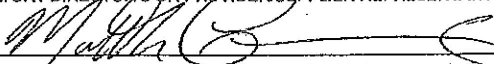
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS-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 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 observations, record review, and staff interviews the facility failed to implement interventions for fall prevention for 2 of 4 residents (Resident #3) for floor mats and (Resident #5) for bed alarm. Findings included: 1. A Quarterly Minimum Data Set (MDS) dated 01/29/16 indicated Resident #3 was admitted to the facility on 07/13/11 and was severely cognitively impaired. Resident #3 required extensive assistance with bed mobility, transfers, toileting, dressing and personal hygiene. Resident #3's diagnoses were coded as Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder, and depression. Resident #3's nursing care plan revealed a problem of at risk for falls related to history of falls, impaired cognition, and poor safety awareness. Interventions for prevention of falls and maintain safety were as follows: · Floor mats were to be placed on floor at bedside.	F 323	The Oaks – Brevard is committed to upholding the highest standards of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation with the State of North Carolina Department of Health and Human Services toward the best interest of those who require the services we provide. 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. **F323 Free of Accident Hazards/Supervision/Devices** **Corrective action for those residents to have been affected.** The floor mats were placed at Resident #3's bedside by an LPN on 02/23/16. The bed alarm was placed on Resident #5's bed by a CNA on 02/23/16.	03/15/16

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



TITLE: Administrator

(X6) DATE: 3/15/16

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 323	Continued From page 1 · Scoop mattress. · Bed was to be in low position when Resident #3 was in bed. · Staff were to maintain a well-lit and clutter free environment. The nurse aide care guide indicated Resident #3 required 2 floor mats next to bed and 2 side rails at head of the bed were to be placed in the up position. On 02/23/16 at 9:51 AM Resident #3 was observed in bed and Nurse Aide #1 was providing incontinence care. Floor mats were not observed on the floor at Resident #3's bedside. On 02/23/16 at 9:59 AM Resident #3 was observed in bed with side rails at the head of the bed in the up position. Floor mats were not observed on the floor at Resident #3's bedside. No staff members were observed in Resident #3's room. On 02/23/16 at 10:04 AM an interview was conducted with Nurse Aide (NA) #1 who stated she usually worked on the hallway that Resident #3 resided on. NA#1 stated she was not aware that Resident #3 required an intervention of floor mats on the floor at bedside. NA #1 stated she was not aware that Resident #3 had a nurse aide care guide and she had never looked at Resident #3's nurse aide care guide or any other resident's care guide for specific care interventions. NA #1 further revealed she had never placed floor mats at Resident #3's bedside and verified that Resident #3 was in bed and floor mats were not on the floor. On 02/23/16 at 10:12 AM an interview was	F 323	**Corrective action will be accomplished for those residents to be affected by same deficient practice.** On 03/09/16 all residents identified for fall risk were reviewed. This was completed using an audit tool by the Director of Health Service (DHS). The audit consisted of review of fall interventions listed on each resident's care plan against the resident's care guide and visual observation of each resident to ensure intervention is in place. **Measures put into place or systemic changes made to ensure that the deficient practice will not occur.** On March 10th, the Clinical Competency Coordiantor began education for all nurses' and aides, including weekend and PRN staff on the resident care guide. The education included what the care guide is/consists of and fall interventions needed for those residents identified at risk. Of the 74 nurses' and aides, 72 have completed the in-service. All nurses' and aides will be required to complete the in-service prior to working his/her next scheduled shift. Education on resident care guides has been added to orientation for all new hires. A list of all fall interventions will be kept and updated daily on the care guide as needed when a fall occurs.	

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F 323	Continued From page 2 conducted with Nurse #1 who stated she had not provided a nursing report at the beginning of the shift to NA #1 that Resident #3 required floor mats on each side of the bed for fall safety. Nurse #1 stated she did not know if NA #1 had reviewed Resident #3's nurse aide care guide for specific care interventions. Nurse #1 reviewed the nursing care plan and nurse aide care guide and verified Resident #3 required an intervention that floor mats were to be placed at bedside. Nurse #1 stated floor mats should have been implemented as per care plan for Resident #3. Nurse #1 verified Resident #3 was in bed and floor mats were not on the floor at bedside. Nurse #1 stated she would immediately place floor mats at Resident #3's bedside as per care plan. On 02/23/16 at 10:39 AM and interview was conducted with the Director of Nursing (DON) who stated her expectation was that Nurse #1 and NA#1 would have followed the nursing care plan and nurse aide care guide and implemented intervention of floor mats at bedside for Resident #3. The DON stated her expectation was that NA #1 would have reviewed the nurse aide care guide for specific care interventions for Resident #3 and placed floor mats at bedside per care guide. The DON stated nurse aides were provided education on hire regarding the requirement to implement interventions for resident as per nurse aide care guide. The DON stated her expectation was for Nurse #1 to have provided a nursing report to NA #1 that Resident #3 required an intervention of floor mats at bedside. The DON stated her expectation was that Nurse #1 would have checked Resident #3 to assure floor mats were implemented by NA #1. The DON stated Resident #3 should have had floor mats placed at bedside.	F 323	The Director of Health Services, Clinical Competency Coordinator, Unit Managers and Weekend Supervisor will observe residents identified at risk for fall to ensure interventions are in place for five residents per week times 4 weeks, then three residents per week times 4 weeks, and then 1 resident a week times 4 weeks to ensure fall risk interventions are in place according to the resident care guide. **Facility plans to monitor its performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained.** The Director of Health Services will present the findings of residents identified at risk for falls, review if care guides and observations of residents to the Quality Assurance and Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained.	

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F 323	Continued From page 3	F 323		

2. Resident #5 was admitted to the facility on 06/16/14 with diagnoses including degenerative disease of the nervous system, Alzheimer's disease, and history of falling.
Review of the Minimum Data Set (MDS) quarterly assessment dated 11/23/15 revealed Resident #5 had been identified as severely cognitively impaired with a functional status of extensive 2 person physical assist for bed mobility and transfers.
Review of a care plan dated 02/17/16 revealed a problem identified for Resident #5 of potential for injury from falls related to history of falls. Most recent fall 02/14/16. Interventions included: Bed and wheelchair alarm in place, and ensure alarms were in place and functioning.
An observation of Resident #5 on 02/24/16 at 11:05 AM revealed she was in bed and no bed alarm had been observed to be in place.
An interview was conducted with Nurse Aide (NA) #1 on 02/24/16 at 11:06 AM who stated she usually worked with Resident #5 and was not aware that Resident #5 required an intervention of a bed alarm. She further stated she did not know where Resident #5's care plan was, or what was on it. She stated she had never placed a bed alarm on Resident #5's bed and verified Resident #5 was in bed and no bed alarm was in place
An observation of Resident #5 on 02/24/16 at 11:10 AM with the Director of Nursing (DON) revealed Resident #5 was in bed and no bed alarm had been observed to be in place. The DON had been observed to search resident #5's room and did not find a bed alarm to place on Resident #5's bed. The DON verified that Resident #5 should have had a bed alarm in place. The DON stated it was her expectation of staff to follow Resident #5's care plan regarding

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F 323	Continued From page 4 the placement of a bed alarm while she was in bed.	F 323		