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 06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS OF 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	F 225 One resident was affected by this deficient practice. The employee in question was suspended pending an internal investigation. An internal investigation was conducted and the allegation was unsubstantiated. The Director of Health Services [DHS] did not know to submit a 24 hour and 5 day report as the employee in question was not a licensed employee. The 24 hour and 5 day report have now been submitted. Residents residing on the hall on which this employee worked had the potential to be affected by this deficient practice. Corrective actions for those residents having the potential to be affected by this deficient practice include in-servicing all staff on abuse and investigation policies including regulations related to 24 hour and 5 day reports, in-servicing all nurses on abuse policies and conducting investigations including immediate suspension of the employee in question and collecting	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — DATE

Cecil McCall, Ph.D., NHA — Administrator — 7/20/11

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.

Original Signature Date: 7-14-11

RECEIVED
JUL 21 2011
BY: MH

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, medical record review, and facility documents, the facility failed to report an allegation of abuse and an injury of unknown source to the state agency for one (1) of four (4) residents (Resident #13). The findings are: Resident #13 was admitted to the facility on 11/24/10 with diagnoses of dementia, hypertension and degenerative joint disease. The latest Minimum Data Set dated 04/20/11 revealed the resident had severe conitive impairment. Resident #13 required extensive assistance with activities of daily living. During a group interview on 06/22/11 at 3:00 p.m., Resident #13 reported an incident had occurred in the past that she did not wish to discuss in front of the group. On 06/23/11 at 11:45 a.m. Resident #13 was interviewed. She reported an allegation of physical abuse by a staff member and that her daughter had filed a complaint. She further reported that the person who was the alleged perpetrator was still employed by the facility. Review of a nursing note dated 02/27/11 revealed an incident in which the resident was resistive to care when multiple staff members attempted and failed to perform incontinence care for the resident. No injuries were noted. On 03/04/11 the next nursing note documented a meeting with the resident's daughter to discuss bilateral bruising of forearms. No source of injury was	F 225	statements and/ or interviews with all staff at the time of the accusation. In order to assure that this deficient practice will not occur, The Social Services Director will monitor ABAQIS interviews, weekly x 4 weeks then bi-monthly x 2 then monthly x 2, for potential issues that require investigation and reporting. ABAQIS is a software program used in the Quality Indicator Survey (QIS) for which the facility uses as a QA tool. Resident and Family Interviews are conducted, data is entered into the program, and then the program will identify potential triggers for various care and quality of life areas including abuse. The Administrator will be responsible for validating all alleged violations, investigating, and reporting 24 hour and 5 day reports timely to state agencies as required. The Administrator and/or DHS will bring findings to the monthly Performance Improvement Committee. All triggers will be reviewed to assure investigations have been completed. Completion date July 21, 2011. 7/21/11	

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F 225	Continued From page 2 documented. Review of the grievance log revealed a grievance was filed with the facility on 03/01/11 by Resident #13's daughter. She reported bilateral wrist bruising and an allegation of physical abuse by a staff member. The facility's documentation revealed that staff members were interviewed and the resolution of the grievance involved moving the resident to a different room. Further review of the investigation revealed that a twenty-four hour report of an abuse allegation and a five day report of an abuse investigation were not filed with the state agency. An interview was conducted with the Director of Health Services on 06/23/11 at 3:50 p.m. She reported that she was unable to find an incident report regarding the forearm bruises on Resident #13 and she did not know the cause of the injuries. She reported she should have filed a twenty-four hour and a five day report for an injury of unknown source. She further stated that the abuse allegation was made against an unlicensed staff member. She stated she was not aware she needed to report an abuse allegation made against an unlicensed staff member to the state agency.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226	**F 226** One resident was affected by this deficient practice. The employee in question was suspended pending an internal investigation. An internal investigation was conducted and the allegation was unsubstantiated.	

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F 226	Continued From page 3 by: Based on staff and resident interviews, medical record review, and facility documents, the facility failed to follow their policy by failing to report an allegation of abuse and an injury of unknown source to the state agency, and by failing to interview the alleged perpetrator for one (1) of four (4) residents (Resident #13). The findings are: 1. The facility policy entitled Abuse dated December 2001 read in part: "Once an occurence is identified involving alleged mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of patient/resident property, the occurence will be immediately reported to the Administrator. The Administrator of designee will immediately notify the appropriate state agencies and the legal representative or interested family member of the incident and the pending investigation. Using the 24 Hour Report from the Department of Health and Human Services of North Carolina Healthcare Personnel Registry, the Administrator shall see that the Health and Human Services of North Carolina Healthcare Personnel Registry is notified within 24 hours or as soon as practicable of all allegations which appear to a reasonable person to be related to patient/resident abuse, neglect or misappropriation of patient/resident property. The five day working report with investigation will be sent to the North Carolina Department of Health and Human Services." Resident #13 was admitted to the facility on	F 226	The Director of Health Services [DHS] did not know to submit a 24 hour and 5 day report as the employee in question was not a licensed employee. The 24 hour and 5 day report have now been submitted. Residents residing on the hall on which this employee worked had the potential to be affected by this deficient practice. Corrective actions for those residents having the potential to be affected by this deficient practice include in-servicing all staff on abuse and investigation policies including regulations related to 24 hour and 5 day reports, in-servicing all nurses on abuse policies and conducting investigations including immediate suspension of the employee in question and collecting statements and/ or interviews with all staff at the time of the accusation. In order to assure that this deficient practice will not occur, The Social Services Director will monitor ABAQIS	

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F 226	Continued From page 4 11/24/10 with diagnoses of dementia, hypertension and degenerative joint disease. The latest Minimum Data Set dated 04/20/11 revealed the resident had severe conitive impairment. Resident #13 required extensive assistance with activities of daily living. During a group interview on 06/22/11 at 3:00 p.m., Resident #13 reported an incident had occurred in the past that she did not wish to discuss in front of the group. On 06/23/11 at 11:45 a.m. Resident #13 was interviewed. She reported an allegation of physical abuse by a staff member and that her daughter had filed a complaint. She further reported that the person who was the alleged perpetrator was still employed by the facility. Review of a nursing note dated 02/27/11 revealed an incident in which the resident was resistive to care when multiple staff members attempted and failed to perform incontinence care for the resident. No injuries were noted. On 03/04/11 the next nursing note documented a meeting with the resident's daughter to discuss bilateral bruising of forearms. No source of injury was documented. Review of the grievance log revealed a grievance was filed with the facility on 03/01/11 by Resident #13's daughter. She reported bilateral wrist bruising and an allegation of physical abuse by a staff member. The facility's documentation revealed that staff members were interviewed and the resolution of the grievance involved moving the resident to a different room. Further review of the investigation revealed that a twenty-four hour report of an abuse allegation and	F 226	interviews, weekly x 4 weeks then bi-monthly x 2 then monthly x 2, for potential issues that require investigation and reporting. ABAQIS is a software program used in the Quality Indicator Survey (QIS) for which the facility uses as a QA tool. Resident and Family Interviews are conducted, data is entered into the program, and then the program will identify potential triggers for various care and quality of life areas including abuse. The Administrator will be responsible for validating all alleged violations, investigating, and reporting 24 hour and 5 day reports timely to state agencies as required. The Administrator and/or DHS will bring findings to the monthly Performance Improvement Committee. All triggers will be reviewed to assure investigations have been completed. Completion date July 21, 2011. 7/21/11	

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

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F 226	Continued From page 5 a five day report of an abuse investigation were not filed with the state agency. An Interview was conducted with the Director of Health Services on 06/23/11 at 3:50 p.m. She reported that she was unable to find an incident report regarding the forearm bruises on Resident #13 and she did not know the cause of the injuries. She reported she should have filed a twenty-four hour and a five day report for an injury of unknown origin. She further stated that the abuse allegation was made against an unlicensed staff member. She stated she was not aware she needed to report an abuse allegation made against an unlicensed staff member to the state agency. She stated she should have followed the facility policy and filed a twenty-four hour and five day report to the state agency. 2. The facility policy entitled Abuse read in part: "Interviews will be conducted of all pertinent parties, utilizing open ended questions. Written signed statements from any involved parties will be obtained and notarized if indicated. Statements will be gathered from the suspect." Resident #13 was admitted to the facility on 11/24/10 with diagnoses of dementia, hypertension and degenerative joint disease. The latest Minimum Data Set dated 04/20/11 revealed the resident had severe conitive impairment. Resident #13 required extensive assistance with activities of daily living. During a group interview on 06/22/11 at 3:00 p.m., Resident #13 reported an incident had occurred in the past that she did not wish to discuss in front of the group. On 06/23/11 at	F 226		

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F 226	Continued From page 6 11:45 a.m. Resident #13 was interviewed. She reported an allegation of physical abuse by a staff member and that her daughter had filed a complaint. She further reported that the person who was the alleged perpetrator was still employed by the facility. Review of a nursing note dated 02/27/11 revealed an incident in which the resident was resistive to care when multiple staff members attempted and failed to perform incontinence care for the resident. No injuries were noted. On 03/04/11 the next nursing note documented a meeting with the resident's daughter to discuss bilateral bruising of forearms. No source of injury was documented. Review of the grievance log revealed a grievance was filed with the facility on 03/01/11 by Resident #13's daughter. She reported bilateral wrist bruising and an allegation of physical abuse by a staff member. The facility's documentation revealed that staff members were interviewed and the resolution of the grievance involved moving the resident to a different room. Further review of the investigation revealed that although a number of staff members were interviewed, the alleged perpetrator was not interviewed. An interview was conducted with the Director of Health Services on 06/23/11 at 3:50 p.m. She reported that she should have followed the facility abuse policy and interviewed the alleged perpetrator.	F 226		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281	**F 281** One resident was affected by this deficient practice. Orders were corrected June 22, 2011.	

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

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F 281	Continued From page 7 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to clarify a medication order and ensure a lab was done as ordered for one (1) of twenty (20) sampled residents. (Resident #6) The findings are: 1. Resident # 6 was admitted to the facility from a local hospital on 6/13/11 with diagnoses that included rheumatoid arthritis, pelvic fracture and osteoarthritis. Hospital records indicated Resident #6 had taken 5 milligrams of Prednisone three times a day prior to admission to the hospital as well as while admitted to the hospital from 6/8/11-6/13/11. The list of discharge medications included Prednisone 5 mg tablet for rhematoid arthritis with meals. The facility nurse that wrote admission orders on 6/13/11 transcribed this discharge order on the facility physician order sheet and June Medication Administration Record (MAR) as Prednisone 5 milligrams, one orally with meals for rheumatoid arthritis. On the June MAR for Resident #6 the only time indicated for administration of the Prednisone was at 7:00 AM. On 6/14/11 the charge nurse working from 2:00 PM-10:00 PM (over the unit in which Resident #6 resided) noted in the nursing communication book the need to contact the resident's physician regarding the Prednisone order. On 6/23/11 at 4:05 PM the charge nurse that wrote the note	F 281	All residents have the potential to be affected by this deficient practice. Corrective actions for other residents include that chart audits were conducted to review admissions medications and lab orders. Measures to assure that this deficient practice will not occur include in-servicing all licensed nurses on admissions processes and follow up to physician orders and in-services on lab policies and follow-up. To assure that solutions are sustained, the DHS and/ or ADHS will monitor new admissions orders and labs daily x4 weeks , then weekly x 2, then monthly x 2. The DHS or ADHS will bring findings to the monthly Performance Improvement Committee. Included in sustaining this solution, triple checks by licensed nurses will be required for all orders and new admissions. The DHS will monitor this on an on-going basis. Completion date July 21, 2011. 7/21/11	

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F 281	Continued From page 8 stated the family of Resident #6 came to her on 6/14/11 and stated that the resident took Prednisone three times a day at home, as opposed to once a day that she was receiving at the facility. The charge nurse stated it was after physician office hours so she wrote the note in the commmunication book for the oncoming nurse to follow-up with the resident's physician for clarification of the order. On 6/14/11 the charge nurse working from 10:00 PM-6:00 AM (over the unit in which Resident #6 resided) noted in the nursing communication book that clarification was needed for the Prednisone order as the resident's family reported she took it more than once a day. The 10:00 PM-6:00 AM charge nurse indicated in her note this had been reported to the oncoming licensed nurse working 6/15/11 from 6:00 AM-2:00 PM. On 6/23/11 at 11:55 AM the licensed nurse that worked 6/15/11 from 6:00 AM-2:00 PM stated she thought she had sent a fax to the resident's physician regarding the Prednisone but the fax communications were not kept. Because the concern was not followed up on, the resident continued to receive the 5 milligrams of Prednisone once a day since admission to the facility. On 6/22/11 at 1:55 PM the facility Director of Nursing stated the admission order for Prednisone should have been clarified with the resident's physician. The Director of Nursing stated she could not tell if staff had followed up with the resident's physician regarding the dosing of Prednisone. 2. Resident #6 was admitted to the facility	F 281		

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F 281	Continued From page 9 6/13/11 after hospitalization 6/8/11-6/13/11. On 6/14/11 the resident was seen by her physician and orders were written which included labs for "CPK (creatine phosphokinase), SGOT (serum glutamic oxaloacetic transaminase) and Aldolase-ask hospital to run on blood they drew on 6/9/11". Review of completed labwork in the medical record of Resident #6 did not include results of CPK, SGOT or Aldolase. On 6/22/11 at 9:50 AM the licensed nurse that received the 6/14/11 order for labs stated because the resident was so badly bruised (from a fall prior to admission) it was hard to draw blood from her. The licensed nurse recalled that was the reason the physician wanted the labs done from bloodwork that was drawn at the local hospital (prior to admission to the facility 6/13/11). The licensed nurse called the hospital lab to see if the CPK, SGOT and Aldolase had been completed. The hospital lab reported the labwork had not been done because the blood had hemolyzed and they failed to inform the facility or physician the labwork could not be completed. The licensed nurse stated the need for the labwork is usually put on the Medication Administration Record (MAR) and Lab Order Requistion Log as a reminder to staff. The CPK, SGOT and Aldolase had not been documented on the resident's June MAR or Lab Order Requisition Log for staff to follow up on to ensure the labwork was completed. On 6/22/11 at 10:30 AM the facility Director of Nursing stated the need for labwork should always be put on the MAR as it was the most dependable way for staff to ensure labs were done as ordered.	F 281		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=D	Continued From page 10 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to provide feeding assistance for one (1) of two(2) sampled dependent residents. (Resident #20). The findings are: Resident #20 was readmitted to the facility on 09/13/10 with diagnoses of Alzheimer's Disease and Parkinson's Disease. The most recent Minimum Data Set (MDS) dated 04/09/11 revealed the resident had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. The MDS also revealed the resident required extensive assistance with eating. A review of the care plan for Resident #20, revised 05/05/11, revealed a problem of alteration in nutrition related to decreased cognition and dependence on staff for feeding. Also, he has a history of poor intake. The goal noted the resident will consume adequate nutrition/hydration and maintain stable weight. Approaches included: offering diet as ordered, mechanical soft with chopped meat, offer preferences and update as needed, weight per	F 312	**F 312** One resident was affected by this deficient practice. An assessment of the dining room was conducted on June 24, 2011. All residents on the Memory Support Unit [MSU] who require assistance or cueing with feeding have the potential to be affected. An assessment of the dining room was conducted on June 24, 2011. To assure that this deficient practice will not occur, table assignments have been rearranged to allow staff access to all residents during meal time. CNAs are assigned to assist specific tables and/ or residents. Nurses will monitor all meal times on a daily basis to assure all residents who require assistance receive it in a timely fashion. To monitor performance and make sure that solutions are sustained, the Administrator, DHS, or ADHS will complete observations of the MSU dining room at least one meal daily x4,	

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F 312	Continued From page 11 facility protocol and notify physician of any significant gains or losses, assist with feeding as needed and encourage the resident to eat in the dining room, and offer fluids/snacks between meals. Review of the resident's weights for the last six months revealed his weights have remained stable. On 06/21/11 at 6:35 p.m. Resident #20 was observed in his wheelchair in the memory unit dining room during the supper meal. The resident's tray was observed with soup, ice cream, and carrot salad in bowls along with iced tea and whole milk to drink. He was observed to take his fork to and from the glass and dip it in the iced tea in an attempt to get the tea into his mouth. The resident's clothing protector had partially fallen into his dessert bowl and he was trying to eat his dessert but the clothing protector blocked his efforts to get to his dessert. Staff had set up the resident's tray and he had a spoon available but he was trying to eat his food with a straw. The resident was observed to pick up the ice cream container but he was unable to know where to place it on the tray and he put it in his soup. Continuous observations during the meal revealed no staff offered or provided assistance or cueing to the resident. On 06/21/11 at 6:40 p.m. one of the nursing assistants (NA) providing feeding assistance in the memory unit for the supper meal, NA #4, was interviewed. She stated there was not enough staff to provide the assistance required by all the residents since five totally dependent residents require feeding assistance. On 06/22/11 at 12:31 p.m. Resident #20 was	F 312	then weekly x4, then monthly x 2. Findings will be reviewed during monthly Performance Improvement Committee. Completion date July 21, 2011. 7/21/11	

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 06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS OF BREVARD	300 MORRIS ROAD BREVARD, NC 28712

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F 312	Continued From page 12 observed in the memory unit dining room for the lunch meal. He had on his tray whole milk and iced tea, ground meat on a plate, and beans, cole slaw and ice cream in bowls. Resident #20 poured his iced tea on his ground meat, put his spoon in his milk, attempted to eat his ice cream with a pepper packet, and tried to use a straw to eat his ice cream. Three NA were observed providing feeding assistance to five totally dependent residents. Continuous observations during the meal revealed no NA was observed cueing or assisting Resident #20. On 06/22/11 at 1:05 p.m. an NA assisting residents with the noon meal, NA #5, was interviewed. The NA stated that Resident #20 and several other residents required cueing and assistance but there were five totally dependent residents to feed and only two or three staff available. She stated residents were not being assisted as needed. The licensed nurse during this meal was observed assisting with feeding. On 06/23/11 at 1:24 p.m. The licensed nurse unit manager was interviewed. The unit manager revealed Resident #20 needed prompting and supervision at meals to be able to help feed himself. She said the level of care and feeding assistance the residents needed required another staff person to assist because the resident's behaviors fluctuated every day. The unit manager stated she had asked for help at times when staff on the unit had been short.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	F 315	**F 315** One resident was affected by this deficient practice related to incontinence care. One resident was	

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

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 06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 13 resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure proper technique was used during incontinence care for one (1) of four (4) residents (Resident #4), and failed to ensure that catheter care was performed each shift for one (1) of two (2) residents (Resident #3). The findings are: 1. Resident #4 was admitted to the facility on 12/29/06 with the diagnoses rheumatoid arthritis, congestive heart failure and renal failure. The latest Minimum Data Set (MDS) dated 05/13/11 revealed that Resident #4 had severe cognitive impairment and required extensive assistance with activities of daily living and was incontinent of bowel and bladder. Further review of Resident #4's medical record revealed that on 06/03/11 she was treated with an antibiotic for a urinary tract infection. A review of Resident #4's care plan, dated 05/12/11, revealed a problem of potential for skin breakdown related to decreased mobility and incontinence. Interventions included cleansing of	F 315	affected by this practice related to catheter care. Both residents have been given proper care. Effective June 24, 2011. All residents requiring incontinence care and/ or catheter care have the potential to be affected by this deficient practice. To assure that this deficient practice does not occur, all CNAs will be educated and in-serviced on incontinence care and catheter care, notably assuring catheter care is performed each shift. Catheter care will be a scheduled assigned task on smart charting for residents with catheters. Smart Charting is the electronic documentation system used by CNAs. Catheter care will also be assigned in the Medication Administration Records (MARS) for the nurses to check. To sustain this solution, the ADHS will monitor Smart Charting and the MARS daily x3 weeks , then weekly x2 weeks, then monthly x2 to assure catheter care	

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	345462	A. BUILDING _____ B. WING _____	C 06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS OF BREVARD	300 MORRIS ROAD BREVARD, NC 28712

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F 315	Continued From page 14 the perineal area following each urination and bowel movement. On 06/21/11 at 2:35 p.m. an observation was made of incontinence care for Resident #4 provided by Nursing Assistant (NA) #1. NA #1 placed Resident #4 into bed and removed her pants and unfastened her incontinence brief. The resident was observed to be incontinent of both urine and stool. NA #1 did not have any cleaning supplies with him other than a clean incontinence brief. He left the room to obtain supplies to provide incontinence care and returned with a wet washcloth and a towel. During the incontinence care, NA #1 did not separate and clean the labial area. While cleaning the peri area, the washcloth became visibly soiled with stool throughout. NA #1 failed to obtain clean washcloths and continued to wipe the peri area with the visibly soiled washcloth. An interview was conducted on 06/21/11 at 3:00 p.m. with NA #1. NA #1 reported that he was not prepared to provide incontinence care for Resident #4. He stated he should have used a clean wash cloth once the one he was using became soiled with stool. An interview was conducted on 06/22/11 at 10:10 a.m. with Licensed Nurse (LN) #2. LN #2 reported that NA #1 should have gathered the supplies outside the room needed for providing incontinence care. This would include a basin of soap and water or periwash, washcloths, and a towel. She further reported that a clean part of the washcloth should be used for each wipe from front to back and several washcloths would be	F 315	is being completed. The DHS or AHDS will also observe 5 CNAs a day x 4 weeks, then weekly x4, then monthly x 2 performing incontinence care. Corrections will be made immediately. The DHS and ADHS will bring findings to the monthly Performance Improvement Committee. Completion date July 21, 2011. 7/21/11	

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 06/23/2011

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THE OAKS OF BREVARD	300 MORRIS ROAD BREVARD, NC 28712

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F 315	Continued From page 15 needed. She also reported that when cleaning the peri area the labia should be separated. She went on to say the bulk of the stool could be cleaned with toilet paper prior to washing the peri area front to back. An interview was conducted on 06/22/11 at 10:32 a.m. with the Director of Health Services (DHS). The DHS reported that staff should use soap and water or peri wash to clean residents during incontinence care. The washcloth should be folded and refolded with each wipe. Her expectation is that staff use a clean area of the cloth or a clean washcloth with each wipe. The feces should be wiped first with toilet paper. The labia should be cleaned first front to back. She reported that she expected NA #1 to follow these procedures. 2. Resident #3 was admitted to the facility on 06/04/09 with a diagnosis of cardiovascular accident and neurogenic bladder. The latest Minimum Data Set (MDS) dated 05/03/11 revealed the resident had no short or long term memory problems. The MDS also revealed the resident required extensive assistance with activities of daily living including personal hygiene. The MDS further revealed the resident had an indwelling urinary catheter. A review of the care plan for Resident #3, revised 05/12/11, revealed he had a potential for urinary tract infections related to use of a urinary catheter due to a neurogenic bladder. One intervention for this problem was to perform catheter care (cleaning of the catheter) daily on each shift. On 06/21/11 at 10:02 a.m. Resident #3 was	F 315		

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

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 06/23/2011

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THE OAKS OF BREVARD	300 MORRIS ROAD BREVARD, NC 28712

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F 315	Continued From page 16	F 315		

interviewed. He stated that staff did not perform catheter care every shift. He stated he received catheter care approximately twice a week. At this time, the ADL (Activities of Daily Living) Care Plan Record sheet was observed on the inside of the resident ' s wardrobe door. This care sheet was used by the nursing assistants to review the individualized care of each resident. The sheet for Resident #3 revealed that catheter care needed to be performed each shift.

On 06/23/11 at 10:51 a.m. Nursing Assistant (NA) #2 was interviewed. She stated this was her second day assisting Resident #3 and that her first day working with him was the day before yesterday. She stated that even though he was a new resident to her, she knew what care he needed by referring to the care sheet in his wardrobe. NA #2 stated that she knew that any resident with a catheter required catheter care as part of morning care, but she forgot to do it today and the day before yesterday for Resident #3. NA #2 stated she would go do catheter care for Resident #3 now.

On 06/23/11 at 11:44 a.m. NA #3 was interviewed. She stated that when she worked with Resident #3 she usually performed catheter care when she got the resident up to the bathroom in the morning. She stated that yesterday the resident wished to remain in bed so she did not perform catheter care or offer to perform it. She stated she did not think to do catheter care while the resident was in bed. NA #3 stated the resident had never refused catheter care from her in the past.

On 06/23/11 at 12:15 p.m. the Unit Supervisor

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	345462	A. BUILDING _____ B. WING _____	C 06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 17 licensed nurse was interviewed. She stated that facility policy was to perform catheter each shift. She stated she would expect nursing assistants on the day shift to perform catheter care for Resident #3 as part of morning care while he was still in bed and regardless of whether he wished to get up or remain in bed, because of the importance of catheter care to prevent infection. On 06/23/11 at 1:05 p.m. the Director of Health Services was interviewed. She stated that catheter care should be performed each shift per facility policy. She stated that nursing assistants knew this policy and that catheter care each shift was listed on the care sheet in the wardrobe of any resident with a catheter. She stated she expected nursing assistants to perform catheter care for Resident #3 as part of morning care in bed and on each shift.	F 315		
F 323 SS=D	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, interviews, and medical record review, the facility failed to ensure that staff placed a bed in the lowest position while the resident was unattended for one (1) or four (4) residents (Resident #4).	F 323	**F 323** One resident was affected by this deficient practice. It was corrected immediately. All residents requiring beds to be in the lowest position have the potential to be affected by this deficient practice. To assure that this deficient practice will not occur, all staff will be educated and in-serviced on making sure that beds are in the lowest position for	

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

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 06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS OF BREVARD	300 MORRIS ROAD BREVARD, NC 28712

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F 323	Continued From page 18 The findings are: Resident #4 was admitted to the facility on 12/29/06 with the diagnosis of rheumatoid arthritis, congestive heart failure, and renal failure. Resident #4's most recent Minimum Data Set (MDS) dated 05/13/11 revealed that she had severe cognitive impairment and required extensive assistance with all activities of daily living. The MDS also revealed that the resident had a history of falls. A review of Resident #4's care plan, dated 06/13/11, revealed a potential for falls related to a history of multiple falls and unsteady gait. After a fall from bed, an intervention was added to the care plan on 05/30/11 for staff to ensure the bed was kept in the lowest position. An observation was made on 06/21/11 at 2:35 p.m. of Nursing Assistant (NA) #1 providing incontinence care for Resident #4. NA #1 assisted Resident #4 to bed for incontinence care and raised the bed to a proper working height. There was a mat on the floor next to Resident #4's bed. NA #1 left the room with the bed in the high position and returned approximately two minutes later with incontinence supplies. While NA #1 was out of the room Resident #4 made an unsuccessful attempt to get out of bed. NA #1 came back into the room and continued to provide care with the bed in the high position. An interview with NA #1 was conducted on 06/21/11 at 3:00 p.m. NA #1 reported he should have lowered the bed prior to leaving the room for more supplies as Resident #4 had a history of	F 323	residents with this specific intervention. Staff will be informed of this intervention via CNA Care Plans in the residents rooms and Care Plans in the charts. To assure solutions are sustained, bed positions will be checked daily x 4 weeks, then weekly x 4, then monthly x 2 during rounds performed by Department Heads assigned to particular halls. Findings will be submitted daily then weekly then monthly, as above, to the DHS or ADHS and reviewed in weekly At-Risk meetings. During At-Risk meetings, the clinical staff review residents at-risk of falls among other clinical issues. Completion date July 21, 2011.	7/21/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE OAKS OF BREVARD	300 MORRIS ROAD BREVARD, NC 28712

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F 323	Continued From page 19 falls. He reported that she has a mat on the floor next to her bed to prevent injury if she falls from bed in the lowest position. An interview was conducted on 06/22/11 at 10:10 a.m. with Licensed Nurse (LN) #2 who was the unit manager for the area in which Resident #4 resided. LN #2 reported that Resident #4 had a mat next to her bed due to a history of falls from bed. She reported that the NAs were trained to keep the bed in the lowest position except during care. She expected NAs to raise the bed to provide care but not to leave residents alone or leave the room with the bed in the high position. An interview was conducted with the Director of Health Services (DHS) on 06/22/11 at 10:35 a.m. The DHS reported that due to a history of falls Resident #4 had a mat and a low bed. She expected NAs to raise the bed to provide care but not to leave residents alone or leave the room with the bed in the high position. The DHS stated she expected NA #1 to observe this precaution for safety of the resident.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	**F 328** One resident was affected by this deficient practice. It was corrected immediately. All residents requiring oxygen have the potential to be affected. Oxygen storage has been checked throughout the facility. In-services for all staff on	

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	345462	A. BUILDING _____ B. WING _____	C 06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS OF 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 328	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and staff interviews the facility failed to ensure oxygen cylinders were securely stored for one (1) of two (2) sampled residents utilizing portable oxygen. (Resident #6) The findings are: The facility policy for Oxygen Storage dated January, 2005 read in part, "All oxygen cylinders stored will be secured to the wall or be secured in an approved stand device." During the initial tour of the facility on 6/21/11 from 10:15 AM-10:20 AM a portable oxygen tank in a sleeved jacket (used to hook on the back of a wheelchair) was observed freestanding against a wall in the room of Resident #6. The cylinder was between two wardrobes, across from the bed of Resident #6. To one side of the cylinder was a plastic laundry basket and the other side was a metal portable two wheeled rolling oxygen holder. At the time of the observation Resident #6 was in bed and had oxygen infusing via a concentrator. A wheelchair was at the bedside of Resident #6. On 6/21/11 at 11:00 AM the portable oxygen tank was observed in the same position as seen earlier. At the time of the next observation on 6/21/11 at 1:30 PM the portable oxygen tank was attached to the back of the wheelchair of Resident #6. On 6/21/11 at 2:55 PM the licensed nursing	F 328	the proper storage of oxygen cylinders will be completed. To assure solutions are sustained, oxygen cylinders will be checked daily x 4 weeks, then weekly x 4, then monthly x 2 during rounds performed by Department Heads assigned to particular halls. Findings will be reviewed at Morning Meeting and the monthly Performance Improvement Committee. Compliance rounds of utility rooms where unused and used oxygen cylinders are stored, respectively, are conducted daily by Housekeeping. This is on-going. Findings are reported at Morning Meeting . Completion date July 21, 2011. 7/21/11	

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 06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS OF BREVARD	300 MORRIS ROAD BREVARD, NC 28712

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F 328	Continued From page 21 supervisor (over the unit in which Resident #6 resided) could not explain why an oxygen cylinder would have been stored unsecured in the resident's room. The licensed nursing supervisor stated the two wheeled rolling oxygen holders were kept in the rooms of residents using portable oxygen for storage of the tanks when not in use. On 6/22/11at 10:40 AM the nursing assistant that worked with Resident #6 the morning of 6/21/11 stated she did not notice the portable oxygen cylinder stored against the wall in the room of Resident #6 the morning of 6/21/11. The nursing assistant stated when she started her shift at 6:00 AM Resident #6 was in bed. The nursing assistant stated when she assisted Resident #6 into her wheelchair the portable oxygen tank had been put on the back of the chair. The nursing assistant stated she was not aware the oxygen cylinder had been stored unsecured until it was brought to her attention the morning of 6/22/11. The nursing assistant stated she was aware portable tanks should be stored in the two wheeled rolling holders when not in use. On 6/23/11 at 10:50 AM the Director of Nursing reported she could not determine who stored the portable oxygen tank unsecured in the room of Resident #6. The Director of Nursing stated oxygen cylinders should always be secured when not in use and all staff should be aware of the facility policy on oxygen storage.	F 328		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371	**F 371** No single resident was affected by this deficient practice. All residents have the potential to be affected.	

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 06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS OF BREVARD	300 MORRIS ROAD BREVARD, NC 28712

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F 371	Continued From page 22 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure dishware was stored in a safe, sanitary manner and a system was in place to ensure milkshakes were used prior to expiration. The findings are: 1. During the initial tour of the facility kitchen on 6/21/11 at 9:20 AM a plastic ice scoop holder was observed stored on the horizontal surface of the ice machine. There were holes observed in the bottom portion of the ice scoop holder and water was pooled inside the holder because it was stored on a flat surface. An ice scoop holder was stored inside and the scoop portion came in direct contact with the bottom interior portion. When the ice scoop was removed there were areas on the bottom of the holder with a slimely tan colored appearance. When felt, the tan matter was easily removed. The Assistant Food Service Director (AFSD) was present at the time of the observation and reported the ice machine/scoop holder were included on the cleaning schedule. The AFSD checked the schedule and noted on 6/18/11 the cleaning schedule included to "clean inside lid and all of outside of ice maker". The	F 371	Ice scoops were immediately cleaned. Proper ice scoop storage bins were ordered. The knife was immediately disposed of in a Sharps container. All pots and pans were immediately cleaned. Milkshakes will be thawed on trays and labeled by thaw date and expiration date. The Assistant Food Service Director (AFSD) instructed dietary staff immediately and in-serviced dietary staff on July 14, 2011. The interior ceiling was repaired June 30, 2011. The roof was repaired July 12, 2011. To assure these deficient practices do not occur, the dietary staff has been in-serviced on inspection of equipment and protocol if equipment is damaged. All facility staff will be in-serviced on the proper storage of ice scoops. To maintain compliance, the AFSD will monitor weekly on an on-going basis by conducting a kitchen inspection check.	

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 06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS OF BREVARD	300 MORRIS ROAD BREVARD, NC 28712

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F 371	Continued From page 23 AFSD stated this should include cleaning the ice scoop holder. On 6/23/11 at 6:00 PM the AFSD stated she spoke with the aide that was assigned to clean the ice maker on 6/18/11 and the aide stated she forgot to wash the ice scoop holder. 2. During the initial tour of the facility kitchen on 6/21/11 at 9:40 AM a large knife was observed stored in the magnetic holder located on the wall near the three compartment sink. The tip of the knife had an approximate 1/4" broken area which left a jagged edge on the blade. The Assistant Food Service Director was present at the time of the observation and reported knives should be removed when damaged. No explanation was offered why the knife remained in storage, ready for use. 3. During the initial tour of the facility on 6/21/11 at 9:45 AM seventeen individual milkshakes were observed being thawed in the food preparation sink. On 6/23/11 at 10:55 AM approximately 57 individual milkshakes were observed being thawed in the same sink. Manufacturer directions on each milkshake indicated once thawed, the milkshakes were good for fourteen days. The Assistant Food Service Director (AFSD) was present at the time of the observation and reported staff use approximately 10 milkshakes a day and try to use thawed milkshakes within seven days. The AFSD stated there was not a system in place to ensure all thawed milkshakes were utilized within fourteen days of expiration. 4. On 6/21/11 at 5:05 PM an approximate 3' X 3' area of the ceiling above the clean pot storage was noted to be damaged with areas of peeling drywall and paint directly above upright pots. On	F 371	The facility will integrate equipment status checks into its monthly Performance Improvement Committee on an on-going basis. Completion date July 21, 2011.	7/21/11

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	345462	A. BUILDING _____ B. WING _____	C 06/23/2011

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F 371	Continued From page 24 6/23/11 at 12:25 PM this area remained as seen on 6/21/11 but the drywall appeared to be wet and with a darkened appearance. The Assistant Food Service Director (AFSD) was present at the time of the observation and reported the problem with the ceiling began a couple months prior during a rain storm. The AFSD stated the maintenance director was aware of the issue and was attempting to contain water and obtain bids from outside contractors for repairs. Clean pans stored upright and hanging directly below were removed and chunks of drywall/water were observed on the interior portion of three of the pots. At the time of the observation the maintenance director reported the leak was from the vent pipe off the sink and a pan had been placed in the attic area to attempt to contain water. The maintenance director stated rain that morning had caused the drywall to get wet as he wasn't sure if all the leaks had been contained. The AFSD and maintenance director stated nothing had been put in place in the interim to prevent clean pots (stored directly below the damaged ceiling area) from being contaminated from drywall or water from the roof leaks.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431	F 431 One resident had the potential to be affected by this deficient practice. The medication was immediately removed from the medication cart by the nurse.	

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F 431	Continued From page 25 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review and manufacture's recommendation, the facility failed to remove expired insulin from one (1) of six (6) medication carts. The findings are: Review of an undated information sheet entitled "Common Expiration Date Reminders Once Opened" used by the facility for medication disposal guidelines revealed Insulin expires 28	F 431	All residents prescribed to have multi-dose vials of Humalog insulin indicated for use within 28 days of opening have the potential to be affected. All medications have been checked by the Consulting Pharmacist effective July 13, 2011. All licensed nurses will be in-serviced on the proper labeling of insulin and educated on the expiration dates of insulin. To assure that corrective actions are sustained, medication carts will be inspected daily x 3 weeks, then weekly x 3, then monthly x 2 by the DHS, ADHS, and/ or Consulting Pharmacist. Review of findings will be integrated into monthly Performance Improvement Committee. Completion date July 21, 2011. 7/21/11	

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F 431	Continued From page 26 days after opening. Manufacturer's recommendations for the use of multi-dose vials of Humalog Insulin indicated once opened the Insulin must be used within twenty eight (28) days or discarded. On 06/23/11 at 5:15 PM the medication cart for the 400 hall was observed to contain an open ready for use multi-dose vial of Humalog 100 Units per milliliter insulin with an open date of 5/14/11 written on the vial. An interview on 6/23/11 at 5:30 PM with Licensed Nurse # 1, who was passing medications from the 400 Hall medication cart, confirmed the Insulin was past the expiration date, and stated the insulin should have been removed from active stock. On 6/23/11 at 5:35 PM the DON (Director of Nursing) was interviewed. She stated the facility policy was to label insulin when it was opened and discard it after 28 days. She further indicated it is the medication nurse's responsibility to check insulin dates.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441	**F 441** All residents and staff have the potential to be affected by this practice. To assure that this deficient practice will not occur, all staff will be in-serviced on infection control and hand-washing practices.	

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

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F 441	Continued From page 27 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to ensure staff washed hands after providing incontinence care for one (1) of four (4) residents (Resident #4). The findings are: A review of the facility's policy entitled Hand	F 441	Managers of each department (nursing, dietary, housekeeping/ laundry) will observe 10 employee hand-washing practices daily x 3 weeks, then weekly x 2, then monthly x 2. The facility will review findings in its monthly Performance Improvement Committee. Completion date July 21, 2011. 7/21/11	

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F 441	Continued From page 28 Hygiene dated February 2008 read in part: When to Wash Hands (at a minimum) · Before and after each patient/resident contact · After touching a patient /resident or handling his or her belongings. · Whenever hands are obviously soiled · After contact with any body fluids · After handling any contaminated items (linens, soiled diapers, garbage, etc.) Resident #4 was admitted to the facility 12/29/06 with diagnoses that included rheumatoid arthritis, congestive heart failure and chronic renal failure. Review of Resident #4's most recent Minimum Data Set (MDS) dated 05/13/11 revealed that she had severe cognitive imapirment and required extensive assistance for bathing and hygiene. The MDS further revealed that Resident #4 was frequently incontinent of bowel and bladder. An observation was made on 06/21/11 at 2:35 p.m. of Nursing Assistant (NA) #1 providing incontinence care for Resident #4. Resident #4 incontinence brief was saturated with urine and she had a loose bowel movement. After providing incontinence care NA #1 removed his gloves and did not wash his hands. He gathered the trash bags containing the dirty linen used during incontinence care and exited Resident #4's room, touching the door handle. NA #1 then entered the dirty linen room by using the outside door handle. He then disposed of the linen and exited the room using the inside door handle. NA #1 went into the hall and retrieved a pair of gloves and walked back into the dirty linen room, using the outside door handle. NA #1 donned the gloves and separated the laundry from the trash in the bags he had brought into the dirty linen room. NA #1	F 441		

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F 441	Continued From page 29	F 441		

then removed his gloves, washed his hands, and exited the dirty linen room by using the inside door handle.

An interview with NA #1 was conducted on 05/21/11 at 3:00 p.m. NA #1 reported he should have washed his hands after providing incontinence care and removing his gloves, and prior to touching door handles.

An interview was conducted on 06/22/11 at 10:10 a.m. with Licensed Nurse #2, who was the unit manager. She reported that NA #1 should have washed his hands before and after providing incontinence care and whenever gloves were removed. She further reported that after providing incontinence care, NA #1 should have removed gloves and washed hands before leaving the room. She then stated that he should have held the trash bag in one hand and opened doors with the other clean hand. She stated that dirty linen should be taken to the dirty linen room, deposited in the hamper, and hands should be washed in the dirty linen room prior to exiting the room.

On 06/22/11 at 10:32 an interview was conducted with the Director of Health Services. She reported that it was her expectation that hands be washed after incontinence care and removal of gloves before leaving the room. She further reported that staff should pick up the dirty linen trash bag with one hand and open doors with the other hand. She expected that after staff deposited trash bags in the dirty linen room that they are to wash their hands before leaving the room.