

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/25/2016
NAME OF PROVIDER OR SUPPLIER THE OAKS-BREVARD			STREET ADDRESS, CITY, STATE, ZIP CODE 300 MORRIS ROAD BREVARD, NC 28712		
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F 166 SS=E	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident's family members and staff the facility failed to follow up on grievances made by the family of Resident #1 and failed to resolve ongoing complaints about fresh ice water not being provided on a consistent and regular basis throughout the day (Resident #1).</p> <p>The findings included:</p> <p>1. Resident #1 was first admitted to the facility on 08/06/08 and readmitted on 09/24/15 with diagnoses which included transient ischemic attacks, hypertension, chronic obstructive pulmonary disease, bipolar disorder and malignant neoplasm of prostate. An annual Minimum Data Set (MDS) assessment dated 04/11/16 indicated Resident #1 had moderate cognitive impairment for daily decision making and had no delirium, psychosis, behavioral symptoms or rejection of care. The MDS indicated he required limited assistance with activities of daily living (ADL) except eating for which he required supervision. The MDS indicated he was occasionally incontinent of bladder and always continent of bowel.</p> <p>The care plan for Resident #1, which was last updated on 04/15/16, addressed his need for</p>	F 166	<p>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.</p> <p>This plan of correction constitutes a written allegation of compliance, Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.</p> <p>F166 Right to Prompt Efforts to Resolve Grievances</p> <p>Corrective action for those residents to have been affected. The grievance log was reviewed by the Administrator and all grievances logged</p>	5/4/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/04/2016

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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F 166	<p>Continued From page 1</p> <p>assistance with ADL and history of refusal or forgetting to change soiled clothing and history of refusal to take showers. The interventions were appropriate to address his needs and included: shower as scheduled and as needed, notify nurse if resident refuses assistance with showers, incontinence care after each episode, assist with toileting as needed and encourage resident to take showers.</p> <p>Observations of Resident #1 on 04/25/16 at 11:44 AM, 1:25 PM, 5:32 PM and 6:35 PM revealed he was clean and neatly groomed, had no food spills or stains on his clothing and had no odor or visible sign of incontinence. At 6:35 PM an observation was made with the facility wound care nurse of Resident #1's abdomen and buttocks and he was clean and dry.</p> <p>An interview with a family member of Resident #1 on 04/25/16 at 12:46 PM revealed that she and other family members who visited resident on a regular basis had expressed concern to the facility about finding him wearing clothing soiled with food stains and finding him soiled due to incontinence. The family member described Resident #1 as appearing to be able to do more than he can and being unable to recall when he has had a shower. The family member stated she felt as if her concerns and those of his other family members were ignored and they saw no improvement in the care provided to Resident #1.</p> <p>An interview with Nurse Aide (NA) #1, who stated she was regularly assigned to provide care to Resident #1, revealed she had attempted to get Resident #1 to take a shower on 04/25/16 and had approached him 3 different times but he refused to take a shower each time she offered.</p>	F 166	<p>have been resolved as of May 4, 2016. A scheduled care plan meeting was held on April 26, 2016 with resident #1 family to review resident #1 plan of care. At the conclusion of the meeting, there were no concerns voiced by resident #1 family.</p> <p>Corrective action will be accomplished for those residents to be affected by same deficient practice.</p> <p>The grievance log was reviewed by the Administrator and all grievances logged have been resolved as of May 4, 2016. On May 4, 2016 each hall nurse began observing/monitoring for ice/water pass using an audit tool. This audit consisted of ice/water pass at the beginning of each shift and refilled as needed. The Director of Health Service began observing/monitoring ice/water pass using an audit tool to ensure each resident receives fresh ice water on a consistent basis.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice will not occur.</p> <p>Each hall nurse will observe for ice/water pass during his/her shift to ensure residents are receiving fresh ice water on a consistent basis across all three shifts. Each hall nurse will sign off that fresh ice water pass has been completed via the audit tool.</p> <p>The Director of Health Services, Clinical Competency Coordinator, Unit Managers and Weekend Supervisor will observe for ice/water pass to ensure residents are receiving fresh ice water on a consistent</p>		

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F 166	<p>Continued From page 2</p> <p>NA #1 stated she notified Nurse #1 of his refusal to take a shower. NA #1 described Resident #1 as being pretty independent with toileting and stated he used a urinal which staff emptied for him.</p> <p>An interview with a different family member of Resident #1 on 04/25/16 at 5:53 PM revealed she or other family members visited Resident #1 every day. The family member stated Resident #1 was always wet across his lower abdomen. The family member stated she was aware that Resident #1 would refuse his showers and she had met with staff in a care plan meeting about a year ago and part of his plan of care was for staff to call her when he refused to take a shower so she could persuade him to take a shower. The family member stated the facility called her for the first few weeks after the meeting but then stopped notifying her of Resident #1's refusal to take a shower. The family member stated she wasn't notified on 04/25/16 that Resident #1 had refused to take a shower.</p> <p>An interview on 04/25/16 at 5:44 PM with the Director of Nursing (DON) revealed she had not personally received any complaints from anyone in Resident #1's family but had been made aware of concerns which the family had e-mailed to the Administrator. The DON stated Resident #1 had recently experienced a decline in his condition and she had an inservice with staff on his need for more assistance. The DON stated NAs reported that Resident #1 refused care at times. The DON stated she didn't have any documentation of the inservice as it was done informally. When asked what the facility did to ensure the care needs were met of residents who refused care, she stated staff kept re-attempting</p>	F 166	<p>basis across all three shifts for five residents/hall per week times 4 weeks, then three residents/hall per week times 4 weeks, and then 1 resident/hall a week times 4 weeks to ensure residents are receiving fresh ice water. This observation will be documented via the audit tool.</p> <p>On May 4, 2016 the Senior Nurse Consultant educated the Administrator on the review and sign off of all grievances to ensure appropriate measures were taken to resolve the grievance, the grievance was resolved, the resident was notified when appropriate and the responsible party was notified when appropriate. The education also included reviewing resident council concerns and department head follow-up/resolution.</p> <p>On May 4, 2016 the Administrator educated the Senior Care Partner on the grievance log/process. The Senior Care Partner was educated to track each grievance via the log and assign a number to each grievance, place a copy of the grievance in the grievance book, give the original copy of the grievance to the appropriate department head responsible for follow-up/resolution and submit a copy of the grievance to the Administrator. Once the grievance is resolved/closed out, the Senior Care Partner will replace the copy with the original and keep in the grievance notebook. The Senior Care Partner will take her grievance book to the stand-up meeting held by the Administrator and will report daily which grievance is outstanding and when resolution is due. All grievances are to be closed</p>		

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F 166	<p>Continued From page 3</p> <p>to provide care. The DON described Resident #1 as more compliant when his family was present. When asked if she had done any follow up with the family of Resident #1, the DON stated she had not followed up with his family.</p> <p>An interview on 04/25/16 at 6:56 PM with the Administrator about his awareness of any concerns about the care being provided to Resident #1 revealed he met with the regional long term care ombudsman and the family of Resident #1 about 6 months ago because of numerous concerns expressed by the family. The Administrator stated he thought the concerns were resolved. He stated the facility implemented a weekly phone call between the DON and family but had stopped the weekly phone call. The Administrator was unable to recall the reason for stopping the calls or when the calls were stopped. The Administrator stated he received an e-mail about a week ago from Resident #1's family with several concerns which he addressed immediately. The Administrator stated he replied to the family member via e-mail and had not heard anything further from the family member.</p> <p>2. The resident council minutes were reviewed from October 2015 through April 2016. Documentation dated 10/13/15 addressed to the nursing department indicated the residents reported that water not being passed on the East and West wings remained a problem. A response from the Director of Nursing (DON) indicated an ice pass schedule was posted at the nurse's station and staff would be inserviced at the next pay day.</p> <p>Documentation dated 11/13/15 of the resident council concerns read in part: "Council states that</p>	F 166	<p>out/resolved within three business days. On May 4, 2016 the Clinical Competency Coordinator began education for all staff on the grievance process. The education included the grievance notebook located at each nurses' station, initiation of the grievance form by documenting the concern, documentation of any action taken and submitting grievance to the Senior Care Partner. Of the 137 staff members, 32 have completed the in-service. All staff will be required to complete the in-service prior to working his/her next scheduled shift.</p> <p>On May 4, 2016 the Administrator educated the Department Heads on the process for reporting/following up to resident council concerns. This education included initiating the Patient/Resident Council Minutes/Report Form to the appropriate department head. Each department head is responsible to address each concern and provide follow up to the activity aide within three business days so he/she may provide response at the next resident council meeting. Prior to submitting his/her form, each department head will review their resolution with the Administrator. Of the 10 department heads, 9 have completed the in-service. Each department head will be required to complete the in-service prior to working his/her next scheduled shift.</p> <p>On May 4, 2016 the Clinical Competency Coordinator began education for all nursing staff, including licensed and non-licensed staff on ice/water pass. The education included ice/water pass is to</p>		

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F 166	<p>Continued From page 4</p> <p>at first the aides improved on passing ice, but now it's slacking off again. 600 hall states get ice only when (specifically named NA) works. 500 hall stated they rarely get ice. 100 hall only gets ice when they ask. 400 hall says they get it sometimes." A response from the DON indicated an inservice was held for staff on 12/03/15. The Unit Manager on the 7:00 AM - 3:00 PM and the 3:00 PM - 11:00 PM shifts were to ensure ice was passed and the DON would follow up with the 11:00 PM - 7:00 AM staff to make sure ice was passed.</p> <p>Documentation dated 12/04/15 of the resident council concerns read in part: "Ice pass still a issue. No water at bedtime." A response from the DON read: "inservice regarding ice on 12/03/15."</p> <p>Documentation dated 01/06/16 of the resident council concerns read in part: "water/ice pass continues to be an issue." A response from the DON read: "spot checks of pitchers have shown that ice is being passed. Will increase frequency of spot checks."</p> <p>Documentation dated 02/04/16 of the resident council concerns read in part: "ice pass improved some but not to par still." No response to the concerns was documented.</p> <p>Documentation dated 03/03/16 of the resident council concerns read in part: "ice pass only when asked for; 600 hall - only once daily; 400 hall - no ice; East Wing - sometimes." No response to the concerns was documented.</p> <p>Documentation dated 04/14/16 of the resident council minutes listed only the names of the residents in attendance.</p>	F 166	<p>occur at the beginning of each shift and refill as needed throughout the shift by the aides. Of the 79 licensed and non-licensed staff, 22 have completed the in-service. All licensed and non-licensed staff will be required to complete the in-service prior to his/her next scheduled shift.</p> <p>Education on the grievance process has been added to orientation for all new hires.</p> <p>Education on ice/water pass has been added to orientation for all new hires.</p> <p>Facility plans to monitor its performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The Activities Director will present the findings of resident council to the Quality Assurance and Performance Improvement Committee monthly.</p> <p>The Senior Care Partner will present the total number of grievances by department/category, number of open grievances and number of completed grievances monthly to the Quality Assurance and Performance Improvement Committee monthly.</p> <p>The Director of Health Services will present the findings of ice/water pass observations to the Quality Assurance and Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained.</p>		

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

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F 166	Continued From page 5 An interview was held with the Administrator on 04/25/16 at 6:56 PM about the ongoing complaints from the resident council and the lack of follow-up to the concerns expressed in February and March 2016. The Administrator was unable to provide an explanation for the lack of follow up and the failure to resolve a concern that had been expressed in the resident council meetings for the past 6 consecutive months.	F 166			