		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		B. WING		12/23/2020			
NAME OF PROVIDER OR SUPPLIER THE OAKS-BREVARD			STREET ADDRESS, CITY, STATE, ZIP CODE 300 MORRIS ROAD BREVARD, NC 28712				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIO		
E 000	was conducted onsite information was obtain 12/23/20; therefore, to 12/23/20. The facility with 42 CFR 483.73 r	ne exit date was changed to was found in compliance elated to E-0024 (b)(6),	E 000				
F 000	Facilities. Event ID# INITIAL COMMENTS	VID-19 Focused Infection	F 000				
F 880	offsite through 12/23/ was changed to 12/23 found in compliance w control regulations an CMS and Centers for Prevention (CDC) rec prepare for COVID-15 Infection Prevention &	commended practices to 9. Event ID# VKCW11. & Control	F 880		2/11/21		
SS=D	infection prevention a designed to provide a comfortable environm development and trar diseases and infection §483.80(a) Infection p program.	ntrol blish and maintain an nd control program a safe, sanitary and eent and to help prevent the asmission of communicable ns. prevention and control					
	The facility must esta	blish an infection prevention (IPCP) that must include, at /ing elements:					

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.

PRINTED: 01/28/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED MAME OF PROVIDER OR SUPPLIER 345462 B. WING 12/23/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 MORRIS ROAD THE OAKS-BREVARD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (x5) COMPLE			ID HUMAN SERVICES			FOR	ED: 01/28/2021 MAPPROVED O. 0938-0391
MALE OF PROVIDER OR SUPPLIER STREET ADDRESS, CTY, STATE, ZIP CODE STREET ADDRESS, CTY, STATE, ZIP CODE MALE OF PROVIDER OR SUPPLIER IMAGE OF PROVIDER OR SUPPLIER STREET ADDRESS, CTY, STATE, ZIP CODE IMAGE OF PROVIDER OF STATEMENT OF DEFICIENCES BREVARD, OC 28712 IMAGE OF PROVIDER OF DEFICIENCES PREVIX IEAO OF DEFICIENCY PREVIX IEAO OF DEFICIENCY PREVIX IEAO OF DEFICIENCY PREVIX IF 880 Continued From page 1 Staff, volumeers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; S483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections should be the persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be the reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not infectious agent or organism involved, and (iv) When and how isolation should be the least resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infections of the resident under the circums	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE	E SURVEY
399 MORRIS ROAD BREVARD, NC 2212 OWN PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) DP PROVIDENT RAN OF CORRECTION (EACH OBMECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) 000000000000000000000000000000000000			345462	B. WING		12	2/23/2020
THE DAKS-BREVARD BREVARD, NC 28712 (M)ID PREFIX TAG UMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE RECEDED BY PLLL RECOULTORY OR LSC DENTIFYING INFORMATION) PD PREFIX TAG PROVIDENTIFYING INFORMATION PG CROSS-REFERENCED TO THE APPROPRIATE CM CROSS-REFERENCED TO THE APPROPRIATE CM CROSS-REF	NAME OF PF	OVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, Z	ZIP CODE	
PREFX TG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTFYING INFORMATION) PREFX TG CEACH DEFICIENCY COMMENTE DEFICIENCY COMMENTE DEFICIENCY F 880 Continued From page 1 \$483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to \$483.70(e) and following accepted national standards; F 880 \$433.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (1) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious spend of organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (i) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact with residents to the isolation and (ii) The hand hygine proceedures to be followed Image: Contact with residents to their followed	THE OAKS	3-BREVARD					
 \$483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, stataf, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to \$483.70(e) and following accepted national standards; \$483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease; and (vi)The hand hygiene procedures to be followed 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE	(X5) COMPLETION DATE
§483.80(a)(4) A system for recording incidents	F 880	§483.80(a)(1) A syster reporting, investigatin and communicable dis staff, volunteers, visito providing services und arrangement based u conducted according accepted national star §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whom communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and dura depending upon the ir involved, and (B) A requirement tha least restrictive possitic circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir	em for preventing, identifying, ig, and controlling infections seases for all residents, ors, and other individuals der a contractual upon the facility assessment to §483.70(e) and following indards; a standards, policies, and ogram, which must include, llance designed to identify ole diseases or a can spread to other ; m possible incidents of se or infections should be insmission-based precautions rent spread of infections; olation should be used for a t not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the s under which the facility ees with a communicable kin lesions from direct s or their food, if direct he disease; and procedures to be followed rect resident contact.	F 880			

If continuation sheet Page 2 of 5

		IEDICARE & MEDICAID SERVICES			CONSTRUCTION		D. 0938-039
ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345462		B. WING			12/23/2020	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			12/20/2020	
THE OAKS-BREVARD							
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI> TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From pag	le 2	F 8	380			
	identified under the facility's IPCP and the						
	corrective actions taken by the facility.						
	§483.80(e) Linens.						
		dle, store, process, and					
	transport linens so a	s to prevent the spread of					
	infection.						
	§483.80(f) Annual re	wiew					
	The facility will conduct an annual review of its						
	IPCP and update the						
	This REQUIREMEN	T is not met as evidenced					
	by:						
		ons, staff interviews and			This plan of Correction constitutes the		
		cility failed to ensure dietary e facility's infection control			facilities written allegation of compliand for the deficiencies cited. However,	ce	
		g surgical masks when 1 of 3			submission of this plan of correction is	not	
		Aide #1) failed to wear their			an admission that deficiencies exist or		
		ring both the mouth and nose			that one was cited correctly. This plan		
		kitchen. This failure occurred			correction is submitted to meet		
	during a COVID-19	pandemic.			requirements established by federal ar	nd	
	Findings included:				state law.		
	· ·····g- ·····				Address how corrective action will be		
		policy titled, "COVID-19			accomplished for those residents found	d to	
		and Cohorting Process for			have been affected by the deficient		
		, revised 11/10/20, described			practice;		
		Protective Equipment (PPE) bected to wear while in the			No specific patients were identified to I	ha	
		nich included surgical mask,			affected by this deficient practice. The		
	KN95 mask or N95 r	U			dietary aide found to be out of complia		
					was in-serviced immediately on the		
		lucted in the kitchen on			centers policy, provided a KN95 mask		
		M revealed Dietary Aide (DA)			the traditional face mask partner has b		
		a face mask while she stood			wearing as it provided placement for he		
	at the steam table ar to the residents.	nd plated food to be delivered			glasses to reduce condensation and th center purchased product for her to ap		
					to her glasses to reduce	ירי	
							1

Facility ID: 922980

If continuation sheet Page 3 of 5

					OMB NO. 0938-03	
IATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345462		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED			
		B. WING		12/23/2020		
NAME OF PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS-BREVARD						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC	
F 880	Continued From page	e 3	F 880			
	Continued From page 3 #1 stated she had received education on the use of face masks and was instructed to wear a surgical mask, covering both the mouth and nose, at all times while in the facility. DA #1 confirmed she was not wearing a surgical mask while plating resident food and explained she had removed her mask because the surgical mask and steam from the table caused her glasses to fog up and she could not read the meal tickets. Review of facility in-service training documentation dated 10/07/20 titled, Town Hall/Clinical, included an agenda that read in part, "Town Hall: COVID updates - continue to wear KN95 (mask)." Further review revealed DA #1 had signed the associated in-service attendance form indicating she had received this training. During an interview on 12/21/20 at 12:40 PM, the Director of Nursing stated all staff, including dietary staff, were educated on the use of PPE in the facility and were instructed to wear surgical masks, covering both the mouth and nose, at all			 Address how the facility will identify residents having the potential to be affected by the same deficient pract. As all patients are provided meals, hydration, activity related food, and snacks from the dietary department QAPI (Quality Assurance Performant Improvement) committee has detern that all patients have the potential to affected. Address what measures will be purplace or systemic changes made to ensure that the deficient practice with recur; Upon completion of the centers roo cause analysis it was determined the center had not provide alternatives those partners who were having difficulties wearing mask due to bar such as glasses. 	tice; t the nce mined o be t into ill not t nat the for	
	PM, the Dietary Supe was aware of the cor with DA #1 not wearin kitchen and stated sh during previous conv a surgical mask at all DA #1 had previously read the meal tickets because the surgical fog up. The DS adde face shield to try but to see wearing it eith	nterview on 12/22/20 at 2:10 ervisor (DS) revealed she incern identified on 12/21/20 ing a mask while in the ne had reminded DA #1 ersations that she must wear it times. The DS explained it voiced not being able to in order to plate the food mask caused her glasses to ed she provided DA #1 with a DA #1 stated she wasn't able er. The DS verbalized tructed and expected to wear		The center will provide training by T Director of Health Services related placement of glasses when a mask place to reduce condensation on th glasses on or before 1/21/21. The co- will also provide different mask opti ensure those partners with glasses option that best work with their glass or before 1/21/21. The center will pr anti-fogging agent for partners with glasses to reduce condensation and ensure staff can safely apply mask, not having there vision impaired on 1/21/21. All staff will be educated by Director of Health Services to the a	to is in e enter on to have eses on ovide d , while or y the	

Facility ID: 922980

If continuation sheet Page 4 of 5

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION				OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
			A. BUILDING					
	345462		B. WING			12/23/2020		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
THE OAK			300 MO BREVA					
(X4) ID PREFIX TAG	(EACH DEFICIENC	MARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT FFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO 'ORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPF DEFICIENCY)		OULD BE	(X5) COMPLETIO DATE			
F 880	Continued From pag surgical masks, cove all times.	e 4 ering their mouth and nose, at	F	inte The trai of I pre CD •In• its sol Ro inc cor the rar on He nui bro we bas •In•	erventions/options on or before e Dietary Staff will receive the Health Services Transmission I ecautions and wearing facemas OC/CMC guidance. dicate how the facility plans to performance to make sure that utions are sustained; and utine infection control rounds v lude monitoring face masks winducted 7 days a week, for 2 we in 5 day a week for 2weeks, ar adomly but no less than 3 days an ongoing basis by the Direct alth Services, Kitchen Supervis rse management team. Finding bught to the QAPI team weekly eks and then monthly on an or sis. clude dates when corrective ac completed. e center will have all corrective mplete before or by 2/11/21.	following e Director based sk per monitor t which will ll be reeks, ad then a week tor Of sor, and g will be for four ngoing		

Facility ID: 922980

If continuation sheet Page 5 of 5