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 _____	C 06/11/2015

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

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation event ID #3UBE11.	F 000		
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 278	Enfield Oaks Nursing and Rehabilitation	7/10/15

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

Electronically Signed | 06/25/2015

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F 278	Continued From page 1 facility failed to accurately code Minimum Data Sets (MDS ' s) for 5 of 15 residents (Residents #12, #29, #24, #62 and #31) whose MDS ' s were reviewed. The findings included: 1. Resident #62 was readmitted to the facility on 9/28/11. The quarterly MDS dated 8/19/14 was coded to indicate the resident had no unhealed pressure ulcers. The quarterly MDS dated 11/19/14 was coded to indicate the resident had a pressure ulcer on the prior assessment. Review of progress notes and skin condition assessments from 6/1/14 through the discharge date of 2/1/15 revealed no documentation that Resident #62 had a pressure ulcer during that period. During an interview on 6/10/15 at 4:37 PM, the MDS nurse indicated the pressure ulcer information on the MDS dated 11/19/14 was incorrect due to an item coding error. The MDS nurse explained that she copied MDS information from the prior assessment to the new assessment and missed correcting the datum. #2. Resident #12 was admitted to the facility on 8/13/2014. A nurse progress note dated 3/3/2015 stated " resident pulled catheter out " . A physician ordered dated 3/5/2015 stated to discontinue urinary catheter. The quarterly Minimum Data Set (MDS) assessment dated 5/16/2015 indicated the resident had an indwelling urinary catheter. An observation of Resident #12 on 6/9/2015 at 5:07 PM revealed there was no urinary catheter present.	F 278	Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Enfield Oaks Nursing and Rehabilitation Center¿s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Enfield Oaks Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The Minimum Data Set (MDS) assessments for residents # 12, # 24, and #31 were reviewed and the appropriate modifications were made to include Sections H, M, and O to accurately reflect the residents¿ current condition by the MDS Nurse by 6/11/15. Residents # 29 and # 62 are no longer residents of this facility. A 100% audit of the last completed MDS assessment for all residents to include residents # 12, # 24, and # 31 was initiated on 6/25/15 by the Interim Director of Nursing, Quality Improvement Nurse,	

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F 278	Continued From page 2 An interview was conducted on 6/10/2015 at 2:10 PM, with the MDS nurse. The MDS nurse stated that the urinary catheter was an item coding error, and when she copied the previous MDS information to current MDS, she missed correcting this item. #3. Resident # 29 was admitted to the facility on 2/24/2015. His admission assessment dated 2/24/2015 indicated there were no pressure ulcers present. The admission Minimum data Set (MDS) assessment dated 3/4/2015 indicated one pressure ulcer was present on admission. An interview was conducted with the wound care nurse on 6/10/2015 at 10:36 AM. The wound nurse stated the resident did not have a pressure wound on admission. An interview was conducted with the MDS nurse on 6/10/2015 at 5:14 PM, who stated that this might have been miscoded. She consulted with the wound nurse via telephone, and then stated this was an item coding error. #4. Resident #24 was readmitted to the facility on 11/24/2015 with diagnosis to included paraplegia and pressure ulcer. The quarterly Minimum Data Set (MDS) assessment dated 5/25/2015 indicated the resident was on hospice. No corroborating documentation was found in his medical records to support hospice. An interview was conducted with the Administrator on 6/11/2015 at 9:32 AM. The administrator stated there were no residents, at this time, receiving hospice care in the facility. An interview was conducted with the MDS nurse on 6/11/2015 at 9:46 AM, who stated resident #24 was not on hospice. The MDS nurse reviewed	F 278	MDS Consultant, and Facility Consultant on 6/25/15 to ensure the most recent MDS Assessment accurately reflects the resident¿s current condition to be completed by 6/29/15. For all areas of concern identified, a modification or significant correction of prior assessment (Quarterly/Comprehensive) was completed by the MDS Coordinator, Social Worker, Dietary Manager, and/or Activity Director as indicated by the RAI Manual on 6/30/15. Training was initiated for the Care Plan Team to include MDS Nurse on 6/11/15 by the MDS Consultant regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual to be completed by 6/26/15. Teleconference on MDS completion will be viewed by the Care Plan Team to include MDS Nurse by 6/26/15. When coding the MDS assessment the MDS Nurse and Care Plan Team will follow the instructions for proper coding found in the Resident Assessment Instrument (RAI) Manual and ensure that the assessment accurately reflects the resident¿s current condition. An audit of 25% of completed Minimum Data Set (MDS) assessments will be conducted weekly x 4 weeks, then bi-weekly for 4 weeks, then 10% monthly x 2 months by the Director of Nursing (DON) or RN Quality Improvement (QI) Nurse to ensure compliance and accuracy utilizing a MDS Audit Tool. All identified areas of concern will be addressed immediately by the	

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F 278	Continued From page 3 resident #24 ' s MDS and stated the hospice entry was a data entry error. 5. Resident #31 had been admitted to the facility on 7/07/2010. The Wound Care Flow Sheet dated 2/11/2015 indicated the resident had an unstageable (the wound bed was not visible) wound covered by 100% eschar (a scab like covering of dead tissue). The size was 4.0 centimeters (cm) long by 4.5 cm wide. The Quarterly MDS dated 2/12/2015 indicated the resident had an unstageable pressure ulcer, covered with eschar that was 4.0 cm long by 3.5 cm wide in size. The Wound Care Flow Sheet dated 5/12/2015 indicated the resident had a pressure ulcer, Stage 3 (the wound extends into the tissue beneath the skin, forming a small crater) which was pink and granulated (collagen-rich tissue which forms at the site). The size was 1.5 cm long by 2 cm wide with no depth. The Quarterly MDS assessment dated 5/15/2015 indicated the resident had an unstageable pressure ulcer, covered with eschar that was 4.0 cm long by 3.5 cm wide in size. An interview with the MDS nurse on 6/11/2015 at 11:24AM was conducted. The MDS nurse indicated she had used the copy button in the MDS program during these assessments and had not corrected the prepopulated information.	F 278	DON or QI Nurse through retraining and by modification or significant correction of the MDS assessment by the MDS Nurse to accurately reflect resident¿s current condition. The results of the MDS Audit Tool will be compiled by the Administrator and presented to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		7/10/15

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F 441	Continued From page 4 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 441	The Glucometer on the Station 1	

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F 441	Continued From page 5 policy and manufacturer specifications, the facility failed to sanitize a glucometer after use on 1 of 1 resident (Resident #1) observed during a blood glucose check. The findings included: The facility policy entitled, "Glucometer - Cleaning & Disinfection", revised 9/4/14 read in part, "If no visible blood or bodily fluids are present: a) Use EPA (Environmental Protection Agency)-registered germicidal disposable cloth/wipe to thoroughly wet the entire external surface of the glucometer; b) Then cover/wrap the entire glucometer with the wipe, and c) Place in a plastic disposable cup on the med cart and allow full minutes' exposure time according to the manufacturer's product directions for disinfection of the glucometer." "When glucometer is completely dry, it may be used for next resident or if not proceeding to another resident, store glucometer in med cart of specified storage area. Discard disposable plastic cup after each use." Review of the manufacturer specifications on the germicidal wipe package, kept in the medication cart, included to thoroughly wet the surface with the wipe; ensure surface was visibly wet for 2 minutes; allow to air dry. On 6/10/15 at 4:25 PM, Nurse #1 was observed at the onset of performing "before supper" blood glucose checks. The nurse completed the check for Resident #1 and returned the glucometer to the medication cart after inspecting but not sanitizing it. On 6/10/15 at 4:33 PM Nurse #1 removed the glucometer from the medication cart and gathered supplies to perform a blood glucose check on Resident #15. As the nurse was entering the resident ' s room she was asked what the facility policy was on sanitizing the glucometer. The nurse said the 3rd shift was	F 441	medication cart was sanitized per facility protocol and Nurse # 1 was inserviced on proper technique for cleaning and sanitizing the glucometer by the Director of Nursing (DON) on 6/10/15 with a return demonstration given. 100% inservice was initiated on 6/10/15 by the DON and Staff Development Coordinator for all licensed nursing staff, licensed agency nurses, and medication aids to include Nurse #1 on proper technique for cleaning and sanitizing glucometers with return demonstration given to be completed by 6/28/15. All new licensed nursing staff, medication aids, and licensed agency nurses will be trained during orientation by the Staff Development Coordinator. After performing a blood sugar check on a resident the licensed nurse or medication aide will clean and sanitize the glucometer per facility policy prior to using for another resident or storing on medication cart using the following technique: Apply gloves. When visible blood or body fluids are present, clean by wiping the external surfaces with a cloth damped with soap and water to remove any visible material. If no visible blood or body fluids are present use Environmental Protection Agency (EPA)-registered germicidal disposable wipe to thoroughly wet the entire external surface of the glucometer, then cover/wrap the entire glucometer with the wipe, and place in a disposable cup on the med cart and allow full minutes¿ exposure time according to the	

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F 441	Continued From page 6 responsible for sanitizing the glucometer. She added that if there was visible soiling she would wipe in down with alcohol or a sanitizing wipe, but she had checked and saw no soiling. The SDC (Staff Development Coordinator) was interviewed at 6/10/15 at 4:35 PM in the presence of Nurse #1 and the DON. The SDC explained the policy was to sanitize the glucometer between residents with a sanitizer wipe; the process was to wipe the machine thoroughly, wrap it in the wipe and wait for 2 minutes, then remove and allow to air dry. The DON stated it was her expectation that the glucometer was sanitized after each use. Immediately following the interview, Nurse #1 returned to the medication cart and wiped the glucometer with the germicidal wipe, then discarded the wipe. Nurse #1 was questioned at this time and stated she had not understood that the glucometer had to be wrapped in the wipe. She then used a new wipe to wrap the glucometer and was observed to follow the facility procedure prior to obtaining the blood glucose test for Resident #15.	F 441	manufacturer¿s product directions, remove cloth wipe and discard. Return glucometer to plastic cup to allow to air dry. Remove and discard gloves. Wash and/or sanitize hands with waterless hand hygiene gel. When glucometer is completely dry, it may be used for next resident or if not proceeding to another resident, store glucometer in med cart or specified storage area. Discard disposable plastic cup after each use. The Director of Nursing and Staff Development Coordinator will conduct Glucometer Sanitation Audits 3 x week x 4 weeks, weekly x 4 weeks then monthly x 2 months on first, second, and third shifts using a Glucometer Audit Tool to ensure the above technique is being utilized by licensedd nurses and medication aids. Any concerns with technique will be immediately addressed by the DON or SDC by retraining staff. The Administrator will review the Glucometer Audit Tools weekly x 8 weeks then monthly x 2 months and initial. The DON will compile the results of the Glucometer Sanitation Audits and present to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	