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 02/02/2018

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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		3/2/18

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

Electronically Signed | 02/26/2018

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 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, family and staff interviews the facility failed to notify a Responsible Party of a fall for 1 of 4 sampled residents reviewed for accidents (Resident #42). The findings included: Resident #42 was admitted to the facility on 10/28/15 with the current diagnoses which included Alzheimer's disease and falling. The most recent Minimum Data Set (MDS) dated 12/15/17 indicated she had severe cognitive impairment and required limited assistance with the physical assist of 2 persons for transfers. The MDS also indicated Resident #42 was occasionally incontinent of bladder and bowel. Review of Resident #42's undated Incident Report (IR) revealed, she had a non-witnessed fall from her bed. The IR indicated Resident #42 removed her brief and urinated on the floor which caused her to slip and fall. There was no documentation on the IR that Resident #42's Responsible Party (RP) was notified. Review of Resident #42's SBAR (situation, background, appearance and review/notify)	F 580	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove the deficiency. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. Process that lead to the deficiency Nurse #1 failed to follow the policy related to falls stating that the Responsible Party will be notified if a fall occurs. Process for implementing a plan of correction for specific deficiency "Nurse #1 received 1:1 in-service	

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F 580	Continued From page 2 Communication Form (SCF), which also served as a nurses' progress note, revealed on 01/19/18 Resident #42 got out of bed by herself, urinated on the floor, slipped and fell. The IR indicated she received a nickel sized abrasion on her left knee. The IR noted that the non-injury physician phone line was called on 01/19/18 at 07:00 AM but the IR did not indicate that Resident #42's RP was notified of the fall. On 02/01/18 at 1:36 PM during a telephone conversation with Resident #42's RP, she stated she was not notified of the fall on 01/19/18 and stated that she had recently visited Resident #42 and she complained of hurting all over. The RP stated had she known of the fall she would have known the pain could be a result from the fall. On 02/01/18 at 11:21 PM during an interview with Nurse #1, she stated she did not inform Resident #42's RP of her fall on 01/19/18 because the RP was out of town, but, in retrospect she knew she should have. On 02/02/18 at 6:00 PM during an interview with the Director of Nursing (DON), she stated the RP should have been notified of Resident #42's fall on 01/19/18 no matter if she was out of town.	F 580	education on 2/27/18 related to notification of Responsible Party when a fall occurs. "All nursing staff to be educated on notification of Responsible Party with each fall on 2/27/18. "Chart audit performed of falls within the past 30 days to ensure that Responsible Party notification was made. "An incident log for falls will be printed each morning and cross referenced to the resident□s chart to ensure that the Responsible Party was notified of the fall by the charge nurse. Monitoring to ensure effectiveness of POC "The incident log will be used to audit falls daily x 2 weeks, then 3 times weekly for 2 weeks and then once weekly x 3 months. The Quality Assurance Nurse will report any concerns weekly during the risk meeting and will present concerns to the QAPI committee monthly x 3 months or until substantial compliance is achieved. Title of person responsible for implementing the POC The Interim Director of Nursing will be responsible for the audits and ensuring that compliance is met with notification of falls to the Responsible Party. Date of Compliance: March 2, 2018	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		3/2/18

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F 584	Continued From page 3	F 584		

comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 584	Continued From page 4 Based on observations and staff interviews, the facility failed to maintain the walls in residents' rooms in good repair, replace broken blinds and replace a missing closet door for 5 of 24 resident rooms on 2 of 5 occupied resident halls (Rooms 4, 5, 12, 501, and 505); failed to replace a bedside table with peeling laminate in 1 of 12 resident rooms on 1 of 5 occupied resident halls (Room 510); and failed to label and properly store resident care equipment in 2 of 6 shared resident bathrooms on 1 of 5 occupied resident halls (Bathrooms 501 and 504). Findings included: 1. a. Observations in room #4 on 01/29/18 at 10:37 AM revealed the window blinds were broken. Subsequent observations on 01/30/18 at 8:55 AM and 02/01/18 at 9:56 AM revealed the conditions remained unchanged. b. Observations in room #5 on 01/29/18 at 10:46 AM revealed a chipped and damaged area on the corner of the wall. Subsequent observations on 01/31/18 at 9:59 AM and 02/01/18 at 9:05 AM revealed the conditions remained unchanged. c. Observations in room #12 on 01/30/18 at 9:57 AM revealed the right side of the closet door was missing with peeling laminate along the inside of the closet door frame. Subsequent observations on 01/31/18 at 10:02 AM and 02/01/18 at 9:07 AM revealed the conditions remained unchanged. d. Observations in room #501 on 01/29/18 at 11:57 AM revealed a section of the baseboard missing exposing the drywall from the corner of the wall to the bathroom door. Subsequent observations on 01/31/18 at 11:22 AM and 02/01/18 at 1:23 PM revealed the conditions	F 584	ALLEGED DEFFICIENCIES F584 Safe Environment, facility failed to maintain the walls in residents rooms, replace broken blinds, replace a missing closet door and replace a peeling bedside table in 5 surveyed rooms. In addition a plastic bag containing urinals with an unknown substance was found to have no resident names labeled. Process that lead to the deficiency The facility staff failed to alert the maintenance department in a timely manner regarding maintenance concerns brought to their attention during facility rounds. Nursing staff failed to label resident urinals, bedpans and store them properly. Process for implementing a plan of correction for specific deficiency "All staff were re-educated on 2/22/18 on the correct way to report maintenance concerns to the maintenance director for repair. "Nursing staff and CNAs will be re-educated on 2/28/18 regarding the procedure for labeling and storage of urinals and bedpans. A current list of nurses and CNAs used to cross reference to education list to ensure necessary partners received training. Monitoring to ensure effectiveness of POC "Audits of all rooms completed to	

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F 584	Continued From page 5 remained unchanged. e. Observations in room #505 on 01/30/18 at 10:08 AM revealed damaged area on the corner of the wall with plaster flaking. Subsequent observations on 01/31/18 at 11:20 AM and 02/01/18 at 1:28 PM revealed the conditions remained unchanged. f. Observations in room #510 on 01/30/18 at 9:02 AM revealed a bedside table for the B bed with peeled laminate across the top right edge. Subsequent observations on 01/31/18 at 11:17 AM and 02/01/18 at 1:25 PM revealed the conditions remained unchanged. An interview and environmental tour on 02/01/18 at 3:07 PM with the Maintenance Director (MD) revealed he was the only maintenance staff in the facility and would make repairs as he noticed them but also relied on notification from staff when repairs were needed. The MD confirmed he had been unaware of the repairs needed in rooms 4, 5, 501, 505, and 510. He explained the closet door in room 12 was removed for safety after it had been pulled from the hinge and added he had planned on purchasing a different type of hinge that would provide more stability when the door was replaced but had no date when it would be ordered or repaired. An interview with the Administrator on 02/02/18 at 5:20 PM revealed facility wide environmental improvements were done in stages and explained facility staff completed weekly compliance rounds to identify any potential issues. The Administrator stated he would have expected for staff to notify the MD when repairs were needed.	F 584	determine any areas of concern related to safe environment by the Maintenance Director and Administrator. "Audits of 10 rooms per week x 4 weeks will be completed by the Administrator to ensure compliance with any maintenance concerns. If concerns are noted during that time, work orders will be completed and directed to the Maintenance Department. If concerns arise and or trends are identified, the Maintenance Director will report all finds to QAPI monthly for analysis. "Any areas of concern noted will have work order completed and/or items ordered to correct area. "Audit of all rooms to ensure that urinals and bedpans were labeled and stored according to standard by the Administrator. "Audits of 25 rooms x 1 week, 10 rooms x 2 weeks and 5 rooms x 2 weeks and then 5 rooms weekly x 3 months will be done to ensure that bedpans and urinals are labeled and stored according to standard. "These audits will be brought to QAPI x 3 months or until substantial compliance is achieved. Title of person responsible for implementing the POC The Administrator and QA nurse will be responsible for the implementation of the POC. Date of Compliance: March 2, 2018.	

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F 584	Continued From page 6	F 584		

2. a. Observations of the bathroom for room 501 on 1/29/18 at 11:57 AM revealed a fracture pan situated in between the metal grab bar and wall that was not covered or labeled, a plastic bag tied to the metal grab bar containing a bed pan that was not labeled and a plastic bag with 3 urinals that had a yellow colored liquid substance at the bottom of the bag that was not labeled.

Subsequent observations on 01/31/18 at 11:22 AM and 02/01/18 at 1:23 PM revealed the conditions remained unchanged.

b. Observations of the bathroom for room 504 on 01/30/18 at 10:10 AM revealed a plastic bag tied to the metal grab bar containing 3 urinals with a yellow liquid substance at the bottom of the bag that was not labeled.

Subsequent observations on 01/31/18 at 11:29 AM and 2/1/18 at 1:26 PM revealed the conditions remained unchanged.

During an interview and tour on 02/02/18 at 1:20 PM the Director of Nursing (DON) acknowledged the personal care equipment stored in the shared bathrooms for 501 and 504 were not labeled with the resident's name and both bags of urinals containing a liquid substance should have been discarded. The DON added she was not certain why urinals had been stored in the bathroom for room 501 since it was shared by women residents. She further indicated the fracture pan was not being used by any of the residents' and should have been removed. The DON stated it was her expectation all personal care equipment would be labeled with the resident's name and stored appropriately.

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	345462	A. BUILDING _____ B. WING _____	C 02/02/2018

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F 760	Continued From page 7	F 760		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to administer two doses of Coumadin to 1 of 4 sampled residents on Coumadin. The Coumadin was not administered due to failure to report a lab result to the physician in a timely manner and failure to obtain lab work the day it was ordered. (Resident #52) The findings included: Resident #52 was admitted to the facility 12/01/15 with diagnosis which included atrial fibrillation. The care plan for Resident #52 included a problem area dated 06/19/17 which read, Potential for signs/symptoms of bleeding related to anticoagulant. Approaches to this problem area included to give medications as ordered and to monitor labs as ordered. The Prothrombin Time (PT)/International Normalized Ratio (INR)/Coumadin Flowsheet located in the medical record of Resident #52 included directions which read, "Use flow sheet for individual patients and complete each time a PT/INR (lab used to dose Coumadin and maintain within a therapeutic range) level is drawn. When completed, file in individual patient clinical record. If lab results are not reported within same day of draw, contact physician to	F 760	ALLEGED DEFFICIENCIES F760- Resident #52 had PT/INR due on 6/29/17. The lab was drawn on 6/30/17 and resident did not receive Coumadin dose on 6/29/17. Resident #52 had PT/INR lab order for 7/17/17. The lab was drawn as ordered, but Nurse #3 failed to notify the MD on 7/17/17. Coumadin dose was not administered on 7/17/18. Nurse #4 notified on call MD of PT/INR results and received an order to continue the Coumadin at the current dose. Process that lead to the deficiency "The facility failed to ensure that Coumadin lab orders were drawn timely and that results were called to the MD in order to obtain new orders related to Coumadin dosage. Process for implementing a plan of correction for specific deficiency "All residents currently receiving Coumadin in the facility had an audit of their most recent PT/INR lab orders to ensure that the lab had been reported to the MD and that new orders were received related to Coumadin dose. This	3/2/18

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	345462	A. BUILDING _____ B. WING _____	C 02/02/2018

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F 760	Continued From page 8 determine if Coumadin should be given or held." a. A nurse practitioner progress note dated 06/26/17 noted Resident #52 was being seen for "Coumadin management." The nurse practitioner noted Resident #52 received Coumadin due to her history of atrial fibrillation. The nurse practitioner noted the last INR was 1.88 and that Resident #52 was on 4 milligrams (mg) of Coumadin. The nurse practitioner wrote orders to increase the Coumadin to 4.5 mg every day and recheck the PT/INR on 06/29/17. Review of the PT/INR/Coumadin Flowsheet for Resident #52 noted that on 06/26/17 Resident #52 had orders to give 4.5 mg of Coumadin every day and to check the PT/INR on 06/29/17. Review of the June 2017 Medication Administration Record (MAR) for Resident #52 noted the order for Coumadin was changed from 4.0 mg to 4.5 mg on 06/26/17 and signed as administered from 06/26/17-06/28/17. Hand written on the June 2017 MAR was a block on the 06/29/17 date with PT/INR written inside the block. An arrow hand written on the MAR indicated to give the 4.5 mg of Coumadin from 06/26/17-06/28/17. Review of lab work in the medical record of Resident #52 was a PT/INR which was drawn 06/30/17 with results reported on 06/30/17. The results noted a PT/INR of 26/2.31. These results were noted on the PT/INR/Coumadin Flowsheet for Resident #52 and indicated the results were reported to the physician on 06/30/17 with orders to keep the Coumadin dose at 4.5 mg every day. Review of the June 2017 MAR for Resident #52 noted the Coumadin was not given on 06/29/17	F 760	was completed on 2/6/2018. "A new Coumadin checklist has been implemented in the facility to ensure that labs have been drawn timely and that new orders have been received. "Nurse #3 has received 1:1 education by the Director of Nursing Services related to reporting PT/INR lab orders to the MD on 2/1/18. "Nursing staff were re-educated on 2/6/18 on the process for drawing and reporting PT/INR lab orders. Monitoring to ensure effectiveness of POC "Audits will be completed daily on the newly implemented Coumadin checklist which consists of the resident name, dosage, indication of lab drawn, date of lab draw, indication of next lab due, MD notified, Responsible Party notified and if new orders were received. These audits will be performed daily by the QA nurse and RN weekend supervisor daily x 2months or until substantial compliance is achieved. "Any adverse findings will be reported in Morning Clinical Meeting. "The in-services will be cross referenced to a current list of nursing staff to ensure that all nurses have received the education. "Findings from audits will be presented to the QAPI committee monthly for 3 months. Title of person responsible for implementing the POC	

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F 760	Continued From page 9 due to the delay in obtaining lab work. There were no physician orders or nurses notes in the medical record of Resident #52 regarding the administration of Coumadin on 06/29/17. b. Review of the PT/INR/Coumadin flowsheet for Resident #52 noted that on 07/10/17 Resident #52 had orders to give 4.5 mg of Coumadin every day and to check the PT/INR on 07/17/17. Review of the July 2017 MAR for Resident #52 noted the order for 4.5 mg of Coumadin which was documented as given up through 07/16/17. On 07/17/17 Nurse #3 initialed and circled the MAR, which indicated the Coumadin had not been given at 4:00 PM as scheduled. Review of lab work in the medical record of Resident #52 was a PT/INR which was time stamped as drawn 07/17/17 at 5:00 AM and time stamped as Fax'd to the facility on 07/17/17 at 2:58 PM. Handwritten on the lab was "called on call for new order" by Nurse #4 which was dated and timed on 07/18/17 at 6:30 AM. The 07/17/17 results noted a PT/INR of 29.5/2.71. These results were noted on the PT/INR/Coumadin Flowsheet for Resident #52 and indicated the results were reported to the physician on 07/18/17 with orders to keep the Coumadin dose at 4.5 mg every day. There were no physician orders or nurses notes in the medical record of Resident #52 regarding the administration of Coumadin on 07/17/17. On 01/31/18 at 5:08 PM Nurse #4 reported she routinely worked third shift and typically was not involved in reporting PT/INR results or administering Coumadin. Nurse #4 stated she did recall calling the on call physician on 07/18/17	F 760	The Interim Director of Health Services will be responsible for ensuring that audits are completed daily. Date of Compliance: March 02, 2018.	

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 760	Continued From page 10	F 760		

about the PT/INR results for Resident #52 because they had not been reported on 07/17/17. Nurse #4 stated the Coumadin would not have been given on 07/17/17 by the second shift nurse without a physician's order.

On 02/01/18 at 11:53 AM the Director of Nursing (DON) stated when there were orders for a PT/INR staff were supposed to block the due date of the PT/INR on the individual residents MAR as a reminder to not give another dose of Coumadin before the PT/INR results were back and the physician was notified. The DON stated the nurses could obtain the PT/INR lab results via Fax or by looking for the results on the computer. The DON explained the lab service was from out of state and lab work was usually done early in the morning; with most results back by the afternoon before Coumadin would be administered.

The DON stated Nurse #5 put the order in on 6/26/17 for Resident #52 for the next PT/INR to be done 06/29/17. The DON stated since labs were done electronically, nursing staff would put a requisition in the day before the lab was due. The DON stated she was not aware of a way to see (in the electronic lab system) who put the requisition in and/or what day the lab was requested. The DON did verify the lab ordered to be done 06/29/17 was not done until 06/30/17 which resulted in Coumadin not being administered to Resident #52 on 06/29/17.

The DON stated Nurse #3 was working on 07/17/17 when the PT/INR lab results came back at 2:58 PM for Resident #52 and stated there should have been enough time to report the results to the physician before the 4:00 PM

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 760	Continued From page 11	F 760		

scheduled time for Coumadin to be admiistered. The DON stated because the PT/INR results were not called to the physician until 07/18/17 the Coumadin was not given to Resident #52 on 07/17/17. The DON stated she could not explain what happened and there was nothing in the nurses notes, 24 hour nursing report or physician orders to explain what happened with the PT/INR lab ordered for Resident #52 on 06/29/17 or 07/17/17.

On 02/01/18 at 12:11 PM Nurse #3 stated she could not explain what happened on 07/17/17 in relation to the lab and Coumadin for Resident #52. Nurse #3 verified her signature (which was circled) on the MAR on 07/17/17 beside the Coumadin order for Resident #52 and indicated it meant the medication had not been given.

On 02/01/18 at 3:30 PM a staff member with the lab service stated the requisition for the PT/INR was sent for Resident #52 on 06/29/18. The staff member stated requisitions had to be given the day before a lab was ordered. The staff member stated they could not determine who put the requisition in or if it had been requested prior to 06/29/18.

On 02/01/18 at 5:06 PM the physician of Resident #52 stated he expected PT/INR lab results to be done as ordered and reported to the physician/nurse practitioner in a timely manner so that Coumadin orders could be obtained. The physician stated Coumadin would not be given until PT/INR were reported to the physician/nurse practitioner. The physician stated missing one dose of Coumadin on two separate occasions did not harm Resident #52 and didn't seem to affect subsequent PT/INR results.

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F 760	Continued From page 12 On 02/02/18 at 2:30 PM Nurse #5 verified she wrote the 06/26/18 entry in the PT/INR/Coumadin Flowsheet for Resident #52 which indicated the next PT/INR was due on 06/29/18. Nurse #5 stated it was her practice to put the need for the lab the day before it was due in the electronic record. Nurse #5 stated she could not remember the specifics of the 06/29/17 lab for Resident #52 or explain why it was not done until 06/30/18. On 02/02/18 at 6:50 PM the Administrator stated he expected PT/INR labs to be done as ordered and promptly reported to the physician/nurse practitioner so new Coumadin orders could be obtained.	F 760		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		3/2/18

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F 812	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard a container of pudding that was outdated and stored in the kitchen refrigerator available for use and failed to label 4 plastic containers of dry cereal with a date when opened. Findings included: During the initial tour of the kitchen on 01/29/18 at 10:10 AM an observation of the kitchen refrigerator revealed a 12-quart container of chocolate pudding, with approximately one-fourth remaining, dated 01/24/18. There was no use by date listed on the container. An interview on 01/29/18 at 10:10 AM with the Dietary Manager (DM), who was present during the observation, stated food items stored in the refrigerator were dated the day the item was prepared and the use by date for leftovers was 3 days after the date prepared. The DM acknowledged the items in the refrigerator were available for use and stated the pudding should have been discarded on 01/27/18. He added it was the responsibility of all dietary staff to check the refrigerator daily and discard expired items. During a second tour of the kitchen on 02/01/18 at 9:15 AM an observation of the pantry revealed 4 plastic containers of dry cereal all marked with the date "10/20." There was no use by dated listed on the container. An interview on 02/01/18 at 9:15 AM with the DM, who was present during the observation, stated the containers were refilled on a weekly basis and	F 812	ALLEGED DEFFICIENCIES F812 Food Procurement, Store/Prepare/Serve-Sanitary; A 12 quart container of chocolate pudding and four plastic containers of dry cereal found on 1/29/18 in the kitchen refrigerator and dry storage area were found to have no date present and were not discarded as necessary. Process that lead to the deficiency Failure to check dates daily by the dietary staff led to this citation. Dietary staff were re-educated on 2/22/18 by the Dietary Manager on Food Storage preparation, distribution and serving food under sanitary conditions. Specific education related to the daily processes of food labeling and discarding procedures were emphasized. Allegation of Compliance with the removal of immediate Process for implementing a plan of correction for specific deficiency A 100% audit of all refrigerators and dry storage areas within the kitchen was completed by the Dietary Manager on 1/29/18 to ensure facility was in compliance and at that time no other items were identified to be out of date. Monitoring to ensure effectiveness of POC	

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F 812	Continued From page 14 dietary staff had just forgotten to put the correct date on the containers. The DM was unable to recall the exact date when the containers had been refilled with cereal but indicated it was most likely the beginning of the week. The DM stated he would expect for staff to label the containers of cereal with the correct date when refilled. An interview on 02/02/18 at 5:20 PM with the Administrator revealed he would expect for all expired food to be discarded.	F 812	Dietary refrigerators and dry storage areas will be audited twice daily by the Dietary Manager for 3 weeks and once daily thereafter for 3 months to ensure compliance is assured on-going. Monitors will be presented to the QAPI committee by the Dietary Manager for 3 months or until the issue is resolved or consistent compliance is achieved. The committee will make revisions to plan as deemed necessary. Title of person responsible for implementing the POC Dietary Manager Date of Compliance 3/02/18	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		3/2/18

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F 842	Continued From page 15 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 842		

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F 842	Continued From page 16 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to obtain clarification of a medication order for 1 of 6 residents with medications reviewed. (Resident #77) The findings included: Resident #77 was admitted to the facility 01/01/18 with diagnoses which included acute and chronic respiratory failure with hypoxia, anemia, fractured left arm, depression, anxiety and dementia with behavioral disturbance. The current care plan dated 01/17/18 for Resident #77 included the following problem areas: -Potential for alteration in behavioral/psychosocial status related to less than daily episodes of combative behaviors and rejection of care. Approaches to this problem area included medications as ordered by physician. -Potential for decline/changes in cognition related to diagnosis dementia. Review of admission physician orders for Resident #77 noted medications ordered included a daily dose of 5 milligrams of Aricept and 10 milligrams of Namenda (both used to treat dementia).	F 842	Process that lead to the deficiency "Nurse #2 failed to clarify an order that did not have the dosage ordered by MD. Process for implementing a plan of correction for specific deficiency "Nurse #2 received 1:1 education on 2/27/18 regarding the procedure if an order is not complete. "Nursing staff to receive education on procedure for clarification of incomplete orders on 2/27/18. This education to include components of a complete order and how to transcribe to the MAR with examples. The in-service will include education on signing off medications in the MAR. "Education will be cross referenced to a current list of nursing staff to ensure all nurses received education. Monitoring to ensure effectiveness of POC "Audits of new orders for completeness will be done daily by taking all new MD orders and reviewing them for date, name of resident, dose, route, frequency and	

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F 842	Continued From page 17 On 01/19/18 the psychiatrist assessed Resident #77 and noted, "Mild cognitive impairment with word-finding difficulty aggravated by delirium from recent illness. Cognition has been improving with clearing of delirium with no recent combative behavior. Change Namenda and Donepezil (Aricept) to Namzaric (a combination drug to treat dementia) 28/10 milligram every AM." The psychiatrist hand wrote an order which read, "Namzaric 28/10 milligram AM dementia." On 02/01/18 at 5:06 PM the physician for Resident #77 stated he expected medication to be given as ordered and that there was a practitioner in the facility four days a week if clarification was needed of an order. On 02/02/18 at 3:00 PM Nurse #2 verified she noted the orders dated 01/19/18 for Resident #77 and handwrote on the January 2018 Medication Administration Record (MAR), "Namzaric 25/10 milligram, 9:00 AM, diagnosis dementia". The only time the Namzaric was signed and documented as given (since ordered on 01/19/18) was 01/23/18. When asked about the order, Nurse #2 stated she did not administer the medication because the order was incomplete; noting it lacked dosing. Nurse #2 stated she wrote it on the MAR as written but also wrote a note in the doctor's book asking for clarification of the order. On 02/02/18 at 3:49 PM the Director of Nursing (DON) stated the facility had recently identified concerns that MARs were not always signed to indicate a medication had been given. The DON stated interventions were in place to address the concern which included training and monitoring. The DON stated documentation written in the	F 842	indication for use. This will be done by QA nurse and RN weekend supervisor. Audits will be completed daily x 2 months or until substantial compliance is achieved. "Audits will be done of the MAR daily on all new orders to ensure that they have been transcribed correctly. This will be done by QA nurse and RN weekend supervisor. Audits will be completed daily x 2 months or until substantial compliance is achieved. "Audits of the MAR for signatures of nurses when medications are given will be done 2 x week for 4 weeks and then weekly x 3 months. "Any discrepancies found during the audits will be brought and discussed in morning clinical meeting. "Audit findings will be brought to QAPI x 3 months or until substantial compliance is achieved. Title of person responsible for implementing the POC The Interim Director of Nursing will be responsible for implementing the POC. Date of compliance: March 2, 2018	

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F 842	Continued From page 18 doctor's book by nursing staff was not kept once reviewed by the doctor/nurse practitioner. The DON stated she tried to look at the doctors book on a routine basis to ensure any concerns were addressed but could not recall any specifics about the order for Namzaric for Resident #77. The DON looked at the order for Namzaric and agreed it was not complete and needed clarification. At the time of the interview the DON called the facility pharmacy to see if they sent a request for clarification prior to filling the order for the Namzaric. The pharmacist stated they did not question the order and sent the medication on 01/20/18. The DON stated she could not explain what happened to the request for clarification and indicated it should have been addressed if written in the doctor's book. On 02/02/18 at 6:30 PM the Administrator stated he expected orders to be complete when written on the MAR.	F 842		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	F 865		3/2/18

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F 865	Continued From page 19 §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in December of 2016 for two cited deficiencies. One recited deficiency was originally cited in December 2016 on a Recertification survey and again on the current Recertification survey. The repeat deficiency was in the area of Food and Nutrition Services/kitchen sanitation (F371/865). A second deficiency was originally cited in December 2016 on a Recertification survey and again on the current Recertification survey. The repeat deficiency was in the area of Administration/accuracy or medical records (F514/842). The continued failure of the facility during two federal surveys of record show a pattern of the faciity's inability to sustain an effective Quality Assurance Program. The findings included: 1.a. 483.60 Food and Nutrition Services/Kitchen Sanitation- Based on observations and staff interviews the facility failed to discard a container of pudding that was outdated and stored in the kitchen refrigerator available for use and failed to label 4 plastic containers of dry cereal with a date when opened. During a recertification survey on December 2, 2016 the facility was cited for failure to discard	F 865	ALLEGED DEFFICIENCIES F865 QAPI Program/Plan, Disclosure/Good Faith Attempt. Facility failed to maintain implemented procedures and monitoring processes to ensure repeat citations regarding Food and Nutrition Services/kitchen sanitation(F371/865) did not recur as cited during the December 2016 and January 2018 annual surveys. Process that lead to the deficiency Change in facility Administration during June of 2017 led to the failure in follow-up of the QAPI program with current and past interventions related to F371/865. Allegation of Compliance with the removal of immediate Process for implementing a plan of correction for specific deficiency The Quality Assurance, Performance Improvement Committee was re-educated on the purpose and function of the committee by the Administrator on 2/22/18. The Committee consists of the Medical Director, Administrator, Director of Nursing Services, Financial Counselor, Social Services Director, Nurse Navigator, Clinical Care Coordinator, Case Mix Director, Activities Director, Medical	

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F 865	Continued From page 20 milk and bread products in the kitchen storage areas with expired use by or best buy dates, completely close foods products in kitchen freezer storage and discard yogurts with expired expiration dates stored in one of three facility nourishment refrigerators. During the current recertification survey the faciity was cited for failure to discard a container of pudding that was outdated and stored in the kitchen refrigerator available for use and failed to label 4 plastic containers of dry cereal with a date when opened. b. 483.70 Medical Records - Based on medical record review and staff interviews the facility failed to obtain clarification of a medication order for 1 of 6 residents with medications reviewed. (Resident #77) During a recertification survey on December 2, 2016 the facility was cited for failure to document administered medications in the medical records for 1 of 6 residents reviewed for pharmacy services. During the current recertification survey the facility was cited for failure to obtain clarification of a medication order. During an interview on 02/02/18 at 6:50 PM the Administrator confirmed he was responsible for the Quality Assessment and Assurance Committee however, he had only worked in the facility since June 2017. He acknowledged he was familiar with the citations the facility had received during their prior recertification survey. He stated it was his expectation that repeat deficiencies would not happen again. He	F 865	Records Director, Dietary Manager and Maintenance Director. The expired pudding and dry cereal noted to have been expired or did not have a date in the kitchen were discarded. Monitoring to ensure effectiveness of POC The QAPI Committee will meet on a monthly basis to discuss improvement initiatives as well as a retrospective analysis to examine facility processes and procedures to determine reasons for failure to discard items as indicated in F812. In addition the committee will develop subcommittees to specifically look at findings and recommend interventions that will achieve consistent compliance. All refrigerators and dry storage areas were audited for expired items as well as items that had no date present. Staff were educated to identify and discard potentially unsafe foods. The QAPI Committee will develop systematic procedures and new approaches to repair causes of failed procedures by dietary staff. A check system by the Dietary Manager was devised to include 2 audits daily to identify expired foods and those that do not have dates present. The QAPI committee will review these audits for 3 months to ensure substantial compliance is achieved and deficiencies do not recur. The Senior Nurse Consultant and the Registered Dietician will review the QAPI Committees progress and make changes to the committees approaches as deemed	

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F 865	Continued From page 21 explained he was in the process of overhauling systems in the facility including hiring compliance officers to monitor medical records.	F 865	necessary. Title of person responsible for implementing the POC Administrator Date of Compliance 3/02/18	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure the call light system was functioning in 1 of 12 sampled rooms on 1 of 5 occupied resident hallways (Room 512). Findings included: Observations of the bedside call bell for the A bed in resident room 512 on 01/29/18 at 11:49 AM revealed the light in the hallway above the resident's door or on the call system unit in the resident's room did not activate when the call bell was pushed. Observations of the bedside call bell for the A bed in resident room 512 on 01/30/18 at 9:43 AM revealed the light in the hallway above the resident's door or on the call system unit in the resident's room did not activate when the call bell	F 919	ALLEGED DEFFICIENCIES F919 Resident Call System, facility failed to ensure call light system was functioning in 1 sampled room identified on 1/29/18 Process that lead to the deficiency The failure in facility processes that led to this citation resulted in staff members not reporting to Maintenance when a call light was not functioning in a timely manner. Process for implementing a plan of correction for specific deficiency The call light not functioning in room 512 was immediately fixed on 2/1/18 by the Maintenance Director. All staff will be re-educated on] 2/22/18 on	3/2/18

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 02/02/2018

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 919	Continued From page 22 was pushed. Observations of the bedside call bell for the A bed in resident room 512 on 02/01/18 at 1:00 PM revealed the light in the hallway above the resident's door or on the call system unit in the resident's room did not activate when the call bell was pushed. An interview and tour with the Maintenance Director (MD) on 02/01/18 at 3:07 PM revealed he checked the call lights in each resident's room during the first week of every month to ensure they were functioning properly. He was unaware the call light for the A bed in room 512 was not functioning and added he would make repairs to call lights as he noticed them but also relied on notification from staff or residents when repair was needed. During the tour of room 512 at 3:56 PM, a newly admitted resident in 512B was holding the call light and stated it was not working. The MD checked the call lights for both the A and B bed. He confirmed they were not functioning properly and would need to be repaired. An interview with the Administrator on 02/02/18 at 5:20 PM revealed facility staff completed weekly environmental compliance rounds to identify potential issues. He explained managers had certain rooms they were responsible for checking which included call lights. The Administrator stated he would have expected staff to notify the MD when call lights were not functioning.	F 919	the correct process for reporting when call lights are not functioning to the Maintenance Director so that he can replace and or fix call lights as indicated. A 100% audit of all call lights was completed on 2/1/18 by the Maintenance Director to ensure all call lights were functioning. No other call lights were identified to be broken and or not functioning. Monitoring to ensure effectiveness of POC The Administrator/Maintenance Director will audit all facility call lights once daily for 3 weeks and once weekly thereafter for 3 months to ensure all call lights are functioning. The Administrator/Maintenance Director will present audit tools to the QAPI committee for review and or recommendations to ensure compliance is assured on-going. Title of person responsible for implementing the POC Administrator and Regional Environmental Consultant Date of Compliance 3/02/18	