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 06/28/2018

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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow professional standards of care for 1 of 3 residents reviewed for pain management (Resident #1). The findings included: Resident #1 was admitted to the facility 04/03/18 with diagnoses that included heart failure, respiratory failure and pain among others. The admission Minimum Data Set (MDS) dated 04/20/18 revealed Resident #1 had scheduled narcotic medication daily and as needed (PRN) narcotic medication. The MDS also revealed Resident #1 was alert and oriented with no cognitive impairment. Record review of the June 2018 Medication Administration Record (MAR) for Resident #1 indicated the following medication were being taken for pain: ·Hydromorphone (Dilaudid) 2 milligram (mg) tablet (tab) - give 1 tab by mouth (po) three times daily (tid) at 6:00 AM, 12:00 PM and 6:00 PM. Record review of the controlled medication record for Resident #1 on 06/28/18 at 10:25 AM revealed the Hydromorphone had already been signed as given at 12:30 PM for that day.	F 658	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 and procedure for medication administration. Process for implementing a plan of correction for specific deficiency "Nurse #1 received 1:1 in-service education on 6/30/2018 by the Director of Health Services related to the appropriate procedures for medication administration and recordkeeping guidelines.	7/26/18

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

Electronically Signed | 07/23/2018

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F 658	Continued From page 1 During an interview with nurse (N #1) on 06/28/18 at 10:52 AM, N #1 stated he had signed off the Hydromorphone had been given around 7:45 AM. N #1 also stated that he just got busy during the day and he pre-signed the controlled medication records since he would document they were given on the MAR. N #1 further stated he knew he was not supposed to be doing this. During an interview with the Director of Nursing (DON) on 06/28/18 at 11:28 AM, the DON stated her expectation was for all nurses to wait until they administered a medication before signing off on the MAR or the controlled medication record that it had been given.	F 658	"All nursing staff will be re-educated by 7/26/18 on the correct procedures for administering medications and the process for signing off on those medications by the Director of Nursing Services. The in-service will be cross referenced to a current list of nursing employees to ensure all nurses have been educated. Monitoring to ensure effectiveness of POC "The Director of Health Services will randomly conduct medication pass observations daily x 1 week and weekly x 3 to ensure nurses are not pre signing the MAR□s prior to giving the medications. "The Director of Health Services will conduct audits of 3 med pass observations monthly x 3 months. "The Director of Nursing Services will report all finding to the QAPI committee monthly x 3 to ensure compliance is maintained. Title of person responsible for implementing the POC The Director of Nursing will be responsible for ensuring that compliance is met. Date of Compliance: July 26, 2018	
F 697 SS=E	Pain Management CFR(s): 483.25(k)	F 697		7/26/18

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F 697	Continued From page 2 §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to give as needed narcotic pain medication with an indication of pain level, location of pain or monitoring for effectiveness for 2 of 3 residents observed for pain management (Residents #1 and #6). The findings included: 1. Resident #1 was admitted to the facility 04/03/18 with diagnoses that included heart failure, respiratory failure and pain among others. The admission Minimum Data Set (MDS) dated 04/20/18 revealed Resident #1 had scheduled narcotic medication daily and as needed (PRN) narcotic medication. The MDS also revealed Resident #1 was alert and oriented with no cognitive impairment. Record review of the June 2018 Medication Administration Record (MAR) for Resident #1 indicated the following medications were being taken for pain: · Hydromorphone (Dilaudid) 2 milligram (mg) tablet (tab) - give 1 tab by mouth (po) three times daily (tid) · Hydromorphone 4 mg tab - give 1 tab po at bedtime · Gabapentin 800mg tab - give 1 tab po tid	F 697	Process that lead to the deficiency "The facility failed to follow-up and assess for effectiveness when PRN pain medication was given. In addition, the facility failed to document on the pain location and intensity of 2 patients reviewed that had received a PRN pain medication. Nurse #1 failed to follow professional standards of practice related to documenting effectiveness of PRN Pain Medications. Process for implementing a plan of correction for specific deficiency "All residents currently receiving a PRN pain medication were audited by the Director of Health Services on 7/2/18 to ensure effectiveness, location and intensity were documented after the PRN pain medication was administered. "A new pain assessment was conducted on the two patients noted to have been given a PRN pain medication to evaluate if their pain level. "A new PRN Pain Medication follow-up checklist has been implemented in the facility to ensure that nurses are documenting the effectiveness, location and intensity were documented after the	

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F 697	Continued From page 3 · Hydromorphone 4mg tab - give 1 tab po every 8 hours PRN Record review of administration of as needed pain medication revealed Resident #1 was given Hydromorphone 4mg (prn dose) twenty-seven times between 06/01/18 and 06/28/18. The pain flow sheet on the back of the June MAR revealed pain location, intensity and effectiveness were only monitored for 4 of the 27 times prn medications were given to Resident #1. Record review of nurses notes from 06/01/18 to 06/28/18 indicated no documentation of notification of the physician regarding the use of a prn narcotic medication 27 times in a 28 day period. During an interview on 06/28/18 at 10:52 AM with Nurse #1 who administered 21 of the 27 prn pain medications, he stated the morning medication pass was very heavy and he was sorry he had not documented the pain level and location, as well as the effectiveness of the prn pain medication he had given for Resident #1. Nurse #1 also stated he knew he was supposed to be documenting pain level, location and effectiveness of prn pain medications, but he often did not have enough time to do that for each person and get his medication pass done. During an interview with the Director of Nursing (DON) on 06/28/18 at 11:28AM, the DON stated her expectation was for all nurses to be monitoring on the back of the MAR when a prn pain medication was given. The DON also stated that pain was the 5th vital sign and she would expect effectiveness of pain medication to be a priority to a nurse for determining if the doctor	F 697	PRN pain medication was administered. "Nurse #1 has received 1:1 education by the Director of Nursing Services related to assessing the effectiveness of PRN Pain Medications and how to document this. This was conducted on 6/30/18. "Nursing staff were re-educated on 6/30/18 by the Director of Health Services on the process for documenting the effectiveness of a PRN Pain Medications. Monitoring to ensure effectiveness of POC "The Director of Health Services will audit all PRN Pain Medications daily x 3 weeks and weekly x 4 to ensure nurses are documenting the effectiveness of the PRN Pain Medications. "The Director of Health Services will audit 10 PRN Pain Medications monthly to ensure nurses are documenting the effectivness of the PRN Pain Medications x 2 months. "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 The Interim Director of Health Services will be responsible for ensuring that audits	

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F 697	Continued From page 4 should be contacted if it was not effective. During an interview with the Administrator on 06/28/18 at 5:40 PM, the Administrator stated the nurses needed to be monitoring and documenting information about the status of each resident who received an as needed narcotic pain medication. 2. Resident #6 was readmitted to the facility on 05/23/18 with diagnoses that included: type 2 diabetes mellitus with foot ulcer; cellulitis of the right foot; right leg below the knee amputation; peripheral vascular disease; left heel wound debridement and left transmetatarsal amputation related to gangrene; unstageable pressure ulcer to left heel; and excoriation to buttocks. A record review of Resident #6's significant change/5-day minimum data set (MDS) assessment dated 05/30/18, indicated Resident #6 had frequent pain within the last 5 days. The MDS also indicated that Resident #6 was alert and oriented to person, place, and time with no cognitive impairment. A record review of Resident #6's care plan dated 06/08/18, included a problem area of the potential for increase in pain. Approaches to this problem area included: observe for pain during activities of daily living (ADL) care; provide pain management as indicated; assess for pain during wound care; assess location, frequency, duration and intensity of pain; document assessment of pain; report increased pain trend to physician; attempt non-pharmacological pain relief measures such as repositioning and back rubs; administer pain medications as ordered; document effectiveness; review pain management plan and document findings and provide diversional activities, if applicable. A record review of Resident #6's physician orders	F 697	are completed daily. Date of Compliance: July 26, 2018.	

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F 697	Continued From page 5	F 697		

for June 2018, indicated Resident #6 had an order for:
" Scheduled Oxycodone 5 mg by mouth every 6 hours around the clock for chronic pain.
" Continue Oxycodone 5 mg by mouth every 4 hours as needed (PRN) for pain.
A record review of the June 2018 MAR for Resident #6 noted the PRN dose of Oxycodone was administered 22 times during the month of June and included: June 2nd, 3rd, 4th, 5th, 6th, 8th, 9th, 10th, 11th, 12th, 13th, 14th, 15th, 16th, 17th, 18th, 19th, 20th, 21st, 23rd, 24th, and 26th. Of the 22 doses of PRN Oxycodone administered to Resident #6, there were 15 times an indication for use was not noted on the June MAR and included: June 2nd, 5th, 6th, 8th, 9th, 11th, 13th, 14th, 15th, 17th, 18th, 21st, 23rd, 24th, and 26th.
A record review of June 2018 nurses' notes in the medical record of Resident #6 on the dates the PRN Oxycodone was administered without indication did not indicate a reason for administration.
On 06/27/18 at 1:57 PM, an interview was conducted with Resident #6, who stated his buttocks hurt if he sat too long. He stated that sometimes his back and left leg hurts. He stated that staff come in pretty quickly with pain medication when he asked for it and that most of the time his pain was managed well.
On 06/28/18 at 11:28 AM, an interview was conducted with the DON and she stated her expectation regarding the administration of PRN pain medication. She stated any PRN pain medication should be signed out recording the name of the medication, dose, time, route, indication for administering, location of the pain, behaviors related to increased pain such as: grimacing, guarding, or frowning. The DON also indicated that the following should also be

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F 697	Continued From page 6 included on the back of the MAR: resident's pain level, non-medicinal pain interventions, and side effects of pain medication. She stated that the nurses should follow up within one hour to determine the effectiveness of the medication. She stated that the nurses should also document a nurses' note regarding when a pain medication was administered and the reason for administering, along with a follow up regarding the effectiveness of the pain medication. She stated that she was not aware that the nurses were not documenting the effectiveness and indication for use of PRN medications. On 6/28/18 at 5:40 PM, an interview was conducted with the Administrator and he stated his expectation was that the PRN medications needed to be documented for its effectiveness by the nurse. He stated that the nurse should check the pain level before administering the pain medication and after the pain medication had been administered, the nurse would go back to assess the resident within one hour by asking the resident if the medication had worked and determine if the resident was still in pain.	F 697		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and interviews the facility failed to provide a nosey cup to one of two residents reviewed for	F 810	Process that lead to the deficiency Resident # 10 was observed during meal	7/26/18

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F 810	Continued From page 7 adaptive devices. (Resident #10) The findings included: Resident #10 was admitted to the facility 12/26/15 with diagnoses which included dysphagia, cognitive communication deficit, severe intellectual disabilities, anxiety, extrapyramidal movement disorder and schizophrenia. The current care plan for Resident #10 was last updated 03/14/18 and included the following problem area and approaches: a. Potential for alteration in nutrition related to mental retardation, schizophrenia. Receives mechanically altered diet, therapeutic diet and requires assistance with meals. Potential for aspiration. Approaches to this problem area included: -assist with meals as needed, meal tray preparation -nosey cup with meals b. Self care deficits related to diagnoses of schizophrenia. Requires assist with daily decisions. Requires extensive assist with activities of daily living. Able to feed self with supervision. Approaches to this problem area included: -meal tray preparation, assist with meals as needed. June 2018 physician orders for Resident #10 included, nosey cup at all meals. Review of therapy documentation noted Resident #10 had been seen by the Speech Therapist from 02/17/18-03/03/18 with discharge functional outcome/clinical impression noted as, Patient continues to exhibit impulsive behaviors during	F 810	time to not have a nosey cup present on her tray as ordered and as indicated on the care plan. The Certified Nursing Assistants setting up the meal tray for Resident #10 failed to contact Dietary when the nosey cup was not present on the tray. Per the dietary sheet, adaptive equipment was noted on Resident #10 as needing a nosey cup. The C NA failed to ensure the patient received the adaptive equipment prior to setting up her tray. Process for implementing a plan of correction for specific deficiency "The Dietary Manager updated all meal ticket sheets on 6/30/18 to reflect all new orders and changes consistent with Physician Orders. "The Dietary Manager re-educated kitchen staff on 6/30/18 to ensure all adaptive equipment is present on the trays when they leave the kitchen. "All Nursing Staff to be re-educated by 7/26/18 on how to read resident meal tickets and to ensure adaptive equipment is present and utilized as ordered. In addition, nursing staff will be educated regarding the procedures if and when adaptive equipment is not present, how they are supposed to retrieve the appropriate equipment to ensure the care plan is followed. The Director of Nursing Services is responsible for this education. Monitoring to ensure effectiveness of POC "The Director of Nursing Services will	

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F 810	Continued From page 8 oral intake including overfilling oral cavity, eating at a fast rate, taking too large of bites/sips. Patient is not responsive to clinician cues and is a high risk of asphxiation/aspiration with mechanical soft consistency. Patient clinically tolerates puree consistency. Observations of Resident #10 at 2 of 3 meals noted a nosey cup was not provided at the meal. These observations included: a. 06/27/18 12:30 PM at the lunch meal Resident #10 was observed eating lunch, in her room, in bed. Resident #10 was slouched in the bed and was wearing a light purple shirt that had wet spills down the front of the shirt. The tray card for Resident #10 noted a nosey cup should be served with the meal. A regular plastic cup, not a nosey cup was on the tray of Resident #10. At 12:50 PM Nurse #6 stated the nosey cup was supposed to be provided by dietary staff and included on the tray for Resident #10. At 1:00 PM Nurse #6 returned from the kitchen with a nosey cup for Resident #10 and stated, she won't spill liquids on herself when she uses the nosey cup. The nursing assistant that delivered the tray to Resident #10 at lunch stated it was an oversight that the nosey cup was not identified as missing on the lunch tray of Resident #10 and noted the kitchen should have been called to request the nosey cup. b. On 06/28/18 at 8:05 AM Resident #10 was observed eating breakfast, in her room, in bed. Resident #10 was slouched in the bed and was drinking liquids from a regular plastic cup. The tray card for Resident #10 noted a nosey cup should be served with the meal. The nursing assistant that delivered the tray reported sometimes the nosey cup was sent with the tray and, when it wasn't, a regular cup was given to	F 810	randomly audit 4 patients requiring adaptive equipment per day x 1 week and 2 patients that require adaptive equipment a week x 3 to ensure the plan of care is being followed regarding the presence of adaptive equipment at meal times. "The Director of Health Services will report any adverse findings to the QAPI committee monthly X 3 to ensure compliance is maintained. Title of person responsible for implementing the POC The Director of Health Services is responsible for ensuring the POC is followed Date of Compliance: July 26, 2018.	

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F 810	Continued From page 9 Resident #10. On 06/28/18 at 2:30 PM the Speech Therapist stated the need for the nosey cup had been identified and ordered by a prior Speech Therapist that worked with Resident #10. The Speech Therapist stated she thought it was a good idea to continue use of the nosey cup because Resident #10 had a tendency to slouch in bed when eating. Because of this, the Speech Therapist explained the nosey cup would be safer for Resident #10 to use to prevent spillage of liquids. On 06/28/8 at 3:05 PM the Director of Nursing stated she expected the nosey cup to be provided to Resident #10 with meals as ordered by the physician and per the care plan. On 06/28/18 at 4:10 PM the Food Service Director stated he expected adaptive equipment to be sent with resident meal trays as ordered by the physician and consistent with their care plan. The Food Service Director stated he could not explain why the nosey cup had not been sent at lunch on 06/27/18 and at breakfast on 06/28/18. On 06/28/18 at 5:00 PM the Administrator stated he expected adaptive equipment to be sent to residents consistent with physician orders and their individual care plan.	F 810		

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L 092	.2306(D)(2) MEDICATION ADMINISTRATION 10A-13D.2306 (d)(2) The requirements for self-administration of medication shall include the following: (A) determination by the interdisciplinary team that this practice is safe; (B) administration ordered by the physician or other person legally authorized to prescribe medications; (C) instructions for administration printed on the medication label; and (D) administration of medication monitored by the nursing staff and consultant pharmacist. This Rule is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to obtain physician orders and assess the ability of a resident to self-administer medications for 1 of 3 residents reviewed for medication administration (Resident #1). The findings included: Resident #1 was admitted to the facility 06/25/15 with diagnoses which included traumatic brain injury, mild cognitive impairment and cognitive communication deficit. Resident #1 also required assistance with his activities of daily living. Care plan review for Resident #1 gave no indication he was able to self-administer medications. Record review of the "Resident Independent Self-Administration and Medication Assistance of Medications" Pharmacy Services Assisted Living Version 4, effective date of 08/01/12 and reviewed and revised date of 04/06/18 read in part: Self-administering of medication by a resident is	L 092	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 #2 did not follow the policy for self-medication administration to include receiving a physician order and assessing the patient for appropriateness of self-medication administration. In addition, Nurse #2 left the room prior to ensuring	7/26/18

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THE OAKS-BREVARD	300 MORRIS ROAD BREVARD, NC 28712

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L 092	Continued From page 1 permitted only: · Upon the specific written orders of the physician or other authorized healthcare provider, obtained on a semi-annual basis. · The facility shall ascertain by resident demonstration to the staff and document, at least quarterly, that the resident remains capable of self-administering medications. Record review of physician's orders revealed no order for Resident #1 to self-administer medications. Record review of assessment and nurses progress notes revealed no documentation that a self-administration of medications assessment with resident demonstration had been obtained. During an observation of a medication pass on 06/26/18 at 3:56 PM, Nurse #2 was observed to obtain all oral medications due for Resident #1 and place them whole in a medication cup. Medications obtained by Nurse #2 included the following: · Myrbetriq 50 milligram (mg) tablet (tab) by mouth (po) · Tamsulosin 0.4mg capsule (cap) po · Valsartan 80mg tab po · Famotidine 20mg tab po · Omega-3-Acid 1 gram cap po · Glimepiride 4mg tab po · Sulfasalazin 500mg tab po · Fiber-lax 2 tabs po Nurse #2 proceeded to the room of Resident #1 and was observed placing and leaving his medications on his bedside table, which was	L 092	the patient had taken all of their prescribed medications since it had not been deemed appropriate that the patient would self-administer his own medications. Process for implementing a plan of correction for specific deficiency "Nurse #2 has received 1:1 education by the Director of Nursing Services related to the policy for medication self-administration and the correct procedures for administering medications at bedside. "Nursing staff were re-educated on 6/30/18 on the policy for self-medication administration and also the correct procedures for administrating medication at bedside. "The Director of Health Services will audit all patients on the assisted living wing to determine if they are appropriate for self-medication administration. This will be completed by 7/26/18. Monitoring to ensure effectiveness of POC "The Director of Health Services will randomly audit medication administration daily x 1 week and weekly x 3 to ensure nurses are following the correct procedures for administering medications at bedside. "The Director of Health Services will audit 2 patients per month and will bring the results to QAPI. "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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0563	A. BUILDING: _____ B. WING _____	C 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 092	Continued From page 2 located directly in front of him, and then exited the room. During an interview with Nurse #2 on 06/26/18 at 4:03 PM, Nurse #2 stated there were no residents on the hall that self-administered medications that she was aware of. Nurse #2 also stated Resident #1 was the only resident she left medications for because he could take them himself. Nurse #2 further stated she wasn't sure if there was an order or an assessment for Resident #1 to take his medications independently. During an interview with the Director of Nursing (DON) on 06/26/18 at 4:10 PM, the DON stated there should be documentation in the nurses' notes, care plan, or an assessment if a resident could self-administer medications. The DON further stated her expectation for the nurses would be to follow policy and not allow residents without an assessment and physician order to take medications independently.	L 092	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 The Director of Health Services will be responsible for ensuring that audits are completed and the POC is implemented Date of Compliance: July 26, 2018.	