The Oaks – Brevard is committed to upholding the highest standards of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation with the State of North Carolina Department of Health and Human Services toward the best interest of those who require the services we provide.

This plan of correction constitutes a written allegation of compliance, Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.

F323 Free of Accident Hazards/Supervision/Devices

Corrective action for those residents to have been affected.

The floor mats were placed at Resident #3's bedside by an LPN on 02/23/16.

The bed alarm was placed on Resident #5's bed by a CNA on 02/23/16.
Corrective action will be accomplished for those residents to be affected by same deficient practice.

On 03/09/16 all residents identified for fall risk were reviewed. This was completed using an audit tool by the Director of Health Service (DHS). The audit consisted of review of fall interventions listed on each resident's care plan against the resident's care guide and visual observation of each resident to ensure intervention is in place.

Measures put into place or systemic changes made to ensure that the deficient practice will not occur.

On March 10th, the Clinical Competency Coordinator began education for all nurses' and aides, including weekend and PRN staff on the resident care guide. The education included what the care guide is/consists of and fall interventions needed for those residents identified at risk. Of the 74 nurses' and aides, 72 have completed the In-service. All nurses' and aides will be required to complete the in-service prior to working his/her next scheduled shift.

Education on resident care guides has been added to orientation for all new hires.

A list of all fall interventions will be kept and updated daily on the care guide as needed when a fall occurs.
The Director of Health Services, Clinical Competency Coordinator, Unit Managers and Weekend Supervisor will observe residents identified at risk for fall to ensure interventions are in place for five residents per week times 4 weeks, then three residents per week times 4 weeks, and then 1 resident a week times 4 weeks to ensure fall risk interventions are in place according to the resident care guide.

Facility plans to monitor its performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained.

The Director of Health Services will present the findings of residents identified at risk for falls, review if care guides and observations of residents to the Quality Assurance and Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained.
2. Resident #5 was admitted to the facility on 06/16/14 with diagnoses including degenerative disease of the nervous system, Alzheimer's disease, and history of falling. Review of the Minimum Data Set (MDS) quarterly assessment dated 11/23/15 revealed Resident #5 had been identified as severely cognitively impaired with a functional status of extensive 2 person physical assist for bed mobility and transfers. Review of a care plan dated 02/17/16 revealed a problem identified for Resident #5 of potential for injury from falls related to history of falls. Most recent fall 02/14/16. Interventions included: Bed and wheelchair alarm in place, and ensure alarms were in place and functioning. An observation of Resident #5 on 02/24/16 at 11:05 AM revealed she was in bed and no bed alarm had been observed to be in place. An interview was conducted with Nurse Aide (NA) #1 on 02/24/16 at 11:05 AM who stated she usually worked with Resident #5 and was not aware that Resident #5 required an intervention of a bed alarm. She further stated she did not know where Resident #5's care plan was, or what was on it. She stated she had never placed a bed alarm on Resident #5's bed and verified Resident #5 was in bed and no bed alarm was in place. An observation of Resident #5 on 02/24/16 at 11:10 AM with the Director of Nursing (DON) revealed Resident #5 was in bed and no bed alarm had been observed to be in place. The DON had been observed to search Resident #5's room and did not find a bed alarm to place on Resident #5's bed. The DON verified that Resident #5 should have had a bed alarm in place. The DON stated it was her expectation of staff to follow Resident #5's care plan regarding...
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<tr>
<th>(X4) ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>(X5) ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 323</td>
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<td>Continued From page 4 the placement of a bed alarm while she was in bed.</td>
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