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	345462	A. BUILDING _____ B. WING _____	09/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS-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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews and record review, the facility failed to permit Resident #198 entry into the main dining room during a meal for 1 of 1 residents observed for choices. Findings included: Resident #198 was admitted to the facility on 09/19/14 with diagnoses including gastrointestinal hemorrhage, dementia, atrial fibrillation and anxiety. His initial Minimum Data Set (MDS) assessment had not been completed as of 09/24/14 as he was newly admitted on the 09/19/14. The initial care plan initiated at the time of admission revealed resident was to remain a long term care resident. The goal for transition to long term care was to be shown with acceptance of care and participation in facility activities. An intervention included encouragement to participate in activities. Review of Resident #198's medical record revealed nursing notes documenting that Resident #198 was noted as having agitation when he attempted to get up, and at night when	F 242	The Oaks □ Brevard is committed to upholding the highest standards of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation with the State of North Carolina Department of Health toward the best interest of those who require the services we provide. While this Plan of Correction is not to be considered an admission of validity of any findings, it is submitted in good faith as a required response to the survey conducted September 22-25, 2014. This Plan of Correction is the facility□s recognition of compliance with Federal and State requirements. F 242 Patient was fed meal in his room on 9/24/14. Resident now eats in the dining room. Dietary Manager and Social Services will interview all residents about their dining	10/23/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/17/2014

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F 242	Continued From page 1 he wanted to go home. There was no documentation in Resident #198's medical record of any agitation in the main dining room. A facility form entitled, "Admission/Nursing Observations Form" dated 9/17/14 reported Resident #198 ambulates with assistance, he is at risk for falls, aspiration, and elopement, needs assistance with eating, has trouble swallowing, and is on Honey thick liquids & pureed diet. During an observation of the main dining room on 09/24/14 at 12:34 PM revealed nurse #4 brought resident #198 into the dining room for the noon meal. She was stopped by Nurse #3 who told her to take Resident #198 back to his room. Further observation revealed Nurse #3 was not assisting a resident in the dining room and there were 2 tables with space for Resident #198 in his geri chair to be accommodated and assisted with his noon meal. During an interview on 09/24/14 with Nurse #3 at 12:37 PM stated Resident #198 had behaviors and had to be assisted with his meals and they did not have enough staff to assist Resident #198. During an interview on 09/24/14 with the Nurse Aide at 12:42 PM who was caring for Resident #198 stated Resident #198 usually eats his meals in the dining room and usually eats well. The NA further stated the resident's family had just arrived and they were attempting to assist Resident #198 with his meal with difficulty. During an interview on 09/24/14 with Resident #198's family at 12:51 PM reported that Resident #198 enjoyed people and it was her preference for Resident #198 to eat in the dining room unless	F 242	location preference to ensure they are eating where they prefer. Education completed with Nurse #3 regarding resident choices and accommodating resident preferences. Staff educated on resident choices and accommodating the choices they make. Dietary Manager will ask new residents their dining location preference when completing food preferences. New Hires/Transfers will be educated in orientation on the importance of allowing residents to choose. Audits of 5 residents will be done daily by the dietary manager, social services director, and/or weekend coordinator for four weeks, then weekly times four weeks, then monthly times 3 months. Audit results will be reported to the Performance Improvement Committee for further recommendations if needed. Interdisciplinary team will interview 40 residents or resident families quarterly regarding resident choices through the Abaqis process. The results of the resident/family interviews regarding choices will be reported to the PI Committee for further recommendations if needed.	

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F 242	Continued From page 2 he was agitated. During an interview on 09/24/14 with Nurse #4 at 1:09 PM stated Nurse #3 had told her there was no room for Resident #198 to eat in the dining room. During an interview on 09/24/14 with the Director of Nursing (DON) at 1:20 PM stated if a resident wants to eat in the dining room then it is his right to do so. There was no reason Resident #198 could not have eaten in the dining room. The DON further stated if a resident had behaviors in the dining room then they can be removed from the dining room. The DON stated it was her expectation that Resident #198 should have been accommodated and assisted with eating his meal in the dining room.	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to place a resident's call light within reach for 1 of 1 residents reviewed for accommodation of needs. (Resident #82).	F 246	F246 Call light was placed within the reach of resident. A longer length call light cord was ordered and placed in residents room on day of delivery 10/15/14 by the Maintenance Director to ensure the call	10/23/14

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F 246	Continued From page 3 The findings included: Resident #82 was readmitted to the facility 05/15/14 with diagnoses which included dysphagia, esophageal stricture, difficulty walking, chronic pain, and multiple vertebral compression fractures. A quarterly Minimum Data Set (MDS) dated 08/24/14 indicated the resident had moderately impaired cognition, makes herself understood, and was able to understand others. The MDS specified the resident required limited staff assistance with walking in hallway, transfers, dressing, and hygiene and had no falls since the previous assessment. The MDS documented the resident's weight was 84 pounds. An observation of Resident #82's room was conducted on 09/22/14 at 4:29 PM. Her bed was positioned with the side of the bed against the side wall of the room and the head of the bed against the back wall. Resident #82 was observed sitting in an easy chair that was positioned in front of the back wall of the room. The resident's call light was observed on foot of her bed which was approximately 5 feet from the easy chair. During this observation on 09/22/14, an interview was conducted with Resident #82. She acknowledged her call light was on the foot of her bed and stated she was unable to reach it from her easy chair. An observation on 09/23/14 at 12:56 PM revealed Resident #82 was sitting in her easy chair in her room eating lunch. The lunch tray was observed on an overbed table located in front of her chair. Her call light was observed over the foot of her	F 246	light would reach the patients recliner. Audit was conducted of each resident room to ensure call light in reach of patients by nursing administration. Partners educated by the Clinical Compliance Coordinator on ensuring call light is in reach of resident before the partner exits the resident□s room. 15 resident rooms will be audited to ensure call light is within reach by the interdisciplinary leadership team weekly for four weeks, then monthly for 3 months. Audit results will be reported to the Performance Improvement Committee for further recommendations if needed.	

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F 246	Continued From page 4	F 246		

bed which was approximately 5 feet from the resident.

An additional observation on 09/23/14 at 3:47 PM revealed Resident #82 was sitting in the easy chair in her room. Her call light continued to be across the foot of her bed and not within reach of the resident.

An observation on 09/24/14 at 8:23 AM revealed Resident #82 was sitting in her easy chair in her room with her breakfast tray on an overbed table placed in front of the easy chair. Her call light remained over the foot of her bed approximately 5 feet from the resident.

An interview with Nurse Aide (NA) #1 was conducted on 09/24/14 at 10:03 AM. Na #1 stated Resident #82 preferred to sit in her easy chair during the day. The nurse aide stated the resident's call light was usually attached to a curtain or some object close to the resident when she was in her easy chair. NA #1 was unaware the call light had not been accessable to the resident over the past 3 days.

An observation was conducted on 09/24/14 at 3:06 PM. NA #2 and another nurse aide that was just starting the evening shift were observed leaving Resident #82's room. At this time, the resident's call light was observed over the foot of her bed while the resident sat in the easy chair.

An interview was conducted with NA #2 on 09/24/14 at 3:12 PM. NA #2 stated Resident #82's call light was usually attached to the curtain or wherever the resident wanted it when she was sitting in the easy chair. NA #2 added the call light cord was long enough to reach the resident

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F 246	Continued From page 5 when she was in the easy chair and Resident #82 was capable of using the call light. NA #2 was unaware the call light was not accessable to the resident at this time. An interview was conducted with Unit Manager (UM) #1 on 09/24/14 at 3:24 PM. UM #1 stated Resident #82's call light should be assessable to her while she was sitting in the easy chair. An interview was conducted with the Director of Nursing (DON) on 09/24/14 at 3:32 PM. The DON acknowledged Resident #82 was ambulatory within her room and that she sat in her easy chair most of the day. The DON stated she expected the call light to be accessable to this resident when she was in the chair as well as in the bed.	F 246		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or 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 label and date/discard outdated food/liquids in 2 of 2 nourishment rooms. The findings included:	F 371	F371 The undated/unlabeled food and liquids were thrown away immediately by the	10/23/14

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F 371	Continued From page 6 1. On 09/24/14 at 3:10 PM, an observation of the 200 hall nourishment room revealed Haagen dazs ice cream was open but not labeled or dated in the freezer. One blue frugal backpack water bottle with 20 ounces of water in bottle with no name or date and a McDonald ' s large drink cup with liquid and straw in cup not labeled or dated in pantry. During an interview on 09/24/14 at 3:42 PM with Nurse #2 stated dietary and nursing staff are responsible for making sure things in the nourishment room are labeled and dated. During an interview on 09/24/14 at 3:45 PM with the Dietary Manager reported dietary staff take the stock out of the nourishment rooms in the evening, housekeeping staff checks to make sure nothing is out of date and the nourishment rooms are clean. She further reported nursing staff make were to make sure items in the nourishment rooms were labeled when they were opened and labeled. During an interview on 09/24/14 at 3:49 PM with the housekeeper stating housekeeping staff clean the nourishment rooms twice a day but they only check to see if items are dated and labeled sometimes. During an interview in the 200 hall nourishment room on 09/24/14 at 3:55 PM with the Director of Nursing (DON) revealed all items in the nourishment room should be for the residents only and not for staff. She further stated the dietary department was responsible for stocking the nourishment rooms and the housekeeping department cleaned the nourishment rooms. The DON stated the items should not be in there and she threw the items away. The DON stated it was her expectation items in the nourishment room should be labeled and dated and for the residents only.	F 371	DHS on 9/24/14. All nourishment rooms were inspected and any unlabeled/undated food and/or liquids were disposed of properly. Partners educated by the Clinical Compliance Coordinator on proper labeling and storage for nourishment rooms. Visual reminders to label and date patient food added to front of nourishment refrigerators on 10/15/14. The refrigerators in the nourishment rooms will be added to the daily housekeeping cleaning schedule. Housekeeping staff have been educated to monitor for and discard undated and unlabeled item when found, if any. Nourishment rooms will be added to the Interdisciplinary Leadership team□s grand rounds to be checked weekly for four weeks, then monthly for 3 months. Audit results will be reported to the PI Committee for further recommendations if needed.	

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F 371	Continued From page 7	F 371		

During an interview with the Administrator on 09/25/14 at 12:54 PM stated he felt the nourishment rooms were definitely something that the facility definitely needed to fix.

2. On 09/29/14 at 3:23 PM, an observation of the 400 hall nourishment room revealed cookies on the bottom shelf of the pantry opened with no label or date. The refrigerator had a 12 ounce can of Pepsi open sitting on top shelf open with no name or date, a sandwich wrapped in tinfoil and in a sandwich plastic bag on the third shelf with no name or date and a 5 pack of 16 ounce diet coke bottles not labeled.
During an interview on 09/24/14 at 3:42 PM with Nurse #2 stated dietary and nursing staff are responsible for making sure things in the nourishment room are labeled and dated.
During an interview on 09/24/14 at 3:45 PM with the Dietary Manager reported dietary staff take the stock out of the nourishment rooms in the evening, housekeeping staff checks to make sure nothing is out of date and the nourishment rooms are clean. She further reported nursing staff make were to make sure items in the nourishment rooms were labeled when they were opened and labeled.
During an interview on 09/24/14 at 3:49 PM with the housekeeper stating housekeeping staff clean the nourishment rooms twice a day but they only check to see if items are dated and labeled sometimes.
During an interview in the 400 hall nourishment room on 09/24/14 at 3:55 PM with the Director of Nursing (DON) revealed all items in the nourishment room should be for the residents only and not for staff. She further stated the dietary department was responsible for stocking the nourishment rooms and the housekeeping

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F 371	Continued From page 8 department cleaned the nourishment rooms. The DON stated the items should not be in there and she threw the items away. The DON stated it was her expectation items in the nourishment room should be labeled and dated and for the residents only. During an interview with the Administrator on 09/25/14 at 12:54 PM stated he felt the nourishment rooms were definitely something that the facility definitely needed to fix.	F 371		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		10/23/14

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F 520	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, and record reviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions that the committee put in place in August of 2013. This was for the one recited deficiency that was originally cited in July 2013 on a Recertification survey, and were subsequently recited in September of 2014 on the current recertification survey. The deficiency was in the area of choices. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. Findings included: This tag is cross referenced to: 1. F 242: Choices: Based on observations, family and staff interviews, and record reviews the facility failed to permit Resident #198 entry into the main dining room during a meal for 1 of 1 residents observed for choices. During the recertification survey of July 2013, the facility was cited for F242 for failing to honor a resident's choice for frequency of bathing. On the current survey the facility was again cited for choices for failing to allow the resident the choice to eat in the main dining room. During an interview on 09/25/14 at 1:15 PM, the Administrator stated he was in charge of the Quality Assessment and Assurance (QAA) meetings. He indicated the meetings were held on a monthly basis. The Administrator revealed he was not working at the facility during their last survey. He acknowledged the QAA process was an on-going process and the plan of correction	F 520	F 520 Performance improvement plan has been implemented for the resident identified in Tag F242 to ensure compliance with the identified deficient practice. No other residents have been identified to have been affected by the alleged deficient practice. Partners educated by the Clinical compliance coordinator on the purpose and function of the PI Committee. Monitoring tools being utilized for F242 will be given to the Administrator and the Director of Health Services as they are completed. Administrator and Director of Health Services will review audits on a weekly, then monthly basis for deficiencies. Audits will be reported to the Performance Importance Committee. Interdisciplinary team will interview 40 residents or resident families quarterly regarding resident choices through the Abaqis process. The results of the resident/family interviews regarding choices will be reported to the PI Committee for further recommendations if needed. The PI Committee will continue to meet monthly to ensure plans are being monitored as proposed for effectiveness	

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F 520	Continued From page 10 remained on-going for choices. He stated the staff should be aware of all resident rights, and does not know why the QAA process did not work for the choice issue. The Administrator acknowledged teaching of the staff would continue.	F 520		