**Statement of deficiencies and plan of correction**

<table>
<thead>
<tr>
<th>(K4) ID PREFIX TAG</th>
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<tr>
<td>F 281 SS=0</td>
<td>483.20(k)(3)(i) Services provided meet professional standards</td>
<td>F 281</td>
<td>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.</td>
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- The services provided or arranged by the facility must meet professional standards of quality.

- This REQUIREMENT is not met as evidenced by:
  - Based on staff interviews and documentation review the facility failed to follow physician orders to obtain orthostatic blood pressure sets for one (1) of three (3) sampled residents who had experienced falls (Resident #2).

- The findings are:
  - Resident #2 was admitted to the facility on 4/22/2011 and re-admitted on 7/3/11 with diagnoses that included a hip fracture and Alzheimer's disease among others. The most recent Minimum Data Set (MDS) dated 5/2/11 specified the resident had severely impaired cognitive function and had a history of falls.
  - Resident #2's Care Area Assessments (CAAs) dated 5/4/11 specified a new fall care plan was started related to history of falls and unsteady gait. Resident #2's fall care plan updated 5/16/11 specified interventions to avoid a fall related injury included:
    - three (3) sets of orthostatic blood pressures
  - Resident #2's medical record revealed a physician's order dated 5/16/11 for three sets of orthostatic blood pressures. Further review of the medical record revealed only one (1) documented set of orthostatic blood pressures on the

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**Laboratory Directors or Provider/Supplier Representative's signature**

**Title**

**(K6) Date**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which is considered to be a violation of state law. The facility must be corrected to meet the deficiencies. Provider/supplier must submit a plan of correction to the Department of Health and Human Services indicating how they intend to correct the deficiencies. An audit by the Department of Health and Human Services to confirm the correction will be scheduled at the provider/supplier's discretion. This notice and audit is final and no further action is required unless the audit discovers new deficiencies.

**Received**

**By:** MH

**Facility ID:** 922860

**Event ID:** PVFX11

**Printed:** 07/25/2011

**Omb No:** 0938-0391

**Form Approved:**

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**Form CMS-2587 (02-06) Previous Version Obsolete**

**AUG 3, 2011**
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Medication Administration Record (MAR) dated 5/20/11.

On 7/19/11 at 1:10 p.m. licensed nurse (LN) #1 was interviewed and reported that when a physician order was written for orthostatic blood pressure the licensed nurse who received the order was responsible for transcribing the order onto the MAR. She stated that the orthostatic blood pressures would be initiated within 24 hours of receiving the order.

On 7/19/11 at 1:20 p.m. the Director of Health Services (DHS) reviewed Resident #2's medical record and confirmed she was only able to locate one set of orthostatic blood pressures. The DHS was interviewed and reported orthostatic blood pressures could be documented anywhere in the medical record and after additional review of Resident #2's medical record only located one documented set of orthostatic blood pressures. The DHS also reported she would expect orthostatic blood pressures to be initiated the same day the order was written and was unable to explain why the only documented set of orthostatic blood pressures for Resident #2 was completed on 5/20/11. The DHS offered no explanation why the Resident's orthostatic blood pressures were not documented as having completed as ordered.

On 7/19/11 at 1:30 p.m. the Assistant Director of Health Services (ADHS) was interviewed and reported she had obtained the physician's order for orthostatic blood pressure sets on Resident #2 after the resident fell while standing up. She also reported that the licensed nurse assigned to Resident #2 on 5/16/11 would have been

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3. Measures/Systemic Changes:
Nurses will receive in-service and education on proper documentation of orthostatic blood pressure checks.

4. Monitoring:
Monitoring to be completed through random scheduled audits by DHS/ADHS/Nurse-in-Charge. Any areas of non-compliance will be corrected at the time of discovery. The findings will be reported to the physician immediately and monthly to facility's performance improvement committee for patterns or trends and further interventions will be developed as necessary to ensure continued compliance. Audits will be conducted for a minimum of 90 days, followed by monthly audits until substantial compliance is achieved and maintained for an additional 90 days.
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responsible for transcribing the order onto the
MAR. She added the licensed nurse would have
also been expected to report to the oncoming
licensed nurse during shift report the order to
obtain orthostatic blood pressure sets. She
stated that ideally the order should have been
initiated within 24 hours and performed on
consecutive shifts or days. She was unable to
explain why the resident had only one
documented set of orthostatic blood pressures.

F 323

483.25(h) FREE OF ACCIDENT
HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident
environment remains as free of accident hazards
as is possible; and each resident receives
adequate supervision and assistance devices to
prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff
interviews, the facility failed to provide a safety
alarm as a care planned fall intervention for one
(1) of three (3) sampled residents who had
experienced falls (Resident #1).

The findings are:

Resident #1 was admitted to the facility 1/3/06
with diagnoses including seizure disorder and
debility. The latest Minimum Data Set (MDS)
dated 6/6/11 indicated impaired cognition and
dependence on staff assistance for all care
including transfers, dressing, eating, and hygiene.

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F323

1. Corrective Action:
One resident was affected and the torso
alarm was immediately put in place.

2. Others with Potential to be Affected:
Residents with torso alarms have the
potential to be affected. An audit was
conducted to ensure residents with torso
alarms have the alarms in place.
A review of a care plan dated 3/25/11 revealed Resident #1 had a potential for falls that may cause injury related to a seizure disorder treated by medication which was refused at times. The goal of the care plan stated the approaches will minimize the risks for injuries due to impaired physical mobility and the possibility of seizure activity. Approaches dated 3/25/11 included medication as ordered by the physician and assist to move at own pace, do not rush. The care plan was noted updated on 7/11/11 due to a fall experienced on 7/10/11. Added approaches included a torso alarm when in bed, bed in low position, and mats on floor at bedside.

A review of Resident #1's medical record revealed a nurse noted dated 6/15/11 at 6:00 a.m. The note documentation included at 1:30 a.m., a nursing assistant reported Resident #1 demonstrated jerking motions and moving about in bed. The note continued medication as ordered by the physician was administered resulting in subduing of jerking motions.

An observation of Resident #1's room on 7/19/11 at 9:06 a.m. revealed the bed was in low position and mats were observed on the floor at the bedside. No torso alarm was observed. Resident #1 was not in the bed on this observation.

An observation on 7/19/11 at 12:58 p.m. revealed Resident #1 was lying in the bed. The bed was observed in low position with mats on the floor at bedside. No torso alarm was observed.

An interview with the Director of Health Services

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3. Measures/Systemic Changes:
Staff will receive in-service and education on ensuring torso alarms are appropriately placed for patients with this intervention. Nurses will document torso alarm function and placement every shift for affected patients.

4. Monitoring:
Monitoring to be completed through random scheduled audits by DHS/ADHS/Nurse-in-Charge. Any areas of non-compliance will be corrected at the time of discovery. The findings will be reported to the physician immediately and monthly to facility's performance improvement committee for patterns or trends and further interventions will be developed as necessary to ensure continued compliance. Audits will be conducted for a minimum of 90 days, followed by monthly audits until substantial compliance is achieved and maintained for an additional 90 days.
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
THE OAKS OF BREvard

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

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(DHS) on 7/19/11 at 10:30 a.m. revealed
Resident #1 experienced a fall on 7/10/11. She
stated this fall out of bed was unwitnessed and
may have been contributed to seizure activity.
She added this resident had no previous history
of falls.

An interview with Nursing Assistant (NA) #1 on
7/19/11 at 1:10 p.m. revealed to her knowledge,
Resident #1 had not had a torso alarm. She
stated the nursing assistant care guide located in
each resident's room provided guidance for the
resident's care. During this interview, NA #1 was
unable to find torso alarm in Resident #1's
nursing assistant care guide. NA #1 added this
was the first time she has cared for Resident #1
since the resident experienced a fall on 7/10/11.

An interview was conducted on 7/19/11 at 1:50
p.m. with the DHS and the Assistant Director of
Health Services (ADHS). During the interview,
the DHS and ADHS were unable to locate a torso
alarm in Resident #1's bed or in the room. The
DHS and ADHS were unable to find a torso alarm
added to the nursing assistant care guide for
Resident #1. The DHS stated it was the
responsibility of the ADHS to ensure nursing
assistant care guides where kept up to date. The
DHS added she expected the torso alarm to be in
place as care planned.

An interview with Licensed Nurse (LN) #2 on
7/19/11 at 2:25 p.m. revealed she had cared for
Resident #1 on this date. She added she had not
seen a torso alarm in Resident #1's room.

An interview with NA #2 on 7/19/11 at 2:40 p.m.
revealed she had cared for Resident #1 on the
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<td>Continued From page 5 evening shift of 7/18/11. She stated she did not see a torso alarm in the resident's bed. NA #2 explained when a torso alarm is in place on a resident's bed, a beep is heard when the resident's weight contacts the mattress. She added when she assisted Resident #1 to bed after supper on 7/18/11, she did not hear that beep. NA #2 continued she was unaware Resident #2 was supposed to have a torso alarm while in bed.</td>
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