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

PRINTED: 01/05/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' ' '	E CONSTRUCTION		TE SURVEY MPLETED
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			A BUILDING		·	С
		345462	B. WING		<u> </u>	12/19/2011
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP O O MORRIS ROAD	ODE	t
THE OAK	S OF BREVARD	•	. BF	REVARD, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	THE APPROPRIATE	(X5) COMPLETION DATE
F 250 SS=D	RELATED SOCIAL S The facility must provide services to attain or no practicable physical, nowell-being of each resemble. This REQUIREMENT by: Based on record revifacility failed to provide scheduled medical approach (4) sampled resident #4) The findings are: Resident #1 was admits a service of the servic	ide medically-related social maintain the highest mental, and psychosocial sident. is not met as evidenced ew and staff interviews the le transportation to oppointments for one (2) of dents. (Residents #1 and	F 250	Appointments for Resident 4 were in rescheduled and for Corrective action having the potent includes restructuransportation and oversight to assurant medically necessary Measures include scheduler who will making and confir appointments. The review all necessary	Resident 1 and mediately amilies notified for all resident ial to be affect ring scheduling incomplete residents recry transportation be responsibled in the scheduler will ry appointments.	d. s ed g and reased elve ontime e for ts at
, and the second	diagnoses of Alzheim diabetes, and hyperte #1's most recent Minit dated 11/15/11, reveat cognitive impairment, she was dependent for Review of grievance of showed Resident #1 her physician on 09/11 Indicated that Resider medical appointment, and was waiting at the resident to arrive. An interview was conducted a medical medical appointment, and was waiting at the resident to arrive.	er's disease, renal failure, nsion. Review of Resident mum Data Set (MDS), aled she had severe The MDS further revealed or all care.		the time of resider return from appoin scheduler will creat maintain transport residents to be ker and following day's scheach day, and the stransportation logs stations.	ntments. The te, disseminate ation logs for a tat nurses standing driver will reviedule at the classification.	e, and all tions. ew the ose of update

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 regulate to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:H9QG11

Facility ID: 922980

JAN II don invalion sheet Page 1 of 5



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILD	ING!	С		
		345462	B, WING		12/19/2011		
1	OVIDER OR SUPPLIER			DDE			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC- CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE COMPLI THE APPROPRIATE DAT	ETION .	
F 250	appointment. Guest master schedule/cate calendar is sent to the alert them to the med scheduled for their rethe time of the appoint have the resident rea. An interview was conwith the Guest Service primary responsibility facility. The GSD repis arranged or ordere information from the put on a schedule in Services then puts on week. He reported or scheduled for her me AM, locally. He reported the was still with the catheir physician's officanotify Resident #1's finer at the physician's he did call the facility not be back in time to appointment. He reported family who was woffice. A telephone interview at 2:00 PM with the Still	k with the resident is a staff informs Guest on of the scheduled medical Services then makes a ndar for the week. This a nurses on the floors to ical appointments sidents. The calendar notes on the time to	F 2:	The scheduler and the directly to the Senior (SCP). They will meet the schedule for the The SCP will assist the driver in the event or conflicts to assure the arrangements are mand that families are and that families are solutions are sustaine review transportation (4) weeks and then weeks and then month and will report Administrator daily for and then weekly for fathen monthly for four Regular weekly meetings on an ongoing. Review of scansportation will be the facility's monthly Improvement/ Qualit meetings on an ongoing.	r Care Partner t weekly to review following week. e scheduler and f any scheduling eat appropriate ade for residents notified. e that these d, the SCP will logs daily for four eekly for four (4) thly for four (4) rt progress to the or four (4)weeks our (4) weeks and r (4) months. engs that include and SCP will be cheduling and integrated into Performance y Assurance		

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION _ IDENTIFICATION NUMBER:		(x2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		345462	B. WING			12/19/2011		
	ROVIDER OR SUPPLIER S OF BREVARD			3	EET ADDRESS, CITY, STATE, ZIP C 00 MORRIS ROAD BREVARD, NC 28712	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN C (EACH CORRECTIVE AS CROSS-REFERENCED TO DEFICIE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 250	two people who were for appointments calle Living) Coordinators. resident had an appointments from the facility get another resident thour later. She report over the schedule to ritimes did not conflict. An interview was comply with the facility's attemption that the transportation emply senior Care Partner to conflicts in the transport for transportation emply senior Care Partner to conflicts in the transport to the diagnoses of diab hypertension. Review recent Minimum Data revealed she was cogminimal assistance with the concern when the reto a medical appointment either. The and waited at the medical revealed at the medical reverse of the graph	reported that there were responsible for scheduling and ADL (Activities of Daily She further reported if one interest forty-five (45) ity, it would be impossible to a local appointment an ed she should have looked make sure that appointment ducted on 12/19/11 at 2:10 administrator. She reported a system was not working in that her expectation was alloyees to work with the consure there were no ortation schedule. Intitled to the facility with eles mellitus and of Resident #4's most Set dated 11/19/11 nitively intact and needed the activities of daily living. In form for Resident #4 dated at Resident #4's family filed esident was not transported tent on 11/10/11. The facility cal appointment for ansport Resident #4 to that the family was not notified lical office for two hours. In grievance form revealed the interest were for treatment.	F	250	On weekends and/o not in the facility, a cappointed to comple monitoring. This may Administrator, Week Manager, or Director Completion date is Ja	designee will be te oversight vinclude the end Nurse of Health Services.	1/16/1	υ.
					·			

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION		(X3) DATE SU COMPLET	LED
		345462	B. WIN	G_			ľ	C 9/2011
THE OAKS OF BREVARD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				3	REET ADDRESS, CITY, STATE, ZIP C 100 MORRIS ROAD BREVARD, NC 28712	ODE -		
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFI TAG		PROVIDER'S PLAN Ó (EACH CORRECTIVE A CROSS-REFERENCED TÓ DEFICIE	THE APPROL	D BE	(X5) COMPLETION DATE
	revealed that Residen regarding transportation appointment. The facing family that they were used to her medical appointment of the appointment was some cared for Resident #4. resident had a medical nursing staff who work notified. Then nursing Services/Transportation appointment. Guest Smaster schedule/salen calendar would be sen floors to alert them to the scheduled for their resinct the time of the appointment and was her medical appointment.	e form dated 11/23/11, It #4's family filed a concern on to a medical lity notified Resident #4's unable to transport Resident ointment on 11/23/11 and It was scheduled for another on 12/21/11 and the family ity would not be able to The facility gave the family iment as 3:00 PM and told to transport the resident. If the medical office for cointment they were told scheduled for 9:30 AM. Inceed with LN #1 who She reported when a I appointment scheduled with the resident was staff informed Guest on of the scheduled medical ervices then made a dar for the week. This It to the nurses on the he medical appointments idents. The calendar would pointment as well as the ont ready. Inceed on 12/19/11 at 1:15 She reported that the Ithe times of her unable to transport her to	F	250				
	at 2:00 PM with the Sei	nior Care Partner (SCP)						

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

	IDENTIFICATION NUMBER;	A. BUILDING		(X3) DATE SURVEY COMPLETED		
	345462	B. WING	·	12/	C 19/2011	
		300 M	IORRIS ROAD	•		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	I SHOULD BE	(X5) COMPLETION DATE	
whose responsibility transportation. She people who were reappointments called Living) Coordinators resident had an appinitudes from the faction get another resident hour later. She report over the schedule to times did not conflict. An interview was con PM with the facility's that the transportation very well. She report residents were to be	ris over site and back-up for reported that there were two sponsible for scheduling for ADL (Activities of Daily. She further reported if one ointment forty-five (45) ellity, it would be impossible to to a local appointment and the she should have looked make sure that appointment in administrator. She reported on system was not working the details and the scheduled in scheduled.	F 250				
	Continued From page whose responsibility transportation. She repoil who were responsibility transportation. She repoil who were responsibility transportation. She repoil who were responsible to the sent and an appropriate from the fact get another resident hour later. She repoil over the schedule to times did not conflict. An interview was con PM with the facility's that the transportation very well. She report residents were to be	PROVIDER OR SUPPLIER KS OF BREVARD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PROVIDER OR SUPPLIER KS OF BREVARD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 whose responsibility is over site and back-up for transportation. She reported that there were two people who were responsible for scheduling for appointments called ADL (Activities of Daily Living) Coordinators. She further reported if one resident had an appointment forty-five (45) minutes from the facility, it would be impossible to get another resident to a local appointment an hour later. She reported she should have looked over the schedule to make sure that appointment times did not conflict. An interview was conducted on 12/19/11 at 2:10 PM with the facility's administrator. She reported that the transportation system was not working very well. She reported that her expectation was residents were to be transported to scheduled	PROVIDER OR SUPPLIER KS OF BREVARD SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 whose responsibility is over site and back-up for transportation. She reported that there were two people who were responsible for scheduling for appointments called ADL (Activities of Daily Living) Coordinators. She further reported if one resident had an appointment forty-five (45) minutes from the facility, it would be impossible to get another resident to a local appointment an hour later. She reported she should have tooked over the schedule to make sure that appointment times did not conflict. An interview was conducted on 12/19/11 at 2:10 PM with the facility's administrator. She reported that the transportation system was not working very well. She reported to scheduled	PROVIDER OR SUPPLIER KS OF BREVARD STREET ADDRESS, CITY, STATE, ZIP ODE 300 MORRIS ROAD BREVARD, NC 28712 PROVIDER'S PLAN OF CORRECTION	

Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 12/19/2011 NH0563 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 300 MORRIS ROAD THE OAKS OF BREVARD BREVARD, NC 28712 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) L 170 One resident was affected by this L 170 ,2802(A) SOCIAL SERVICES practice. 10A-13D.2802 (a) The facility shall provide medically-related social The Guest Services Director (GSD) services to attain or maintain the highest practicable physical, mental providing transportation was late in and psycho-social well-being of each picking up Resident #2 from an resident. appointment. Resident #2 chose to This Rule Is not met as evidenced by: return to the facility by himself. He is Based on record review, resident and staff alert and oriented Upon return, interview, the facility failed to provide transportation services to return a resident to the Resident #2 was immediately examined facility after a scheduled appointment for one (1) by the Medical Director who was in the of three (3) residents (Resident #2). facility at the time and interviewed by The findings are: the Activities of Daily Living Cocoordinator (ADLQ) and the Resident # 2 was readmitted to the Assisted Living section of the facility with diagnoses of Administrator. Resident #2 agreed not Aortocoronary Bypass, General Muscle to return from appointments by himself Weakness, Respiratory Abnormality and Difficulty in Walking. Resident #2 was identified by the but to wait for transportation. The GSD Administrator as alert, oriented and interviewable. was reprimanded by the Administrator and took responsibility for the delay. Review of Resident #2's medical record revealed documented an encounter note by the facility physician on 9/6/2011 which stated in part: Corrective action for all residents "This is an acute visit for Resident #2. I am having the potential to be affected seeing him today secondary to shortness of breath. The patient did have his cardiac includes restructuring scheduling and rehabilitation, then went for half-an hour walk, transportation and providing increased afterward he was very fatiqued, lightheaded, and oversight to assure residents receive not feeling himself. When I went to see the resident, he was sitting down resting. " medically necessary transportation. Further review of Resident #2's medical record revealed a Nurse's notes for 9/6/2011 at noon that documented: "Resident returned from heart path. He walked to the facility. He was tired and exhausted * Division of Health Service Regulation Laboratory director's or provider/supplier representative's signature

STATE FORM

JAN 1 2 2012

Dolminia

Division •	<u>of Health Service Regu</u>	lation				<u> </u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER NH0563			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SU COMPLET		
NAME OF PE	OVIDER OR SUPPLIER	<u> </u>	STREET ADDR	RESS, CITY, ST.	ATE, ZIP CODE		
THE OAKS OF BREVARD			300 MORRI BREVARD,				
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC' REGULATORY OR I		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
	10:35 AM and revealed Service Director (GSE from his medical apportunity of the color of the col	rviewed on 12/19/2011 and the facility 's Guest D) transported him to anointments. as interviewed on AM and revealed that ack to the facility follow in 9/6/2011 when the fa go back to the hospital DO PM the Activities of I #1 (ADLC) was intervie y, September 6, 2011 s as from the Hospital ment that Resident #2 h as scheduled after his as not sure about the tin ther stated when she the hospital; she paged d was finally able to contaff member. ADLC #1 d he was in a meeting at t #2 up from his continued interview ADI GSD was contacted he the facility to go to the	ring acility to Daily ewed she had he of htact and LC	L 170	Measures include as scheduler who will be making and confirm appointments. The serview all necessary the time of resident return from appoint scheduler will create maintain transportain residents to be kept. The scheduler and the directly to the Senior (SCP). They will meet the schedule for the factiver in the event of conflicts to assure the arrangements are maintain transportation. To monitor and assure solutions are sustaine review transportation (4) weeks and then we	pe responsible for ing all scheduler will appointments at admission and/or ments. The e, disseminate, and tion logs for all at nurses stations. The care Partner weekly to review following week. The scheduler and any scheduling at appropriate de for residents motified. The scheduler four the scheduler for the scheduler and any scheduling at appropriate de for four the scheduler for four feekly for four (4)	
	told her he was all righ An interview was cond 12:30 PM on 12/19/20 been transporting resid		i		weeks and then month months and will repor Administrator daily for and then weekly for fo then monthly for four	t progress to the r four (4)weeks our (4) weeks and	

SSM111

Division of	of Health Service Regu	lation		 -			
		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB NH0563		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/19/2011	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, ST/	TE, ZIP CODE		
THE OAKS OF BREVARD			300 MORRIS BREVARD, N	ROAD			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	(X6) COMPLETE DATE
,	AM for physical theral During further intervied dropped Resident #2 appointment on 9/6/20 late he went to pick hit time of 10:00 AM. The caught up in work and up Resident #2 from the and stated he took respicked him up as school on 12/19/2011 at 2:00 Partner (SCP) confirm and backup with facility August 2011. She fur looking over the transmaking sure appointment overscheduled but shool of the medical pointment and should. The Administrator was at 2:10 PM and reveal primary transporter ar working very well and should. The Administrator was at death of the should be over looking was "doable " and contransporters, Dr. office in the medical appoint changes. In a follow-up interview PM, Resident # 2 confrom his appointment and Tuesday (9/6/2011 back road from the hound 12/19/2011 at 4:30.	resday and Thursday a by at the local hospital. W GSD revealed he had off for his 9:00 AM 1011 but was not sure him up after the appointed e GSD stated he was a forgot to go back and his appointment at 10:00 sponsibility for not having duled. 10 PM the Senior Care need her role was oversity transportation since ther stated she should portation schedules annents have not been en had not been doing it is interviewed on 12/19/led that the GSD was the stated that Senior Care Partner (States and any families involved the schedules any with the estand any families involved the schedules any with the stated the Hospital to the facility. 10 PM the back road round the position of the schedules and the had walked be at the Hospital to the facility.	t 9:00 d ow ed pick 0 AM ng ght be d 2011 he ther SCP) it blick cility n the	L 170	Regular weekly meet the scheduler, driver ongoing. Review of s transportation will be the facility's monthly Improvement/ Quality meetings on an ongoing on weekends and/ on the facility, a cappointed to complemonitoring. This may Administrator, Week Manager, or Director Completion date is Ja	t, and SCP will be cheduling and e integrated into Performance ty Assurance bing basis. Tr when the SCP is designee will be the oversight pinclude the tend Nurse of Health Services.	1/16/12
(where Resident #2 sta	ited he had walked was	5				

Division of	of <u>Health Service Regu</u>	lation		. <u> </u>	.	<u> </u>		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM NH0563						(X3) DATE SURVEY COMPLETED 12/19/2011		
NAME OF PR	ROVIDER OR SUPPLIER	Miloso	STREET ADDR	ESS, CITY, ST	ATE, ZIP CODE	<u>; </u>	121	
THE OAKS OF BREVARD			300 MORRIS BREVARD, N					·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD O THE APPROP	9E	(X5) COMPLETE DATE
L 170	L 170 Continued From page 3 observed to be approximately .8 miles long			L 170				
								ı
3								
	,							
								1