STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345101	A. BUILDING _____ B. WING _____	05/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENFIELD OAKS NURSING AND REHABILITATION CENTER	208 CARY ST ENFIELD, NC 27823

(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 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based upon physician, pharmacy consultant and staff interviews and record reviews the facility failed to monitor anticoagulant medication for 2 of 2 sample residents (Resident # 39 and Resident #65) receiving coumadin medication. Also the facility failed to assess 1 of 3 sample residents (Resident #59) on a psychotropic medication.	F 329	**Response Preface** Enfield Oaks Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality care of our residents. The plan of correction is submitted as written allegation of compliance. Enfield Oaks Nursing and Rehabilitation Center's response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does is constitute an admission that any deficiency is accurate. Further, Enfield Oaks Nursing and Rehabilitation Center reserves the right to submit documentation to statement of deficiencies through informal dispute resolution, formal appeal procedures and/or any other legal proceedings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Allman	administrator	6/21/12

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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F 329	Continued From page 1 Findings Include: 1. Resident #39 was admitted to the facility on 4/30/09 with diagnoses of diabetes, hypertension, Deep Vein Thrombosis (DVT) and cerebral vascular disease. The annual minimum data set dated 4/12/12 indicated Resident #39 to require minimal to significant assistance with his activities of daily living and his balance was not stable in most areas. The care plan documented in the facility computer system indicated there was trauma potential for bleeding related to anticoagulant therapy. Some of the approaches to this potential problem were to monitor lab values and notify the physician of the lab results as needed. A record review of the facility ' s Medication Administration Record (MAR) revealed Resident #39 coumadin dosage to be 7.5 milligrams (mg) daily during the month of October 2011. There was a standing order for Prothrombin Time (PT) and International Normal Ratio (INR) labs to be conducted monthly. A record review of the facility ' s PT/INR lab work was conducted. The PT/INR dated 10/25/11 revealed a critical INR of 7.5 (normal range 0.8-1.2) and PT of 78.4 seconds (normal range 9.1-12 seconds). The lab work revealed the nurse was called with the results on 10/26/11 at 7:56am and the results were faxed to the physician on 10/26/11 at 12pm. A review of the October 2011 MAR revealed the resident was scheduled to be given 7.5mg of Coumadin at 8:00pm.	F 329	**F329** 1. Resident #39 INR was re-drawn per physician's order on 5/31/12 by the Nurse Consultant with an INR of 1.3 (normal range 0.8-1.2). The Physician was notified of the INR results on 5/31/12 by the Director of Nursing. There was no new order to change the Coumadin dose by the physician. Resident #39 will continue to have his INR drawn per physician order and monthly per lab policy. 2. Resident #65: INR was drawn by the charge nurse on 5/24/12 per physician's order with an INR of 1.09 (normal range 0.8-1.2). The Physician Assistant was notified of the INR results on 5/24/12 by the lab nurse. New orders were received and initiated on 5/24/12 by the charge nurse. 3. Resident #59 DISCUS was completed on 5/25/12 by the facility consultant.	

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F 329	Continued From page 2 An interview with Nurse #3 on 5/25/12 at 9:32am revealed she worked on 10/25/11. She could not specifically recall the resident ' s critical lab on 10/25/11. If there was a critical or abnormal lab she would have faxed the lab to the physician ' s office. If the physician had not responded, she would then call the physician' s office. Resident ' s # 39 ' s physician would have asked what were Resident #39' s coumadin dosage and the prior and current INR lab work. He would then make adjustments and request a follow-up INR. A record review of the facility ' s October 2011 MAR revealed a physician order dated 10/27/11 to repeat PT/INR on 10/31/11 and call the physician with the results. A record review of the facility nurse notes was conducted. The note dated 10/28/11 revealed there was a physician order obtained to hold coumadin until Monday 10/31/11 and repeat a PT/ INR and call the physician with results. A record review of the facility ' s MAR for October 2011 revealed the coumadin was held from 10/27/11 to 10/31/11. There was no evidence that the PT/INR was repeated on 10/31/11. The MAR for November 2011 indicated coumadin was given on 11/1/11 to 11/2/11. The coumadin was held again on 11/3/11 to 11/4/11. There were no physician orders for holding coumadin on these days. A record review of the follow-up lab revealed a redraw PT/INR was conducted on 11/4/11. The	F 329	A 100% audit of all resident's to include resident #39 and #65 medications to include Coumadin was completed by the Director of Pharmacy Clinical Services on 5/25/12 and 6/5/12 to ensure labs have been monitored and drawn per lab policy. A repeat lab audit was completed by the Facility Consultant on 6/1/12. The Director of Nursing was notified of any lab values that had not been obtained. All labs identified as not obtained were drawn by 6/8/12 by the Director of Nursing, Charge nurses and Lab nurse. A second audit of 25% of resident census was conducted by the Regional Pharmacy Clinical Manager on 6/6/12, with no concerns identified. A DISCUS review was completed by the Pharmacy Consultant on 6/4/12 for 100% of all residents receiving psychotropic medications to include resident #59. All identified areas of concern were corrected by the Director of Nursing.	6/22/12

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F 329	Continued From page 3 lab results were reported to the facility on 11/05/11. This lab volume was indicated as insufficient specimen. There were no lab results. There was no evidence that the physician was notified of the lack of lab results. A review of the November 2011 MAR revealed the resident was given 7.5mg of Coumadin on 11/5/11 through 11/8/11. There was another lab redraw conducted on 11/8/11 which revealed the INR was 2.0 (normal range 0.8-1.2) and PT 21.2 seconds (normal range 9.1-12 seconds). The lab results were reported to the facility on 11/9/11. There was no date of when the results were reported to the physician. The lab results revealed the physician ordered to give 10mg of coumadin now (one time dose) and repeat the PT/INR in 1 week. The November 2011 MAR revealed the resident was given 10 mg of Coumadin on 11/9/11 and 7.5 mg of Coumadin from 11/10/11 through 11/17/11. The lab work dated 11/17/11 revealed an INR of 3.5 (normal range 0.8-1.2) and PT 37.1 seconds (normal range 9.1-12 seconds). The lab results were reported to the facility on 11/18/11 and the results were faxed to the physician on 11/18/11 at 2pm. There was no indication on the lab work for intervention or physician response. An interview with Nurse #3 on 5/25/12 at 9:32am revealed she could not recall why there was not a redraw done until 11/4/11. She indicated if there was an insufficient specimen to follow up on a critical INR, she would have called the physician that day for a redraw. She could not understand	F 329	100% of licensed nurses were in serviced by the Director of Nursing regarding notifying the physician timely of critical labs on 5/30/12, obtaining labs per physician order on 6/7/12, notifying the physician of concerns with a lab specimen on 6/7/12, dating when lab results are reported to the physician on 6/20/12, physician response in a timely manner to lab results on 6/20/12, physician response to pharmacy recommendation timely on 6/20/12, and DISCUS policy on 6/20/12. All newly hired licensed nurses will be in serviced regarding notifying the physician timely of critical labs, obtaining labs per physician order, notifying the physician of concerns with a lab specimen, dating when lab results are reported to the physician, physician response in a timely manner to lab results, physicians response to pharmacy recommendations timely, and DISCUS protocol during the orientation process by the Director of Nursing.	6/22/12

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F 329	Continued From page 4 why the second redraw took until 11/8/11. If the physician has not responded for a critical INR, she might have held the coumadin medication based upon her nursing judgment until the physician got back into contact with her. A record review of the facility pharmacy notes revealed on 11/8/11 the documentation of the critical lab work on 10/25/11. There was an indication that coumadin was held on 10/27/11 and remained held until Monday (10/31/11) and to recheck the INR. There was an unsuccessful lab redraw. The pharmacist indicated she was awaiting INR results. There were no pharmacy recommendations. The pharmacist note dated 12/8/11 revealed on 11/8/11 the INR was 2 (normal range 0.8-1.2). The note indicated on 11/10/11 that 10mg of coumadin was given and to check INR. The INR (on 11/17/11) was indicated to be too high. There was a recommendation by the pharmacist to check the INR as soon as possible. The pharmacist note indicated an e-mail was sent to the Director of Nursing (DON) and Administrator. A record review of the consultant pharmacist e-mail dated 12/8/11 to the DON and Administrator revealed the pharmacist recommended to follow-up with the physician for an INR. The INR on 11/17/11 was 3.5 (normal range 0.8-1.2). It indicated there were no changes made to his coumadin regimen. There was not a follow-up INR on the chart. An interview with the Pharmacy Director on 5/24/12 at 5:27pm revealed the MAR documented the coumadin was held on 10/26/11.	F 329	All newly admitted resident's medications to include Coumadin will be reviewed by the lab nurse to ensure medications are monitored per lab policy and documented on the laboratory log. The Director of Nursing or Facility Consultant will review the laboratory log to ensure labs have been drawn timely, results received, physician notified with physician response, and new orders are followed utilizing a Laboratory Log Monitoring QI tool weekly x 8 weeks the bi-weekly x4 weeks then monthly. All new lab orders for all residents to include resident #39 and #65 to include PT/INR will be reviewed by the lab nurse and documented on the daily lab log daily. The Director of Nursing or Facility Consultant will review the daily lab log to ensure labs have been drawn timely, results received, physician notified with physician response utilizing a Laboratory Log Monitoring QI tool weekly x8 weeks then bi-weekly x4 weeks then monthly. The Pharmacy Consultant will complete monthly routine audits of 100% of resident's charts to include medications, physician	6/22/12

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F 329	Continued From page 5 He was unclear why the dosage for 11/1/11 to 11/2/11 was given then held. They could not find a lab for 10/31/11. He could not answer to why the redraw was not conducted until 11/4/11. A record review of the facility ' s lab work revealed a PT/INR lab was conducted on 12/19/11. The INR was 3.6 (normal range 0.8-1.2) and PT 38.1 seconds (normal range 9.1-12 seconds). The nurse note dated 12/19/11 indicated a PT/INR lab was conducted on 12/19/11 at 1:12pm. The note dated on 12/20/11 at 7:20pm indicated the physician called the facility and the PT/INR lab value was discussed. There was an order to hold the coumadin 7.5 mg for that night and change coumadin to 5mg daily. There was not a monthly PT/INR conducted for February 2012. The PT/INR dated 4/26/12 revealed the INR was 1.7 (normal range 0.8-1.2) and PT was 18.2 seconds (normal range 9.1-12 seconds). The lab work indicated the physician was made aware on 4/27/12. There was no physician orders related to the lab results on 4/26/12. A record review of the facility ' s nurse notes was conducted. The note dated 4/27/12 indicated that the physician was notified about the PT/INR lab drawn on 4/26/12. The facility was awaiting a call back from the physician. The next documentation regarding the 4/26/12 lab work was on 5/23/12 at 7:14pm. The note, written on 5/23/12, indicated a third notification was sent to the physician about the 4/26/12 lab work on	F 329	orders, DISCUS, and labs monthly x3 months. All resident's to include resident #59 receiving antipsychotic medications will be reviewed by the Director of Nursing monthly utilizing a DISCUS Monitoring QI Tool to ensure a DISCUS has been completed per policy. The Director of Nursing will compile audit results of the Laboratory Log Monitoring and Pharmacy Audit tool and DISCUS monitoring QI Tools and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance.	6/22/12

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F 329	Continued From page 6 5/23/12. There were no new orders received related to the coumadin dose. The facility obtained an order for a PT/INR to be conducted the next day. On 5/23/12 at 10:45pm a lab specimen was drawn. An interview with the DON on 5/23/12 at 6:49pm revealed the physician may have gotten confused where to put his notes in response to the lab work for 4/26/12. A record review of the facility lab work revealed on 5/4/12 the INR was 1.3 (normal range 0.8-1.2) and PT 14.1 seconds (normal range 9.1-12 seconds). There was no physician response on the lab work. The nurse notes for May 2012 did not indicate any physician response for the lab work on 5/4/12. A record review of the facility physician orders dated 5/24/12 indicated to change coumadin to 6mg daily. They were to start coumadin upon receipt from pharmacy. They were to recheck PT/INR in 1 week on 5/31/12. An interview with the Physician on 5/24/12 at 11:38am revealed Resident #39 has been on coumadin for more than two years. He could not recall the critical lab work for Resident #39 back in October 2011. Typically for a critical INR lab work he would immediately hold the coumadin medication and does follow-up lab work in a couple of days. He would not wait longer than this for a follow-up lab work. Usually the nurse from the facility either called him or faxed him the lab results. He would respond via phone to the nurse, if he was called. When the lab results were faxed, he would write down the suggestions	F 329		

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F 329	Continued From page 7 on the lab work and fax back to the facility. He could not recall being notified of the lab work on 4/26/12 with an INR of 1.7 (normal range 0.8-1.2). He would want to keep Resident #39 INR between 2-2.5. He would adjust the coumadin if the INR was 1.7 by increasing the coumadin dose to 7.5mg and getting a redraw. Resident #39 has been on coumadin a while and probably could be taken off the medication. An interview with the DON on 5/23/12 at 6:49pm revealed the facility hired a new lab nurse initially but had to replace the lab nurse on two more occasions. The monitoring of PT/INR lab work was based upon their policy of getting the coumadin lab work conducted monthly without specific dates. The new lab nurse, Nurse #1 was doing the lab monitoring and referred to the monthly calendar at the desk to request labs. This was the monitoring they do for all lab work. There were no specific tools or audits used. A record review of the facility ' s routine laboratory determinations policy revealed coumadin procedure of PT/INR should be performed 1 week of initiation or change of coumadin, then monthly. An interview with the Nurse Consultant on 5/24/12 at 3:49pm revealed she was unaware of any problems with lab monitoring and coumadin. The company has a coumadin audit form. She was unsure if the facility was using this and would have to verify. She was aware the physician had issues with visiting the facility on a regular basis. They have hired a new Medical Director. Ultimately the DON would be responsible for insuring physician; lab and medication orders	F 329		

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F 329	Continued From page 8 were carried out. A record review of the facility ' s coumadin audit form created on 9/28/09 was conducted. It indicated the following monitoring areas for coumadin: dosage order, PT/INR order, MAR location, lab schedule, follow-up results, notification of the physician, results on the chart, adverse reactions and nurse notes. There were no coumadin audit forms completed by the facility. An interview with Nurse #1 on 5/24/12 at 9:59am revealed when he received a physician order he would transcribe it and verify the order on his shift. There was a booklet at the nursing station with standing order lab protocols. He was designated as the lab draw nurse in March 2012. He picked a day at the beginning of each month and reviewed all of the medical charts for lab orders. For coumadin and any other lab ordered monthly, he would look back for the last day the lab was drawn and request the lab work to be conducted for the same day next month. He would place a lab request sheet in a booklet at the nurse station and the DON would look through them to verify them. He then would draw the lab work. He would contact the lab company the day of the lab draw, so that they may pick up the specimen. The lab company would usually be in the facility by 1:30pm to pick it up. The lab results would be faxed to the facility next day. If the lab company was unable to pick up the specimens timely, facility staff would go to the nearest hospitals to get the labs completed. When there is a critical or abnormal lab result he would call the physician during business hours. If it was after hours, he would call the physician on	F 329		

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F 329	Continued From page 9 call. If he were unable to reach a physician he would call the other physician that covered the facility. If he were unable to contact the physician during business hours, he would try to contact the physician ' s office nurse or anyone at the office who could receive the message. An interview with Nurse #2 on 5/24/12 at 4:35pm revealed the charge nurse assigned to the resident received the lab results. If they were abnormal, she would notify the physician and obtain new orders. She would write orders and update the MAR as related to medication. An interview with the new Pharmacy Consultant on 5/24/12 at 10:50am revealed their consults were completed monthly. They hired a new Pharmacist in January 2012. Typically the prior month PT/INR would not be referenced to due to the coumadin levels changes so much. They did make recommendations for Resident #39 in February 2012 and March 2012. There were no new coumadin levels and results, upon the consultant pharmacist date of visits in February 2012 and March 2012. In April 2012, they indicated labs were drawn and a follow-up was completed for March 2012. When there was a critical coumadin lab, they would notify the DON and Administrator while at the facility so the physician could make adjustments. Each physician can be different in how they would handle critical lab of 7.5 INR. Some would be aggressive and provide vitamin k and some would hold coumadin. For someone with the diagnosis of DVT a normal INR range would be 2-3. Adjustments were typically made when the INR was out of this range. An INR of 3.5 would be high. A PT of greater than 30 seconds would	F 329		

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F 329	Continued From page 10 be high for someone with DVT but the INR level is what would be reviewed. A record review of the facility physician notes revealed notes for 12/26/11 and 1/31/12. There was no documentation of INR/PT labs or coumadin medication. An interview with the Nurse Consultant and DON on 5/24/12 at5:40pm was conducted. The Nurse Consultant indicates she knew the pharmacists do their monthly audit on standing orders. Otherwise the medical records staff audit and investigation portion based upon the QI Action Team Lab monitoring policy had not been followed and obviously a new system would need to be in place. She could not answer to why there was not an investigation process conducted for the delayed lab redrawn on 11/4/11 and 11/8/11. Their policy was supposed to be followed. 3. Review of the undated facility policy titled " Antipsychotic Drug Therapy " read in part: " D. Scheduling of assessments with the DISCUS (dyskinesia identification system condensed user scale) will be as follows: 1. (residents) prescribed antipsychotics (should have an) evaluation once every six months. " Resident #59 was admitted 10/10/11. Cumulative diagnoses included schizophrenia, depression and psychosis. Review of the resident ' s physician orders revealed an order, dated 04/10/12, for Seroquel 12.5 mg (milligrams) twice a day. Further review of the physician ' s orders revealed an order on admission for the resident to received	F 329		

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	345101	A. BUILDING _____ B. WING _____	05/25/2012

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F 329	Continued From page 11 Seroquel 25 mg twice a day. Per Lexicomp's Geriatric Drug Information Handbook, 14th edition, Seroquel is an antipsychotic drug used for treatment of schizophrenia. Per the literature, under the section titled Adverse Reactions, involuntary movements are listed as a possible adverse reaction. Review of the Resident #59 ' s care plan, updated on 04/27/12, indicated the resident was on an antipsychotic medication and at risk for side effects of the medication. One of the interventions listed was to administer the DISCUS per facility protocol. Review of the of the resident ' s medical record revealed a DISCUS had been completed when the resident was admitted on 10/10/11. An interview, on 05/24/12 at 8:55 AM, was conducted with the Director of Nursing (DON). The DON relayed the DISCUS should be completed every six months and was to be completed by the hall nurse. An interview, on 05/24/12 at 4:00 PM, was conducted with Nurse #2. Nurse #2 relayed she was not aware of who was assigned to complete the DISCUS. She indicated upon admission the charge nurse does not complete the DISCUS at the time of admission and she thought the MDS (Minimum Data Set) Nurse would complete it. An interview, on 05/24/12 at 5:45 PM, was conducted with the DON. The DON relayed that the computer system used by the facility would flag when a DISCUS needed to be done for a	F 329		

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F 329	Continued From page 12 resident. She stated she had not noted that the Resident #59 had been flagged to have a DISCUS completed. The DON stated she would have the completed the DISCUS, but had not seen it flagged in the computer system. An interview, on 05/25/12 at 11:50 AM, was conducted with the DON. The DON indicated she had reviewed Resident #59 ' s chart and found the admitting nurse had entered an incorrect date for the next DISCUS to be done in six months. She stated the nurse no longer was at the facility. The DON relayed since the wrong date was entered for when the next DISCUS was due, the computer system did not trigger the information to be flagged when it was actually due. The DON confirmed she had not received a recommendation from the consultant pharmacist for the completion of the DISCUS. She indicated the DISCUS should have been completed per policy. An interview, on o5/25/12 at 1:45 PM, was conducted with consultant pharmacist on site, stated the pharmacist who reviewed chart on 05/01/12 overlooked the need for the DISCUS to be completed. 2. Resident #65 was admitted to the facility on 5/2/12 with diagnoses of Deep Vein Thrombosis (DVT) of bilateral lower limbs, Bilateral Below Knee Amputations (BKA), Respiratory Failure and Anemia. Resident #65 was admitted to the facility from an acute care hospital with orders for Coumadin 5 milligrams (mg) by mouth each day. The resident was also receiving Cipro, an antibiotic for a Urinary Tract Infection (UTI). The combination of these two medications has the	F 329		

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F 329	Continued From page 13 potential to increase bleeding time or an increased anticoagulant effect. On 5/2/12 the pharmacist for the facility made a recommendation to obtain an International Normal Ratio (INR) lab test due to the possible interaction between Cipro and Coumadin. The pharmacist advised to obtain the lab on the third day following the start of Cipro. Review of the resident ' s Medication Administration Record (MAR) for May 2012 showed the resident started the Coumadin 5mg dose on 5/2/12 at 6:00PM. The MAR indicated the resident had received this dose each day since admission through 5/24/12. The MAR did not reflect the increase until 5/25/12. A review of the medical record revealed a laboratory result dated 5/17/12 as the date the specimen was collected. The INR result was 1.3 which is high on a range of normal being 0.8-1.2. Expected values for a person receiving Coumadin with a history of DVT are 2.0-3.0. The PT result was 13.6, which is high on a range of 9.1-12. The ranges stated in this paragraph are the reference intervals (normal values) used by this lab. Preferred values by physicians for patients on Coumadin with DVT is 1.5-2.5 times the normal value. There was an entry hand written on the lab result by Nurse #5 noting the result. An interview with Nurse #5 on 5/24/12 at 3:10PM noted that she had called Dr. Billy and obtained an order for Coumadin 6mg by mouth each day. This was an increase from the current dose of Coumadin 5mg.	F 329		

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F 329	Continued From page 14 An interview was conducted with a Nurse #2 who was in charge of Resident Hall B on 5/24/12 at 11:00AM. The nurse stated normal procedure was to call the physician with abnormal lab results, write a verbal or telephone order in the Physician ' s Orders and update the MAR. The pharmacy was also notified so the new medication can be sent to the facility. An interview was also held with Nurse #3, who was in charge on another hall, at 11:20AM. The nurse stated if any abnormal lab results were returned, the physician was notified immediately and the MAR was updated with any new orders. The nurse reported a physician ' s verbal or telephone order was written for any new orders. An interview with the Regional Nurse Consultant #2 on 5/24/12 at 3:15PM revealed the facility did not have a written policy or procedure on abnormal laboratory values to direct staff on appropriate actions to take upon receipt of abnormal labs. An interview of the Director of Nursing (DON) on 5/24/12 at 3:45PM revealed that it was the expectation the nursing staff notified the physician of abnormal lab values and take verbal or telephone orders and to make sure they were carried out.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 333		

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F 333	Continued From page 15 Based on record review and staff interviews, the facility failed to carry out physician ' s orders for 1 (Resident #65) of 2 sampled residents. Findings include: Resident #65 was admitted to the facility on 5/2/12 with diagnoses of Deep Vein Thrombosis (DVT) of bilateral lower limbs, Bilateral Below Knee Amputations (BKA). Resident #65 was admitted to the facility from an acute care hospital with orders for Coumadin (an anticoagulant medication) 5 milligrams (mg) by mouth each day. A review of the resident ' s medical record revealed a phone call was made to the resident ' s physician in reference to abnormal laboratory results on 5/18/12. Review of the result revealed a hand written note that documented a phone call was made to the physician and new orders that were received. A lab specimen for Prothrombin Time (PT) and International Normal Ratio (INR) was drawn on 5/17/12. The PT was 13.6, being high with normal values of 9.1-12. The INR lab test result was 1.3, which is also high on a normal range of 0.8-1.2. Nurse #5 noted that she called the physician on 5/18/12 and received orders to change the resident ' s Coumadin dosage to 6mg instead of 5mg by mouth once a day. Review of the current Medication Administration Record (MAR) for May 2012 revealed the resident received Coumadin 5mg by mouth each day of May 3 until May 24. No entry of Coumadin 6mg was noted on the May 2012 MAR. Review of physician ' s orders for May 2012 revealed an order had been written on 5/24/12 to change	F 333	F333 The Physician was made aware of resident #65 Coumadin on 5/24/12 by the Director of Nursing. New orders were received and initiated on 5/24/12 by the Charge Nurse. Resident #65 continues to receive Coumadin per physician order. 100% audit of all resident's to include resident #39 and #65 medications to include Coumadin was reviewed by the Director of Pharmacy Clinical Services on 5/25/12 to ensure residents are receiving medications per physician order. All identified areas of concern were reported to the Director of Nursing and corrected by the Director of Nursing and Facility Consultant by 6/8/12. A second 100% audit of all residents medications was completed by the Director of Nursing, MDS nurse, and Facility Consultant to ensure residents are receiving medications per physician order on 5/31/12.	6/22/12

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F 333	Continued From page 16 Resident #65 ' s dosage to 6mg of Coumadin by mouth once a day. An interview was conducted on 5/24/12 at 11:00AM with the Nurse#2. The nurse stated the resident was ordered Coumadin 5mg by mouth once a day at 6:00PM. An interview was held on 5/24/12 at 11:30AM with Nurse #3. The nurse stated when new orders were obtained from the physician, the MAR was updated and the new orders were written on a physician ' s order sheet as a telephone order . During an interview with the resident ' s assigned registered nurse on 5/24/12 at 11:20AM, she stated when the physician gave new orders, the nurse wrote an order in the physician ' s orders, updated the MAR, and notified the pharmacy so new medication was sent to the facility. An interview with the Director of Nursing (DON) was held on 5/24/12 at 3:00PM. She stated when nurses receive new orders, they should write the order in the physician ' s orders, transcribe it to the MAR, and fax it to the pharmacy so they can send the medication to the facility.	F 333	100% in-service with all licensed nurses regarding medication transcription was completed on 6/7/12 by the Director of Nursing. All newly hired licensed nurses will be inserviced regarding medication transcription during orientation by the Director of Nursing. The Director of Nursing, RN Supervisor or MDS Nurse will review all new orders for all residents to include resident #65 through the pink slip process to ensure orders have been transcribed to the MAR correctly utilizing a Pink Slip QI tool daily x4 weeks, then weekly x4 weeks, then monthly x 2 months. The Director of Nursing will compile audit results of the Pink Slip QI Tool and present to the Quality Improvement Committee Meeting monthly.	6/22/12
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance.	

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F 428	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and consultant pharmacist interview, the facility failed to ensure the pharmacy consultant identified a DISCUS evaluation needed to be completed for 1 (Resident #59) of 3 sampled resident on antipsychotic medications, and the facility failed to consult with the resident ' s physician when there was a need to alter treatment for 1 of 2 sampled residents (Resident #65). The facility failed to report pharmacy recommendations to the physician in a timely manner for 1 (Resident #65) of 2 sampled residents with pharmacy recommendations. Findings include: Review of the undated facility policy titled " Antipsychotic Drug Therapy " read in part: " D. Scheduling of assessments with the DISCUS (dyskinesia identification system condensed user scale) will be as follows: 1. (residents) prescribed antipsychotics (should have an) evaluation once every six months. " Resident #59 was admitted 10/10/11. Cumulative diagnoses included schizophrenia, depression and psychosis. Review of the resident ' s physician orders revealed an order, dated 04/10/12, for Seroquel 12.5 mg (milligrams) twice a day. Per Lexicomp's Geriatric Drug Information Handbook, 14th edition, Seroquel is an	F 428	F428 Resident #59 DISCUS was completed on 5/25/12 by the Facility Consultant. Resident #65 INR was drawn on 5/24/12 per physician's order by the charge nurse with an INR or 1.09 (normal range 0.75-1.50). The Physician Assistant was notified of the results on 5/24/12 by the Lab nurse. New orders were received an initiated on 5/24/12 by the Charge nurse. A DISCUS review was completed by the Pharmacy Consultant on 6/4/12 for 100% of all residents to include resident #59 receiving psychotropic medications. A 100% audit of all resident's to include resident #65 medications to include Coumadin was completed by the Director of Pharmacy Clinical Services on 5/25/12 and 6/5/12 to ensure labs have been monitored and drawn per lab policy. The Director of Nursing was notified of any lab values that had not been obtained. All labs identified as not obtained were drawn by 6/8/12 by the Director of Nursing, Charge nurses and Lab nurse. A second audit of 25% of	6/22/12

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F 428	Continued From page 18 antipsychotic drug used for treatment of schizophrenia. Per the literature involuntary movements are listed as a type of adverse reaction possible. Review of the Resident #59 ' s care plan, updated on 04/27/12, indicated the resident was on an antipsychotic medication and at risk for side effects of the medication. One of the interventions listed was to administer the DISCUS per facility protocol. 1. Review of the of the resident ' s medical record revealed a DISCUS had been completed for the resident on 10/10/11. Further review of the medical record revealed no additional DISCUS evaluation. An interview, on 05/24/12 at 8:55 AM, was conducted with the Director of Nursing (DON). The DON relayed the DISCUS should be completed every six months and was to be completed by the hall nurse. An interview, on 05/24/12 at 5:45 PM, was conducted with the DON. The DON relayed that the computer system used by the facility would flag when a DISCUS needed to be done for a resident. She stated she had not noted that the Resident #59 had been flagged to have a DISCUS completed. The DON stated she would have the completed the DISCUS, but had not seen it flagged in the computer system. An interview, on 05/25/12 at 11:50 AM, was conducted with the DON. The DON relayed the wrong date was entered for when the next DISCUS was due; and, the computer system did not trigger the information to be flagged when it	F 428	resident census was conducted by the Regional Pharmacy Clinical Manager on 6/6/12, with no concerns identified. 100% of licensed nurses were in serviced by the Director of Nursing regarding notifying the physician timely of critical labs on 5/30/12, obtaining labs per physician order on 6/7/12, notifying the physician of concerns with the specimen 6/7/12, dating when lab results are reported to the physician on 6/20/12, physician response in a timely manner to lab results on 6/20/12, physician response to pharmacy recommendations timely on 6/20/12, and DISCUS policy on 6/20/12. All newly hired licensed nurses will be inserviced regarding notifying the physician timely of critical labs, obtaining labs per physician order, notifying the physician of concerns with a lab specimen, dating when labs results are reported to the physician, physician response in a timely manner to lab results, physician response to pharmacy recommendations timely, and DISCUS protocol during the orientation process by the Director of Nursing.	6/22/12

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F 428	Continued From page 19 was actually due. The DON confirmed she had not received a recommendation from the consultant pharmacist for the completion of the DISCUS. She confirmed the DISCUS should have been completed per policy. An interview, on 05/25/12 at 1:45 PM, was conducted with the consultant pharmacist on site. He stated the pharmacist who reviewed the chart on in May failed to note the need for a DISCUS to be completed. The consultant pharmacist indicated the pharmacist should have identified the need and informed the facility. 2. Resident #65 was admitted to the facility on 5/2/12 with diagnoses of Deep Vein Thrombosis (DVT) of bilateral lower limbs and Bilateral Below the Knee Amputations. Review of the hospital discharge summary dated 5/2/12 revealed recommendations for medications including Coumadin (an anticoagulant) 5 milligrams (mg) by mouth once a day and Cipro (an antibiotic) 500mg every 12 hours. Review of the resident ' s medical record revealed recommendations from the pharmacist dated 5/2/12 for a Prothrombin Time (PT) and International Normal Ratio (INR), which are lab tests to measure the bleeding time. These tests were to be drawn while receiving the medications and 3 days after completing the Cipro. This was recommended due to potential drug interactions between the two medications which include an increased anticoagulant effect or an increased risk of bleeding. Review of the pharmacist ' s 5/2/12 recommendation revealed the physician signed off in agreement to do the lab tests on 5/15/12.	F 428	The Pharmacy consultant will complete monthly routine audits of 100% of resident's charts to include resident #59 and resident #65 medications, Physician orders, DISCUS, and labs. A member of the Pharmacy Management team will complete a second audit of 25% of current resident's census to include Medications, physician orders, DISCUS, and labs monthly x3months. All resident's receiving antipsychotic medications to include resident #59 will be reviewed by the Director of Nursing monthly utilizing a DISCUS Monitoring QI Tool to ensure a DISCUS has been completed per policy. The Director of Nursing will compile audit results of DISCUS Monitoring QI Tool and pharmacy audit tools and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when	6/22/12

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F 428	Continued From page 20 Record review of the Medication Administration Record (MAR) revealed Resident #65 started the Coumadin and Cipro on 5/3/12 in the facility and completed the Cipro on 5/16/12. The Cipro was to be completed after 6 days; therefore the lab, as recommended by the pharmacist should have been drawn periodically between 5/2/12 and 5/8/12. The final lab test should have occurred on 5/11/12. The physician was in agreement with these recommendations, but did not sign the recommendations until 5/15/12. The lab tests were drawn on 5/17/12. An interview with the pharmacist consultant on 5/24/12 at 2:45PM revealed the physician should have been made aware of the recommendations before 5/15/12 so the drug interaction possibility could have been monitored. If the physician is not in the facility when recommendations are made by the pharmacist, they are faxed to the physician ' s office to make him aware and orders can be written according to the pharmacist consultant. An interview was conducted with the Director of Nursing (DON) on 5/24/12 at 3:00PM. The DON stated it was her expectation for all staff who receive recommendations from providers to make sure the physician was aware of them. This can be by phone or faxing recommendations to his office. Followup should be done also, to obtain orders or further instruction.	F 428	required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance.	6/22/12
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	F 431		

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F 431	Continued From page 21 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. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews, the facility failed to maintain the proper temperature between 36° (degrees) to 46° F (Fahrenheit) in 1 of 1 medication storage room. Findings include:	F 431	F431 All medications from the medication refrigerator were removed by the MDS nurse on 5/24/12 and re-ordered on 5/24/12. Medication room refrigerator temperature was reset on 5/24/12 by facility maintenance staff. There are no other refrigerators in the facility for medication storage. All licensed nurses were in-service on storage of refrigerated medications on 5/24/12 by the Director of Nursing and MDS Nurse. All newly licensed nurses will be in serviced on storage of refrigerated medications during the orientation process by the Director of Nursing. The Administrator will review the medication room refrigerator temperature log 3x per week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months utilizing a Refrigerator Temp QI tool to ensure medications are being stored at proper temperature.	6/22/12

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ENFIELD OAKS NURSING AND REHABILITATION CENTER	208 CARY ST ENFIELD, NC 27823

(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 22 Review of a facility form titled " Temperature Chart for Refrigerators and Freezers ", dated 10/09/09, indicated the med room refrigerator temperature should be maintained between 36 to 46° (degrees) F (Fahrenheit). The form also listed corrective action and read in part: " 1) If temperature registers above CCL (climate control level), immediately notify maintenance department, notify manager. 2) Retake temperature in 1 hour. If temperature again registers above CCL, initiate product removal/relocation procedure." Medications observed stored in the refrigerator were: 13 vials of Lantus insulin; 6 vials of Humalog insulin; 11 vials of Novolin insulin; 2 vials of Novolog insulin; 1 vial of Levemir insulin; 11 Novolin Flexpens; 3 vials of pneumococcal vaccine; 11 vials of Phenegran. Lantus, Humalog, Novolin, Novolog, Novolin Flexpens and Levemir are insulin products used to treat diabetes. Phenergan is used for treatment of nausea and vomiting. The manufacturer product information for Lantus insulin read in part: "unopened Lantus vials should be stored in a refrigerator at 36-46° F. Lantus should not be allowed to freeze"; for Humalog insulin reads in part: "unopened Humalog should be stored in a refrigerator at 36-46° F, but do not freeze. Do not use Humalog if it has been frozen"; for Novolin insulin reads in part: "unopened Novolin should be stored in a refrigerator at 36-46° F. Do not freeze. Do not use Novolin if it has been frozen"; for Novolog insulin reads in part: "unopened Novolog should be stored in a refrigerator at 36-46° F. Do not freeze. Do not use Novolog if it has been frozen"; for Levemir insulin reads in part: "store unopened Levemir should be stored in a refrigerator at	F 431	The Administrator will compile the audit results of Refrigerator Temp QI Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and /or frequency of continued monitoring. The Administrator is responsible for overall compliance.	6/22/12

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F 431	Continued From page 23 36-46° F. Do not freeze. Do not use Levemir if it has been frozen"; for Novolin Flex pens reads in part: "Flexpens should be stored at in a refrigerator at 36-46° F. Do not freeze. " The manufacturer product information for pneumococcal vaccine read in part: "unopened and opened vaccine should be stored at in a refrigerator at 36-46° F. Do not freeze." The manufacturer product information for Phenergan read in part: "store in refrigerator between 36-46° F. Do not freeze." Review of the medication room refrigerator temperature chart, for the period of May 1 to 24, 2012, showed documentation that the med room refrigerator temperatures was read two times a day, in the morning (AM) and in the evening (PM). The chart reflected that 31 out of 47 temperatures were documented at 28° F; that 12 out of 47 temperatures were documented at 30° F; and, 4 out of 47 temperatures were documented at 32° F. On 05/24/12 at 3:00 PM, an observation of the medication storage room was made accompanied by Nurse #3. Nurse #3 unlocked the medication room refrigerator upon request. At the time the medication refrigerator was opened the thermometer was viewed and registered at 32° F and was confirmed by Nurse #3. An interview, on 05/24/12 at 3:30 PM, was conducted with Nurse #3. She indicated the medication refrigerator temperature was read by the day shift nurse in the AM and was read by the evening shift nurse in the PM. A second interview, on 05/24/12 at 5:00 PM, was conducted with Nurse #3. She indicated she had not noted the range of the temperature for the refrigerator in the medication room or that the	F 431		

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F 431	Continued From page 24 temperature was out of range. Nurse #3 relayed the she should call the maintenance person when the temperature of the refrigerator was out of range. An interview, on 5/24/12 at 5:45 PM, was conducted with the Director of Nursing (DON). The DON indicated she would have expected the nurses to have noticed the refrigerator temperature was out of range; to have notified her, and she in turn would have contacted maintenance to check the refrigerator and follow up.	F 431		
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	F 520		

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F 520	Continued From page 25 a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based upon record reviews, physician, pharmacist and facility staff interviews the facility failed to monitor a plan of action for identifying problems with lab monitoring. Findings Include: Resident #39 was admitted to the facility on 4/30/09 with diagnoses of diabetes, hypertension, Deep Vein Thrombosis (DVT) and cerebral vascular disease. The annual minimum data set dated 4/12/12 indicated Resident #39 to require minimal to significant assistance with his activities of daily living and his balance was not stable in most areas. The care plan documented in the facility computer system indicated there was trauma potential for bleeding related to anticoagulant therapy. Some of the approaches to this potential problem were to monitor lab values and notify the physician of the lab results as needed. A record review of the facility' s Medication Administration Record (MAR) revealed Resident #39 coumadin dosage to be 7.5 milligrams (mg) daily during the month of October 2011. There was a standing order for Prothrombin Time (PT) and International Normal Ratio (INR) labs to be conducted monthly. A record review of the facility' s PT/INR lab work was conducted. There was a critical PT/INR lab on 10/25/11. The lab work revealed the nurse	F 520	**F520** Resident #39 INR as re-drawn per physician's order on 5/31/12 by the Nurse Consultant with an INR of 1.3 (normal range 0.8-1.2). The Physician was notified of the results on 5/31/12 by the Director of Nursing. There was no new order to change the Coumadin dose by the physician. Resident #39 will continue to have his INR drawn per physician order and monthly per lab policy. A 100% audit of all resident's to include resident #39 medications to include Coumadin was completed by the Director of Pharmacy Clinical Services on 5/25/12 and 6/5/12 to ensure labs have been monitored and drawn per lab policy. A repeat lab audit was completed by the Facility Consultant on 6/1/12. The Director of Nursing was notified of any lab values that had not been obtained. All labs identified as not obtained were drawn by 6/8/12 by the Director of Nursing, Charge nurses and Lab nurse. The Quality Improvement Committee met on 6/20/12 regarding	6/22/12

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F 520	Continued From page 26 was called with the results on 10/26/11 at 7:56am and the results were faxed to the physician on 10/26/11 at 12:00pm. A record review of the facility' s October 2011 MAR revealed a physician order dated 10/27/11 to repeat PT/INR on 10/31/11 and call the physician with the results. There was no evidence that the PT/INR was repeated on 10/31/11. A record review of the follow-up lab revealed a redraw PT/INR was conducted on 11/4/11. The lab results were reported to the facility on 11/05/11. This lab volume was indicated as insufficient specimen. There were no lab results. There was no evidence that the physician was notified of the lack of lab results. There was another lab redraw conducted on 11/8/11. The lab results were reported to the facility on 11/9/11. There was no date of when the results were reported to the physician. The repeat lab work was conducted on 11/17/11. The lab results were reported to the facility on 11/18/11 and the results were faxed to the physician on 11/18/11 at 2pm. There was no indication on the lab work for intervention or physician response. An interview with Nurse #3 on 5/25/12 at 9:32 pm revealed she worked on 10/25/11. She could not specifically recall the Resident #39 critical lab on 10/25/11. If there was a critical or abnormal lab she would have faxed the lab to the physician office. If the physician had not responded, she	F 520	lab monitoring and reviewed lab protocol. The Quality Improvement Committee Consists of Administrator, Director of Nursing, Facility Consultant and Lab Nurse. A second audit of 25% of resident census was conducted by the Regional Pharmacy Clinical Manager on 6/6/12, with no concerns identified. A DISCUS review was completed by the Pharmacy Consultant on 6/4/12 for 100% of all residents receiving psychotropic medications to include resident #59. All identified areas of concern were corrected by the Director of Nursing. The Administrator, Director of Nursing, Lab Nurse, MDS Nurse, Social Worker and Medical Records were inserviced on the Executive Quality Assurance Committee protocol on 6/21/12 by the Regional Vice President and the Facility Consultant.	6/22/12

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F 520	Continued From page 27 would then call the physician office. She could not recall why there was not a redraw done until 11/4/11. She indicated if there was an insufficient specimen to follow up on a critical INR, she would have called the physician that day for a redraw. She could not understand why the second redraw took until 11/8/11. If the physician has not responded for a critical INR, she might have held the coumadin medication based upon her nursing judgment until the physician got back into contact with her. The pharmacist note dated 12/8/11 revealed on 11/8/11 the INR (on 11/17/11) was indicated to be too high. There was a recommendation by the pharmacist to check the INR as soon as possible. The pharmacist note indicated an e-mail was sent to the Director of Nursing (DON) and Administrator. A record review of the consultant pharmacist e-mail dated 12/8/11 to the DON and Administrator revealed the pharmacist recommended to follow-up with the physician for an INR. The INR on 11/17/11 was high. It indicated there were no changes made to his coumadin regimen and a follow-up INR did not appear on the chart. An interview with the Pharmacy Director on 5/24/12 at 5:27pm revealed he was unclear why the dosage for 11/1/11 to 11/2/11 was given then held. They could not find a lab for 10/31/11. He could not answer to why the redraw was not conducted until 11/4/11. There was not a PT/INR conducted for February 2012.	F 520	The Quality Improvement Committee will meet monthly to review areas of concern and develop and implement appropriate plans of action to include labs, physician orders, and DISCUS. The Administrator is responsible for overall compliance. The Administrator will compile audit results of the Monthly Quality Improvement Committee and review at the Executive Quality Assurance Committee Meeting quarterly. The Executive Quality Assurance Committee consists of the Administrator, Director of Nursing, Lab Nurse, Pharmacy Consultant, Medical Director, Social Worker and Housekeeping Director. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring.	6/22/12

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F 520	Continued From page 28 There was a PT/INR conducted on 4/26/12. The lab work indicated the physician was made aware on 4/27/12. There were no physician orders related to the lab results on 4/26/12. A record review of the facility' s nurse notes was conducted. The note dated 4/27/12 indicated that the physician was notified about the PT/INR lab drawn on 4/26/12. The facility was awaiting a call back from the physician. The next documentation regarding the 4/26/12 lab work was on 5/23/12 at 7:14pm. The note, written on 5/23/12, indicated a third notification was sent to the physician about the 4/26/12 lab work on 5/23/12. There were no new orders received related to the coumadin dose. The facility obtained an order for a PT/INR to be conducted the next day. On 5/23/12 at 10:45pm a lab specimen was drawn. On 5/24/12 the physician was notified of the lab results. An interview with the DON on 5/23/12 at 6:49pm revealed the physician may have gotten confused where to put his notes in response to the lab work for 4/26/12. A record review of the facility lab work revealed a PT/INR test was done on 5/4/12. There was no physician response on the lab work. The nurse notes for May 2012 did not indicate a physician response for the lab work 5/4/12. An interview with the Physician on 5/24/12 at 11:38am revealed typically for a critical INR lab work he would immediately hold the coumadin medication and do follow-up lab work in a couple of days. He would not wait longer than this for a	F 520		

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follow-up lab work. Usually the nurse from the facility either called him or faxed him the lab results. He would respond via phone to the nurse, if he was called. When the lab results were faxed, he would write down the suggestions on the lab work and fax back to the facility. He could not recall being notified of the lab work on 4/26/12.

A record review of the facility' s policy on the Quality Improvement (QI) Action Team for laboratory monitoring dated January 2011 revealed the purpose was to assist the facility staff in ensuring that ordered laboratory test were obtained in a timely manner as prescribed by the ordering physician and facility policy and that the results of ordered test were available in the medical record upon receipt from the laboratory. The monitoring systems should maintain a laboratory log which would contain written or verbal lab physician orders or pharmacy standing laboratory orders. A staff member should be assigned to maintain this log daily. For any laboratory values not received within 3 days after being obtained, should be investigated to ensure that the specimen was drawn or obtained. The pharmacy consultant should review standing pharmacy laboratory orders monthly and notify the DON of any lab values which have not been obtained. The Medical Records staff member should conduct chart audits as determined by policy and will audit laboratory results. Any ordered lab values that were not in the medical record should be brought to the attention of the DON and Administrator for corrective action.

A record review of a facility' s quarterly improvement meeting dated 9/26/11 revealed that

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F 520	Continued From page 30 lab monitoring was one of the concerns identified. It was identified that labs and the lab nurse were out of compliance. The resolution to this problem was to have a new lab nurse in place on 10/5/11. The goal date for resolution was 10/1/11. A record review of the facility' s report of QI Action Team dated March 2012 was provided. It indicated the first area of concern as laboratory monitoring. The labs were not obtained per PT/INR policy. The possible solution was an audit of all residents that had lab orders to be completed from 3/13/12 through 3/15/12 on lab requisitions sheets for a goal date of 3/15/12. There was a list of residents audited and attached to the QI Action Team Sheet. It indicated Resident #39 had a missing lab for February 2012. The second problem area was that the physician orders for labs were not drawn in a timely manner. The possible solution was for physician order to be written for all labs and medication regimens. The third problem was pending lab draws were not being conducted. The possible solution was for all labs to be drawn by nurses and a new lab nurse to be in place by 3/26/12. The newly hired lab nurse will resolve the issue by 3/26/12. An interview with the DON on 5/23/12 at 6:49pm revealed the facility hired a new lab nurse initially but had to replace the lab nurse on two more occasions. The monitoring of PT/INR lab work was based upon their policy of getting the coumadin lab work conducted monthly without specific dates. The new lab nurse, Nurse #1 was doing the lab monitoring and referred to the monthly calendar at the desk to request labs. This was the monitoring they do for all lab work.	F 520		

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F 520	Continued From page 31 There were no specific tools or audits used. A record review of the facility' s routine laboratory determinations policy revealed coumadin procedure of PT/INR should be performed 1 week of initiation or change of coumadin, then monthly. An interview with the Nurse Consultant on 5/24/12 at 3:49pm revealed she was unaware of any problems with lab monitoring and coumadin. The company has a coumadin audit form. She was unsure if the facility was using this and would have to verify. She was aware the physician had issues with visiting the facility on a regular basis. They have hired a new Medical Director. Ultimately the DON would be responsible for insuring physician; lab and medication orders were carried out. A record review of the facility' s coumadin audit form created on 9/28/09 was conducted. There were no coumadin audit forms completed by the facility. An interview with Nurse #1 on 5/24/12 at 9:59am revealed when he received a physician order he would transcribe it and verify the order on his shift. There was a booklet at the nursing station with standing order lab protocols. He was designated as the lab draw nurse in March 2012. He picked a day at the beginning of each month and reviewed all of the medical charts for lab orders. For coumadin and any other lab ordered monthly, he would look back for the last day the lab was drawn and request the lab work to be conducted for the same day next month. He would place a lab request sheet in a booklet at the nurse station and the DON would look	F 520		

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through them to verify them. He then would draw the lab work. He would contact the lab company the day of the lab draw, so that they may pick up the specimen. The lab company would usually be in the facility by 1:30pm to pick it up. The lab results would be faxed to the facility next day. If the lab company was unable to pick up the specimens timely, facility staff would go to the nearest hospitals to get the labs completed. When there is a critical or abnormal lab result he would call the physician during business hours. If it was after hours, he would call the physician on call. If he were unable to reach a physician he would call the other physician that covered the facility. If he were unable to contact the physician during business hours, he would try to contact the physician ' s office nurse or anyone at the office who could receive the message.

An interview with Nurse #2 on 5/24/12 at 4:35pm revealed the charge nurse assigned to the resident received the lab results. If they were abnormal, she would notify the physician and obtain new orders. She would write orders and update the MAR as related to medication.

An interview with the new Pharmacy Consultant on 5/24/12 at 10:50am revealed their consults were completed monthly. They hired a new Pharmacist in January 2012. Typically the prior month PT/INR would not be referenced to due to the coumadin levels changes so much. They did make recommendations for Resident #39 in February 2012 and March 2012. There were no new coumadin levels and results, upon the consultant pharmacist date of visits in February 2012 and March 2012. In April 2012, they indicated labs were drawn and a follow-up was

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F 520	Continued From page 33 completed for March 2012. A record review of the facility physician notes revealed notes for 12/26/11 and 1/31/12. There was no documentation of INR/PT labs or coumadin medication. An interview with the Nurse Consultant and DON on 5/24/12 at5:40pm was conducted. The Nurse Consultant indicates she knew the pharmacists do their monthly audit on standing orders. Otherwise the medical records staff audit and investigation portion based upon the QI Action Team Lab monitoring policy had not been followed and obviously a new system would need to be in place. She could not answer to why there was not an investigation process conducted for the delayed lab redrawn on 11/4/11 and 11/8/11. Their policy was supposed to be followed.	F 520		

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K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/5/12 at approximately noon the following exit access was non-compliant, specific findings include, dining room exit blocked with temporary freezer on a truck located directly outside the exit door.	K 038	Temporary freezer truck removed from exit door area/facility grounds week of 6/11/12. Department heads inserviced on need to have all exits readily accessible at all times by administrator on 6/20/12.	7/14/12
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By document review on 6/5/12 at approximately noon the following fire drills were non-compliant, specific findings include: A. The last five fire drills on third shift for 2011 &	K 050	Maintenance manager inserviced 6/19/12 on need for varying times of fire drills especially on third shift. Administrator will monitor fire drill log monthly x6 months to ensure variation in fire drill times and necessary shifts to ensure continued compliance. Any areas of concern will be addressed with maintenance manager immediately.	

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

[signature] Administrator 6/25/12

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.

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
	345101	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENFIELD OAKS NURSING AND REHABILITATION CENTER	208 CARY ST ENFIELD, NC 27823

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K 050	Continued From page 1 2012 were held between 5:22 AM and 6:02 AM, and 11:00 PM only. Fire drills are to be held at unexpected times. B. First quarter for 2012 indicated that there was not a drill conducted on 2nd shift.	K 050		7/12/12
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/5/12 at approximately noon the following fire alarm panel was non-compliant, specific findings include; A. The panel read pump phase reversal short. B. The digital alarm communicator read trouble Line 2.	K 052	Fire alarm panel indicating pump phase reversal short and digital alarm communicator read trouble line 2 serviced and resolved by 17:00 6/5/12. All systems normal reading since 6/5/12. Facility will continue scheduled monitoring and testing.	6/5/12
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 144	Continued From page 2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By documentation review on 6/5/12: The staff could not substantiate that the emergency generator was exercised under load for a minimum of 30 minutes per month.	K 144	Maintenance manager inserviced on need to indicate when generator test is run under load setting, and ensure load test is run monthly. Administrator will monitor generator test log monthly x6 months to ensure proper testing and continued compliance. Any issues with generator test log will be addressed with maintenance manager immediately.	7/11/12