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 12/19/2011

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 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide transportation to scheduled medical appointments for one (2) of four (4) sampled residents. (Residents #1 and Resident #4) The findings are: Resident #1 was admitted to the facility with the diagnoses of Alzheimer's disease, renal failure, diabetes, and hypertension. Review of Resident #1's most recent Minimum Data Set (MDS), dated 11/15/11, revealed she had severe cognitive impairment. The MDS further revealed she was dependent for all care. Review of grievance forms dated 9/13/11 showed Resident #1 had an appointment with her physician on 09/13/11 at 11:30 AM. The form indicated that Resident #1 did not make it to the medical appointment. The family was not notified and was waiting at the physician's office for the resident to arrive. An interview was conducted with LN #1 who cares for Resident #1. She reported that when a resident has a medical appointments scheduled	F 250	Appointments for Resident 1 and Resident 4 were immediately rescheduled and families notified. Corrective action for all residents having the potential to be affected includes restructuring scheduling and transportation and providing increased oversight to assure residents receive medically necessary transportation. Measures include assigning a full-time scheduler who will be responsible for making and confirming all appointments. The scheduler will review all necessary appointments at the time of resident admission and/ or return from appointments. The scheduler will create, disseminate, and maintain transportation logs for all residents to be kept at nurses stations. The scheduler and driver will review the following day's schedule at the close of each day, and the scheduler will update transportation logs at the nurses' stations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Coleonolluse LNHA	Administrator	1/11/12

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.

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JAN 12 2012
BY: ARC

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F 250	Continued From page 1 nursing staff who work with the resident is notified. Then nursing staff informs Guest Services/Transportation of the scheduled medical appointment. Guest Services then makes a master schedule/calendar for the week. This calendar is sent to the nurses on the floors to alert them to the medical appointments scheduled for their residents. The calendar notes the time of the appointment as well as the time to have the resident ready. An interview was conducted on 12/19/11 at 11:30 with the Guest Services Director (GSD) whose primary responsibility is transportation for the facility. The GSD reported that if an appointment is arranged or ordered by a physician they get the information from the nurses. This information is put on a schedule in Guest Services. Guest Services then puts out a master schedule each week. He reported on 09/13/11 Resident #1 was scheduled for her medical appointment at 11:30 AM, locally. He reported another resident was scheduled for an appointment at 10:30 AM about forty-five (45) minutes away. He reported he was unable to get Resident #1 to her appointment as he was still with the other resident at 11:30 AM at their physician's office. He reported he did not notify Resident #1's family who was waiting for her at the physician's office. He further reported he did call the facility to let them know he would not be back in time to take Resident #1 to her appointment. He reported the facility did not notify the family who was waiting at the physician's office. A telephone interview was conducted on 12/19/11 at 2:00 PM with the Senior Care Partner (SCP) whose responsibility was over site and back-up	F 250	The scheduler and the driver will report directly to the Senior Care Partner (SCP). They will meet weekly to review the schedule for the following week. The SCP will assist the scheduler and driver in the event of any scheduling conflicts to assure that appropriate arrangements are made for residents and that families are notified. To monitor and assure that these solutions are sustained, the SCP will review transportation logs daily for four (4) weeks and then weekly for four (4) weeks and then monthly for four (4) months and will report progress to the Administrator daily for four (4)weeks and then weekly for four (4) weeks and then monthly for four (4) months. Regular weekly meetings that include the scheduler, driver, and SCP will be ongoing. Review of scheduling and transportation will be integrated into the facility's monthly Performance Improvement/ Quality Assurance meetings on an ongoing basis.	

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F 250	Continued From page 2 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 for transportation employees to work with the Senior Care Partner to ensure there were no conflicts in the transportation schedule. 2. Resident #4 was admitted to the facility with the diagnoses of diabetes mellitus and hypertension. Review of Resident #4's most recent Minimum Data Set dated 11/19/11 revealed she was cognitively intact and needed minimal assistance with activities of daily living. Review of a grievance form for Resident #4 dated 11/16/11, revealed that Resident #4's family filed a concern when the resident was not transported to a medical appointment on 11/10/11. The facility rescheduled the medical appointment for 11/16/11 but did not transport Resident #4 to that appointment either. The family was not notified and waited at the medical office for two hours. Further review of the grievance form revealed the missed medical appointments were for treatment at an oncology center.	F 250	On weekends and/ or when the SCP is not in the facility, a designee will be appointed to complete oversight monitoring. This may include the Administrator, Weekend Nurse Manager, or Director of Health Services. Completion date is January 16th, 2012.	1/16/12

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F 250	Continued From page 3 Review of a grievance form dated 11/23/11, revealed that Resident #4's family filed a concern regarding transportation to a medical appointment. The facility notified Resident #4's family that they were unable to transport Resident #4 to her medical appointment on 11/23/11 and 11/28/11. The resident was scheduled for another medical appointment on 12/21/11 and the family was told that the facility would not be able to transport the resident. The facility gave the family the time of the appointment as 3:00 PM and told them they would have to transport the resident. When the family called the medical office for confirmation of the appointment they were told the appointment was scheduled for 9:30 AM. An interview was conducted with LN #1 who cared for Resident #4. She reported when a resident had a medical appointment scheduled nursing staff who work with the resident was notified. Then nursing staff informed Guest Services/Transportation of the scheduled medical appointment. Guest Services then made a master schedule/calendar for the week. This calendar would be sent to the nurses on the floors to alert them to the medical appointments scheduled for their residents. The calendar would note the time of the appointment as well as the time to have the resident ready. An interview was conducted on 12/19/11 at 1:15 PM with Resident #4. She reported that the facility got confused on the times of her appointments and was unable to transport her to her medical appointments. A telephone interview was conducted on 12/19/11 at 2:00 PM with the Senior Care Partner (SCP)	F 250		

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F 250	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 medical appointments.	F 250		

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L 170	.2802(A) SOCIAL SERVICES 10A-13D.2802 (a) The facility shall provide medically-related social services to attain or maintain the highest practicable physical, mental and psycho-social well-being of each resident. This Rule Is not met as evidenced by: Based on record review, resident and staff interview, the facility failed to provide transportation services to return a resident to the facility after a scheduled appointment for one (1) of three (3) residents (Resident #2). The findings are: Resident # 2 was readmitted to the Assisted Living section of the facility with diagnoses of Aortocoronary Bypass, General Muscle Weakness, Respiratory Abnormality and Difficulty in Walking. Resident #2 was identified by the Administrator as alert, oriented and interviewable. Review of Resident #2 ' s medical record revealed documented an encounter note by the facility physician on 9/6/2011 which stated in part: " This is an acute visit for Resident #2. I am seeing him today secondary to shortness of breath. The patient did have his cardiac rehabilitation, then went for half-an hour walk, afterward he was very fatigued, lightheaded, and not feeling himself. When I went to see the resident, he was sitting down resting. " 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 "	L 170	One resident was affected by this practice. The Guest Services Director (GSD) providing transportation was late in picking up Resident #2 from an appointment. Resident #2 chose to return to the facility by himself. He is alert and oriented. Upon return, Resident #2 was immediately examined by the Medical Director who was in the facility at the time and interviewed by the Activities of Daily Living Co-coordinator (ADLC) and the Administrator. Resident #2 agreed not to return from appointments by himself but to wait for transportation. The GSD was reprimanded by the Administrator and took responsibility for the delay. Corrective action for all residents having the potential to be affected includes restructuring scheduling and transportation and providing increased oversight to assure residents receive medically necessary transportation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Colonoglou, LNHA TITLE Administrator (X6) DATE 1/11/12

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L 170	Continued From page 1 Resident #2 was interviewed on 12/19/2011 at 10:35 AM and revealed the facility ' s Guest Service Director (GSD) transported him to and from his medical appointments. Licensed Nurse #1 was interviewed on 12/19/2011 at 10:45 AM and revealed that Resident #2 walked back to the facility following his physical therapy on 9/6/2011 when the facility transportation did not go back to the hospital to get him. On 12/19/2011 at 12:00 PM the Activities of Daily Living Co-coordinator #1 (ADLC) was interviewed and stated on Tuesday, September 6, 2011 she took a call in her office from the Hospital Rehabilitation Department that Resident #2 had not been picked up as scheduled after his therapy. ADLC #1 was not sure about the time of the call. ADLC #1 further stated when she received the call from the hospital; she paged the GSD several times and was finally able to contact him through another staff member. ADLC #1 reported that GSD said he was in a meeting and forgot to pick Resident #2 up from his appointment. During continued interview ADLC #1 revealed once the GSD was contacted he started out the front of the facility to go to the hospital but Resident #2 was coming up the walkway. ADLC #1 revealed she was asked to go to Resident #2 ' s room to see if he was all right. ADLC #1 reported she observed Resident #2 to be out of breath and " shaken up " but he told her he was all right. An interview was conducted with the GSD at 12:30 PM on 12/19/2011. GSD stated he had been transporting residents since June or July and that Resident #2 had a regularly scheduled	L 170	Measures include assigning a full-time scheduler who will be responsible for making and confirming all appointments. The scheduler will review all necessary appointments at the time of resident admission and/ or return from appointments. The scheduler will create, disseminate, and maintain transportation logs for all residents to be kept at nurses stations. The scheduler and the driver will report directly to the Senior Care Partner (SCP). They will meet weekly to review the schedule for the following week. The SCP will assist the scheduler and driver in the event of any scheduling conflicts to assure that appropriate arrangements are made for residents and that families are notified. To monitor and assure that these solutions are sustained, the SCP will review transportation logs daily for four (4) weeks and then weekly for four (4) weeks and then monthly for four (4) months and will report progress to the Administrator daily for four (4)weeks and then weekly for four (4) weeks and then monthly for four (4) months.	

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L 170	Continued From page 2 appointment every Tuesday and Thursday at 9:00 AM for physical therapy at the local hospital. During further interview GSD revealed he had dropped Resident #2 off for his 9:00 AM appointment on 9/6/2011 but was not sure how late he went to pick him up after the appointed time of 10:00 AM. The GSD stated he was caught up in work and forgot to go back and pick up Resident #2 from his appointment at 10:00 AM and stated he took responsibility for not having picked him up as scheduled. On 12/19/2011 at 2:00 PM the Senior Care Partner (SCP) confirmed her role was oversight and backup with facility transportation since August 2011. She further stated she should be looking over the transportation schedules and making sure appointments have not been overscheduled but she had not been doing it. The Administrator was interviewed on 12/19/2011 at 2:10 PM and revealed that the GSD was the primary transporter and their system was not working very well and did not " flow " as it should. The Administrator further stated that her expectations were the Senior Care Partner (SCP) should be over looking the schedule to see if it was " doable " and communicating with the transporters, Dr. offices and any families involved in the medical appointment schedules any changes. In a follow-up interview on 12/19/2011 at 3:30 PM, Resident # 2 confirmed he had walked back from his appointment at the Hospital to the facility on Tuesday (9/6/2011) and he had walked on the back road from the hospital to the facility. On 12/19/2011 at 4:30 PM the back road route where Resident #2 stated he had walked was	L 170	Regular weekly meetings that include the scheduler, driver, and SCP will be ongoing. Review of scheduling and transportation will be integrated into the facility's monthly Performance Improvement/ Quality Assurance meetings on an ongoing basis. On weekends and/ or when the SCP is not in the facility, a designee will be appointed to complete oversight monitoring. This may include the Administrator, Weekend Nurse Manager, or Director of Health Services. Completion date is January 16th, 2012.	1/16/12

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L 170	Continued From page 3 observed to be approximately .8 miles long.	L 170		