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 10/22/2015

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 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 keep food preparation equipment clean and failed to date an opened container of a supplemental beverage. The findings included: 1. Observations of the facility's kitchen on 10/19/15 from 9:05 AM to 9:30 AM revealed the following concerns of food preparation equipment not being clean: a. Observations on 10/19/15 at 9:15 AM of the kitchen's convection oven revealed the oven's inner cooking compartment and glass doors were very unclean with accumulated dried residues and burnt on food spills. Interview with the facility's Dietary Manager (DM) on 10/19/15 at 9:15 AM confirmed the kitchen's convection oven was not clean. The DM stated staff were directed to clean the convection oven once a month and to wipe the oven out in between cleanings. The DM was unsure when the convection oven was last cleaned by staff.	F 371	The Oaks – Brevard is committed to upholding the highest standards of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation with the State of North Carolina Department of Health and Human Services toward the best interest of those who require the services we provide. 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 October 19-22, 2015. This Plan of Correction is the facility's recognition of compliance with Federal and State requirements. F371 1. The convection oven was cleaned and the knives were removed from the knife rack and rewashed by the Dietary Manager on 10/19. The stove top and	11/19/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/08/2015

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 10/22/2015

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 371	Continued From page 1 Further interview with the facility's DM on 10/21/15 at 8:15 AM revealed the kitchen's convection oven was last cleaned by staff on 09/29/15. The DM stated to keep the convection oven cleaner it would be placed on the kitchen's weekly cleaning schedule. b. Observations on 10/19/15 at 9:18 AM of the kitchen's stove top and the stove's metal back splash revealed they were unclean with accumulated dried substances and blackened food spills. Interview with the facility's Dietary Manager (DM) on 10/19/15 at 9:18 AM confirmed the stove top and the stove's metal back splash were not clean. The DM stated that the stove top and the back splash were scheduled to be cleaned every month by staff and wiped down in between cleanings. The DM was unsure when the last time the stove top and metal back splash were cleaned by staff. Further interview with the facility's DM on 10/21/15 at 8:15 AM revealed the kitchen's stove top and metal back splash were last cleaned by staff on 09/29/15. The DM stated to keep the stove top and back splash cleaner they would be placed on the kitchen's weekly cleaning schedule. c. Observations on 10/19/15 at 9:25 AM revealed a knife, stored in the kitchen's knife rack, was unclean with dried substances on its cutting blade. Interview with the facility's Dietary Manager (DM) on 10/19/15 at 9:25 AM confirmed the knife was not clean and that staff should make sure knives are clean prior to storing them for use. 2. Observations on 10/19/15 at 9:35 AM of the facility's 500 Hallway Nourishment Room	F 371	back splashed were cleaned by the Dietary Manager by 11/16/15. The undated container of supplement found in the nourishment room refrigerator was disposed of by the Director of Health Services on 10/19. 2. All food preparation equipment was inspected by the Dietary Manager on 10/19 and found to be in compliance. All nourishment room refrigerators were checked by the Director of Health Services and Director of Environmental Services on 10/19 and found to be in compliance with no opened and undated products. 3 a. Cooks and Dietary Aides were educated on the importance of keeping food preparation equipment clean by the Dietary Manager. Cleaning schedule for food preparation equipment was changed from monthly to weekly and as needed when determined by the cook or dietary manager. b. Nurses and CNAs were educated by the Clinical Competency Coordinator on dating open containers placed in the nourishment room refrigerators. Visual reminders to label and date open items will remain in place on the refrigerator door. 4.Food preparation equipment and nourishment room. refrigerators will be inspected weekly for 4 weeks then twice a month for 4 weeks, and then monthly for 3 months, by the Dietary Manager, Administrator, or Consultant Dietician until	

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 10/22/2015

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 371	Continued From page 2 revealed an opened 32 ounce container of a high protein supplemental beverage was stored in the nourishment room's refrigerator. The opened container was observed to contain approximately 24 ounces of supplement, but there was no date on the container to specify when it was opened by staff. Interview with the facility's Director of Nurses (DON) on 10/19/15 at 9:38 AM confirmed the opened container of high protein supplement was not dated when opened by staff. The DON stated that staff is directed to date supplemental beverages when they are opened and prior to placing them into refrigeration storage. Interview with the facility's Dietary Manager on 10/21/15 at 4:15 PM revealed staff should date supplemental beverages when they are opened and before storing them in nourishment room refrigerators.	F 371	compliance is achieved consistently. The results of the audits with tracking and trending will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the dietary manager for review and recommendations if necessary.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		11/18/15

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 10/22/2015

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 425	Continued From page 3 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to obtain a physician ordered medication from the pharmacy for 1 of 6 residents reviewed for medication administration (Resident #185). The findings included: Resident #185 was admitted to the facility on 09/17/15 with diagnoses that included but was not limited to anxiety, hip surgery, and bipolar disorder. The admission Minimum Data Set dated 09/22/15 indicated Resident #185 was cognitively intact. Resident #185 was discharged from the facility against medical advice on 09/21/15. Review of the admission orders dated 09/17/15 revealed Resident #185 was admitted to the facility with orders that included Risperidone 3 milligrams (mg) every evening at 9:00 PM. Review of the Medication Administration Record (MAR) for September 2015 indicated Resident #185 was ordered Risperidone 3 mg every evening at 9:00 PM. Documentation on the MAR also revealed that on the dates of 09/17/15, 09/18/15, and 09/19/15, Resident #185 did not receive the Risperidone medication as it was ordered.	F 425	1.Resident #185 left the facility against medical advice on 9/21/15. 2. A 100% Audit was conducted by Director of Health Services and Clinical Competency Coordinator to identify if residents of the facility had received medications from pharmacy timely. 3. The Consultant Pharmacist and Clinical Competency Coordinator educated license nursing staff on steps to take if medications do not arrive from the pharmacy and noting non arrivals on the 24 hour report by 11/18/15. The members of the clinical morning meeting, including the RN Unit Manager, Director of Health Services, Social Services Director, Case Max Nurses, RN Senior Care Partner, and Administrator will review the previous day□s new resident admissions daily Monday □ Friday to ensure medications have arrived or that back up procedures have been initiated. The RN Weekend Manager will review on weekends. 4. Medication arrival will be audited weekly for 4 weeks then twice a month for 4 weeks, and then monthly for 3 months,	

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 10/22/2015

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 425	Continued From page 4 On 10/20/15 at 3:30 PM an interview was conducted with the Director of Nursing (DON). She stated she did not know why the order for Risperidone 3 mg at 9:00 PM was not administered to Resident #185 on 09/17, 09/18, and 09/19. The DON stated she would get the information. On 10/20/15 at 4:05 PM an interview was conducted with the DON. She revealed she checked with the facility pharmacy provider and the Risperidone medication was not delivered with Resident #185's medication on 09/17/15. She stated the medication was not available at that time, and was delivered to the facility on 09/20/15. The DON indicated it was her expectation when a medication was not available from the facility pharmacy provider, the nurse administering the medication should call the resident's physician and get an order to hold the medication until available, or get an order to obtain the medication from the facility's back-up pharmacy. She stated in this case, neither of these options were initiated. On 10/21/15 at 9:30 AM an interview was conducted with the DON. She stated the primary pharmacy the facility used to obtain medications had changed since 09/20/15. She revealed the back-up pharmacy used by the facility was a local pharmacy, and the facility could usually get any medications immediately that were needed. On 10/21/15 at 10:00 AM an interview was conducted with Nurse #2. She stated she was on duty during the evenings of 09/17/15, 09/18/15, and 09/19/15. She indicated it was her initials on the MAR to document Resident #185 did not get her Risperidone. Nurse #2 revealed she did not	F 425	by the RN Unit Manager, Clinical Compliance Coordinator, Director of Health Services, or Pharmacist until 100% compliance is achieved. The results of the audits with tracking and trending will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by nursing administration for review and recommendations if necessary.	

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 10/22/2015

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 425	Continued From page 5	F 425		

give Resident #185 the medication because it was not available. She confirmed she called the facility pharmacy and was told the medication would be sent when they received an anti-psychotic medication form with the diagnosis for the medication and a doctor's signature. Nurse #2 revealed the pharmacy was supposed to fax her the form, but she stated she did not receive it. She confirmed the Risperidone was available for Resident #185 on her fourth night in the facility and was issued. She stated she did not notify the facility physician because Resident #185 asked for her Valium medication that was ordered on an as needed basis, in place of the Risperidone that was unavailable. Nurse #2 indicated she did not call the physician to see if the Risperidone could be held until it was available, or get an order to obtain the medication locally.

On 10/22/15 at 8:45 AM an interview was conducted the Nurse Practitioner (NP). She indicated there were systems in place for the facility to obtain medication that was not available from the facility pharmacy provider. She stated the nurses should notify the physician or NP to get an order to obtain the medication from a local pharmacy, or hold the medication until available. The NP stated it was missed in this case and those steps were not initiated. She revealed that Resident #185 did not suffer any ill effects from the missed doses of Risperidone.

On 10/22/15 at 10:10 AM an interview was conducted with the DON. She stated the physician should have been notified that the medication was not available. The DON confirmed the nurse should notify the physician when a medication is unavailable from the facility

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 10/22/2015

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 425	Continued From page 6 pharmacy and get a order to hold the medication until available, or get an order to obtain the medication locally.	F 425		
F 431 SS=E	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 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.	F 431		11/18/15

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 10/22/2015

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 431	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility failed to maintain the refrigerator temperature between 36 and 46 degrees Fahrenheit (F) in 1 of 3 medication refrigerators, failed to remove expired over the counter (OTC) medications from 1 of 3 medication rooms and failed to remove expired medication from 1 of 6 medication carts. The findings included: Review of a policy titled "Medication Storage in the Healthcare Centers" with a revised date of 01/23/15 read in part: "Medications requiring refrigeration are stored at temperatures between 36 and 46 degrees F and are kept in a refrigerator with a thermometer to allow temperature monitoring. Outdated, contaminated or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy, if a current order exists. 1. Inspection of the medication storage room on the Memory Care Unit on 10/22/15 at 8:35 AM revealed the temperature of the refrigerator used to store medications was 32 degrees F. The following medications were stored in the refrigerator: 5 Novolog insulin flexpens, 8 Levemir insulin flexpens, 1 vial Novolog insulin, 3 bottles Latanoprost eye drops (used to treat glaucoma). A heavy accumulation of ice was observed on the	F 431	Refrigerator thermostat was adjusted to maintain a temperature between 36 and 46 degrees by the maintenance director. Expired medications were destroyed by the Director of Health Services. A 100% audit was conducted by the Director of Health Services and the Clinical Competency Coordinator of all medication rooms, medication refrigerators, and medication carts. All medication rooms, refrigerators, and medication carts were found to be in compliance. Consultant pharmacist and clinical competency coordinator educated license nursing staff on the importance of maintaining a 36-46 degree temperature of the medication refrigerator and the importance of discarding medications on the expiration date. Consultant pharmacist and/or Clinical Competency Coordinator also re-educated all licensed nursing staff on the facility policy and procedures regarding medication destruction and storage by 11/18/15. A new temperature log was placed on all medication refrigerators with the recommended temperature range noted on the log and directions to call maintenance if the temperature is above or below the needed range. Medications in the med room will now have the expiration date marked on	

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 10/22/2015

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 431	Continued From page 8 freezer section of the refrigerator. A review of manufacturer's instructions for the storage of the insulin and Latanoprost indicated unopened containers should be refrigerated between 36 and 46 degrees F. A review of the facility's temperature logs for the medication room refrigerator on the Memory Care Unit revealed the temperature had been below 36 degrees F from 09/01/15 through 10/21/15 with the lowest temperature of 30 degrees F on 09/01/15 and 10/05/15. There were 24 dates during that time when the recorded temperature was 32 degrees F. There was no indication on the logs that the temperature was adjusted or that the maintenance director was notified. There were no parameters listed on the logs of the required temperature range. An interview with Nurse # 1 on 10/22/15 at 8:40 AM revealed she was not aware of the required range for the temperature of the medication refrigerator on the Memory Care Unit. Nurse #1 stated the nurse working the 11:00 PM to 7:00 AM shift checked the temperature every night. Nurse # 1 confirmed the log did not have parameters listed for the required temperature range. An interview with the Director of Nursing (DON) on 10/22/15 at 9:03 AM revealed the nurse working the 11:00 PM to 7:00 AM shift was responsible for checking the temperature of the medication room refrigerator every night. The DON stated any variation in the temperature outside the required range of 36 to 46 degrees F should be reported to the maintenance director. The DON looked in the medication room and	F 431	the top of the packaging for medication to make expiration dates easier to identify. New hires will be oriented on these processes during new hire orientation by the Clinical Competency Coordinator. All medication carts and medication rooms will be audited weekly for 4 weeks then twice a month for 4 weeks, and then monthly for 3 months, by the RN Unit Manager, Clinical Compliance Coordinator, Director of Health Services, or Pharmacist until compliance is achieved consistently. The results of the audits with tracking and trending will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by nursing administration for review and recommendations if necessary.	

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 10/22/2015

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 431	Continued From page 9	F 431		

didn't find any information posted on the required parameters for the temperature range of refrigerated medications.

An interview with the Administrator on 10/22/15 at 10:59 AM revealed he expected the nurses to notify the maintenance director if the temperature of the medication refrigerator was outside the required range.

2. Inspection of the medication storage room on the Memory Care Unit on 10/22/15 at 8:45 AM revealed the following expired medications in the cabinet used to store OTC medications:
a. 1 unopened 12 ounce bottle of Milk of Magnesia with an expiration date of August 2015
b. 1 opened, partially used bottle of Cranberry Extract capsules with an expiration date of April 2015
c. 4 unopened 16 ounce bottles of Acetaminophen liquid - 3 bottles had an expiration date of September 2015 and 1 bottle had an expiration date of July 2015
d. 4 opened, partially used 60 tablet bottles of Simethicone 125 milligrams (mg) with an expiration date of August 2015
e. 1 opened, partially used 100 tablet bottle of Simethicone 80 mg with an expiration date of May 2015
There was no other Milk of Magnesia, Cranberry Extract, Acetaminophen liquid or Simethicone available for use that wasn't expired.

An interview with the DON on 10/22/15 at 9:03 AM revealed the nurse who works the 11:00 PM to 7:00 AM shift on Sunday nights is assigned responsibility for checking the medication room for expired medications every Sunday night. The DON stated her expectation was that expired

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 10/22/2015

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 431	Continued From page 10	F 431		

medications were discarded. The DON stated there should not have been any opened OTC medication in the storage cabinet in the medication room. She stated opened, OTC medications should be in the medication cart.

An interview with the Administrator on 10/22/15 at 10:59 AM revealed he expected the weekly checks of the medication room and medication cart to be done and for expired medications to be discarded. He further stated he expected all the nurses using the medication cart to be checking for expired medications and to notify the DON or Staff Development Coordinator of any expired medications.

3. Inspection of the medication cart on the Memory Care Unit on 10/22/15 at 9:55 AM revealed 1 unopened bottle of sterile water with an expiration date of 03/01/15. There was no other sterile water in the medication cart available for use.

An interview on 10/22/15 at 9:00 AM with Nurse #1 revealed the sterile water was used to reconstitute (mix) injectable Geodon.

An interview with the DON on 10/22/15 at 9:03 AM revealed the nurse who works the 11:00 PM to 7:00 AM shift on Sunday night was assigned responsibility for checking the medication cart for expired medications every Sunday night. The DON stated there should not have been any expired medication in the medication cart.

An interview with the Administrator on 10/22/15 at 10:59 AM revealed he expected the weekly checks of the medication room and medication cart to be done and for expired medications to be

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 10/22/2015

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 431	Continued From page 11 discarded. He further stated he expected all the nurses using the medication cart to be checking for expired medications and to notify the DON or Staff Development Coordinator of any expired medications.	F 431		
F 520 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility's Quality Assessment	F 520	Members of the QAPI committee will be educated by a corporate consultant.	11/18/15

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 10/22/2015

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 520	Continued From page 12 and Assurance (QA and A) Committee failed to maintain implemented procedures and monitor the interventions that the committee put in place in September of 2014. This was for one deficiency that was cited in September 2014 on a recertification survey. This deficiency was re-cited on the current recertification survey. The deficiency was in the area of Food Procurement, Storage, Preparation and Distribution. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: F 371: Food Procurement, Storage, Preparation and Distribution: Based on observations and staff interviews the facility failed to keep food preparation equipment clean and failed to date an opened container of a supplemental beverage. During the recertification survey of September 2014, the facility was cited for F 371 for failure to date and label food and opened beverages in 2 nourishment refrigerators. On the current survey the facility was cited for failing to date an opened container of a supplemental beverage in a nourishment refrigerator and failing to keep food preparation equipment clean. During an interview on 10/22/15 at 10:44 AM with the Administrator, he was asked what he thought contributed to continued problems with food storage and kitchen sanitation. The Administrator stated he thought they needed to look at the cleaning schedule and if it wasn't sufficient to keep the food preparation equipment clean, they needed to make adjustments and re-educate	F 520	The convection oven was cleaned and the knives were removed from the knife rack and rewashed by the Dietary Manager on 10/19. The stove top and back splashed were cleaned by the Dietary Manager by 11/16/15. The undated container of supplement found in the nourishment room refrigerator was disposed of by the Director of Health Services on 10/19. All food preparation equipment was inspected by the Dietary Manager on 10/19 and found to be in compliance. All nourishment room refrigerators were checked by the Director of Health Services and Director of Environmental Services on 10/19 and found to be in compliance with no opened and undated products. Cooks and Dietary Aides were educated on the importance of keeping food preparation equipment clean by the Dietary Manager. Cleaning schedule for food preparation equipment was changed from monthly to weekly and as needed when determined by the cook or dietary manager. Nurses and CNAs were educated by the Clinical Competency Coordinator on dating open containers placed in the nourishment room refrigerators. Visual reminders to label and date open items will remain in place on the refrigerator door. Food preparation equipment and nourishment room refrigerators will be inspected weekly for 4 weeks then twice a month for 4 weeks, and then monthly for 3 months, by the Dietary Manager,	

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 10/22/2015

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 520	Continued From page 13 staff. The Administrator stated there was a sign on all the nourishment refrigerators to label and date all items put in the refrigerator so he felt there was a break down with a nurse not following expectations. When asked if the facility had recently done any monitoring of the kitchen or nourishment refrigerators, he stated they monitored both areas for several months and didn't identify any problems so they hadn't done any recent monitoring.	F 520	Administrator, or Consultant Dietician until compliance is achieved consistently. The results of the audits with tracking and trending will be reported to the Quality Assurance Performance Improvement Committee (QAPI) by the dietary manager for review and recommendations if necessary. Corporate oversight will occur of the QAPI meetings monthly for 3 months. Additional recommendations and coaching will be provided based upon the outcomes of these meetings.	