. The care plan did not mention restorative services. Further review of the medical record revealed a Physician's order dated 05/23/14 for a referral to restorative services. Review of a Physical Therapy (PT) note dated 05/23/14 revealed Resident #20 was referred for possible services due to a general physical decline and issues with mobility. The therapy department noted skilled therapy services were not warranted at that time because Resident #20 was not able to consistently follow commands. During an interview on 06/05/14 at 2:35 PM Nurse #9 confirmed she had just taken over the restorative program and functioned in that position when she was not working on a medication cart. Nurse #9 stated Physician's orders and referral sheets from therapy for restorative services were placed in a folder which she checked when she had the opportunity. Nurse #9 further stated she could not recall when she received Resident #20's order for restorative services and had not had time to address the order. An interview with the Rehabilitation (Rehab) Supervisor on 06/05/14 at 3:36 PM revealed when Resident #20 was evaluated on 05/23/14 she had a lot of difficulty because she could not follow directions. The Physician was consulted and a referral was made to restorative services. An interview was conducted with the Director of Nursing (DON) on 06/05/14 at 5:12 PM. During	F 311	weeks, weekly x 4 weeks, then monthly x 3 months Results of the audits, if deficient, will be trended by the Director of Health Services and brought to the Performance Improvement committee, consisting of interdisciplinary team members, for further recommendation. How will Corrective Action be monitored? Daily audits of all new physical therapy referrals and physician□s orders for Restorative services conducted by the Director of Health Services/Clinical Competency Cordinator/Unit Manager/Weekend Coordinator x 4 weeks, weekly x 4 weeks, then monthly x 3 months Results of the audits, if deficient, will be trended by the Director of Health Services and brought to the Performance Improvement committee, consisting of interdisciplinary team members, for further recommendation.	

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 06/05/2014

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

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F 311	Continued From page 11 the interview the DON stated she expected residents to receive restorative services in a timely manner and could not explain why Resident #20 had not yet received restorative services per the Physician's order written on 05/23/14. The DON stated Nurse #9 worked one day a week with the restorative program.	F 311		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, policy review and staff interview the facility failed to securely store a portable oxygen tank for 1 of 1 sampled residents. (Resident #14) The findings included: The facility policy for Oxygen Administration Safety and Storage last updated May 2013 included the following: "Do not fasten an oxygen tank to a patient/resident's bed. Tanks in use must either	F 328	F 328 Corrective Action for those residents affected. The portable oxygen tank was removed and properly secured by the housekeeper in the empty oxygen tank rack. Corrective Action for Those with Potential to be affected. The Administrator, Director of Health Services, Housekeeping and Environmental services conducted rounds of the center for other unsecured oxygen	7/3/14

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	345462	A. BUILDING _____ B. WING _____	C 06/05/2014

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F 328	Continued From page 12 be installed on a stable, wheeled dolly or an oxygen tank stand." Resident #14 was admitted to the facility 01/09/14 with diagnoses which included pneumonia, pleural effusion and chronic obstructive pulmonary disorder (COPD). The latest Minimum Data Set for Resident #14 dated 05/27/14 assessed her with moderate cognitive impairment. The care plan for Resident #14 dated 04/11/14 included the problem area, Potential for respiratory complications related to admitted with diagnoses of pneumonia, diagnosis COPD. Physician orders for Resident #14 included, Oxygen at 2 liters per minute via nasal cannula. During the initial tour of the facility on 06/03/14 at 10:00 AM a portable oxygen tank was observed stored horizontally on a table in the room of Resident #14. This table was positioned against the wall by the entrance door of the room of Resident #14. The tank was inside the sleeve holder, at the back of the table and up against the wall. The tank remained in the same position during additional observations on 06/03/14 at 4:50 PM; 06/04/14 at 9:47 AM, 12:00 PM, 2:30 PM, 3:15 PM and 06/05/14 at 8:30 AM. On 06/05/14 at 1:30 PM housekeeping staff were observed cleaning and detailing the room of Resident #14. The portable oxygen tank was not in the room and the housekeepers stated the resident had just discharged from the facility and the tank was removed from the table and placed in a room designated for oxygen storage. On 06/05/14 at 1:35 PM Nurse #7 (that was	F 328	tanks in the facility was completed. Findings revealed no unsecured oxygen tanks in rooms or common areas. Systemic Changes to Prevent Deficient Practice. Education was conducted for all staff on June 19,2014 by the Clinical Competency Coordinator/Director of Health Services on the proper portable oxygen tank securement procedures. New staff members will be educated in new hire orientation by the Clinical Competency Coordinator on the proper securement of portable oxygen tanks. How will Corrective Action be monitored? The proper storage and securement of oxygen tanks has been added to a compliance rounds inspection to be conducted by facility leadership staff weekly. Results of the compliance rounds will be reviewed by the Administrator areas of noncompliance will be reported to the Performance improvement committee, consisting of interdisciplinary team members, for further recommendations.	

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F 328	Continued From page 13 assigned to the care of Resident #14) stated she had not noticed the portable tank stored on the table in the resident's room. Nurse #7 stated portable oxygen tanks were supposed to be stored on the back of residents wheelchairs or in a oxygen tank dolly. On 06/05/14 at 2:00 PM the facility Director of Nursing (DON) stated portable oxygen tanks were never supposed to be stored unsecured. The DON stated portable oxygen tanks were supposed to be stored on the back of a wheelchair or in a oxygen tank dolly. The DON stated she did not know who had placed the oxygen tank on the table but that all staff should have known not to store an oxygen tank unsecured and should have taken it off the table and stored it according to facility policy.	F 328		
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	F 441		7/3/14

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F 441	Continued From page 14 (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 infection. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to disinfect a blood glucose meter per facility policy after resident use for 1 resident observed during medication pass for 1 of 3 nurses interviewed regarding disinfecting blood glucose meters. (Resident #17). The findings included: A facility policy titled: "Diabetes Monitoring: Blood Glucose Equipment and Supplies" dated January 2011 read in part: "Accuchecks/glucometers or other blood sugar monitor devices will be cleaned and disinfected in the following manner before and after each patient/resident use. Disinfect the meter with a bleach solution wipe (>0.5% sodium hypochlorite) or spray a 1:10 bleach solution on a	F 441	F 441 Corrective Action for those residents affected. Education on glucometer cleaning, by Clinical Competency Coordinator, for nurse #6 with return demonstration. Corrective Action for Those with Potential to be affected. Residents using glucose monitoring equipment has the potential to be affected. All glucose monitoring equipment was cleaned by the Director of Health Services/Clinical Competency Coordinator/Nurse manager per policy.	

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F 441	Continued From page 15 paper towel." A skills competency checklist form titled: "Blood Glucose Equipment and Supplies" used to verify staff competency specified: "Disinfect the meter with a bleach solution wipe or spray a 1:10 bleach solution on a paper towel and ensure meter remains visibly wet for 3 minutes. Allow to air dry." On 06/03/14 at 4:15 PM Nurse #6 was observed checking a finger stick blood sugar on Resident #17. Nurse #6 removed the only glucometer from the medication cart, entered Resident #17's room and checked his blood sugar. He returned to the medication cart and placed the glucometer on top of the medication cart without disinfecting the glucometer. Continuous observation of Nurse #6 revealed the uncleaned glucometer remained on top of the medication cart while he proceeded with administering medications to other residents. On 06/03/14 at 4:50 PM, Nurse #6 was observed removing the uncleaned glucometer from the medication cart and starting into another resident's room. When stopped by the surveyor and asked about disinfecting the glucometer, Nurse #6 stated he had never cleaned the glucometers before or after use and had not been instructed that he needed to do so. Surveyor suggested he check with the Director of Nursing (DON) about the facility's policy on disinfecting glucometers before obtaining the next resident's blood sugar and he did as suggested. An interview on 06/03/14 at 4:57 PM with the DON revealed the facility policy specified glucometers were to be cleaned before and after each use with a bleach disinfecting wipe and allowed to air dry. She stated a container with the bleach wipes was available on the medication cart or in the medication room. Review of the	F 441	Systemic Changes to Prevent Deficient Practice. Education was conducted on June 3, 2014, by the Clinical Competency Coordinator, Director of Health Services, Unit Managers, and Senior Nurse Consultant (SNC) of all nurses on cleaning glucose monitoring equipment with return demonstration competency per policy. No nurse was allowed to work until education and competency was completed on cleaning blood glucose monitoring equipment. Education and Competency of cleaning of the blood glucose monitoring equipment will be completed upon hire and annually of Licensed nurses. Weekly audits conducted by the Director of Health Service/Clinical Competency Coordinator of five licensed nurses from different shifts for one month, results/concerns will be reported to Performance Improvement committee by the Director of Health Services, with reevaluation to see if further auditing is needed, then monthly audits by Director of Health Service/Clinical Competency Coordinator of five licensed nurse for three months, results/concerns will be reported to Performance Improvement committee by the Director of Health Services with reevaluation to see if further auditing is needed.	

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F 441	Continued From page 16	F 441		

label on the container of bleach wipes with the DON revealed the label read: "Wipe surface to be disinfected. Use enough wipes for treated surface to remain visibly wet for 3 minutes. Let air dry." The DON stated newly hired nurses are trained on how to clean glucometers during their orientation on the floor and competency is verified on the skills validation check list which is completed by the nurse who trains the new employee.

During a subsequent interview on 06/03/14 at 5:55 PM the DON provided the Skills Competency Checklist Form for Nurse #6. The DON stated Nurse #2 signed the form indicating Nurse #6 had demonstrated competency in checking finger stick blood sugars and disinfecting glucometers during orientation on 05/14/14.

An interview on 06/05/14 at 2:57 PM with Nurse #2 about the orientation of Nurse #6 revealed Nurse #2 recalled working with Nurse #6 on 05/14/14. Nurse #2 verified that she provided instruction to Nurse #6 on checking finger stick blood sugars and disinfecting of glucometers.