| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 272 SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment. | F 272 | | 6/6/16 |

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

Electronically Signed | 06/01/2016

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.

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 272 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interview the facility failed to initiate a significant change in status assessment for 1 of 1 resident reviewed for Hospice services (Resident #9). Findings included:<br><br>Resident #9 had been admitted to the facility on 5/01/2013. Diagnoses included chronic obstructive pulmonary disease (COPD), cerebrovascular accident (CVA), dementia, depression, psychotic disorder, diabetes and intellectual disability.<br><br>The Hospice certification and plan of care (POC) dated 6/25/2015 indicated Resident #9 had been admitted to Hospice services on this date. Diagnoses included cerebrovascular disease, senile degeneration of the brain and dysphagia. The certification and POC had been signed by the physician.<br>The next Minimum Data Set (MDS) assessment completed for Resident #9 had been a quarterly assessment dated 8/08/2015 and indicated Resident #9 had received hospice care.<br>An interview with the MDS nurse was conducted on 5/12/2016 at 12:40 PM. The nurse stated she was unsure why a significant change in status assessment had not been completed for Resident #9.<br>An interview with the Director of Nursing (DON) was conducted on 5/12/2016 at 12:40 PM. The DON stated a change in condition should have been identified when Hospice services were elected and a significant change in status MDS assessment should have been completed. | F 272 | Enfield Oaks Nursing and Rehabilitation 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.<br><br>F 272 Comprehensive Assessment<br>A Significant Change Status Assessment (SCSA) was initiated by the Facility MDS Consultant for Resident #9 on 2/19/16 and completed on 3/04/16 by the MDS Nurse.<br><br>100% audit of all residents to include residents receiving hospice care and Resident #9 was initiated by visiting MDS Nurse on 5/27/16 to ensure that the SCSA was initiated and completed as indicated | |

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 272 | Continued From page 2 | F 272 | per instructions in Chapter 2 of the MDS 3.0 Manual. Audit was completed on 5/27/16. All concerns were addressed by the MDS nurse immediately by initiating and completing a SCSA as indicated by 6/02/16.<br><br>An inservice on initiating and completing a SCSA per instructions found in Chapter 2 of the MDS 3.0 RAI Manual was conducted by the Facility MDS Consultant on 5/25/16. A 100% inservice was initiated for all CNAs and licensed nursing staff by the Staff Facilitator Assistant on 5/26/16 regarding the need to notify the MDS nurse or DON of any changes in a resident's condition and functioning to include new orders for Hospice Care so that a determination can be made of the need to proceed with initiating a SCSA. All newly hired CNAs and licensed nursing staff will be inserviced by the Staff Facilitator Assistant during orientation regarding the need to notify the MDS Nurse or DON of any changes in the resident condition and functioning to include new orders for Hospice Care so that a determination can be made of the need to proceed with initiating a SCSA.<br><br>When a resident begins receiving Hospice Care services the MDS Nurse will initiate and complete a SCSA following the guidelines provided in Chapter 2 of the MDS 3.0 RAI Manual. Residents will also be routinely monitored for significant changes in condition to determine if the SCSA is required per Chapter 2 of the MDS 3.0 RAI Manual by reviewing the 24 | |

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 272 | Continued From page 3 | F 272 | hour reports for changes in the resident condition, discussion during morning meetings of possible changes in condition, review of pink physician order slips and physical assessment as indicated. The DON, QI nurse and treatment nurse will audit 10% of the residents, to include resident #9, weekly x 8 weeks then monthly x 1 months using a QI Change in Condition Audit tool to determine if a Significant Change Status Assessment is required or has already been initiated by the MDS Nurse or other appropriate staff and initiation of a SCSA | |
| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>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 | F 278 | | 6/6/16 |

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 278 | Continued From page 4<br>resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interview the facility failed to code the Minimum Data Set (MDS) correctly for 4 of 17 residents reviewed for diagnoses (Resident #21, #14, #45, #30) and 2 of 2 residents reviewed for wound assessments (Resident #23, #50).<br>Findings included:<br><br>#1. Resident #14 was admitted to the facility 8/13/14 with diagnoses which included dementia, anxiety, depression and psychotic disorder.<br><br>The most recent quarterly Minimum Data Set (MDS) of 2/9/16 indicated the resident was severely cognitively impaired. The Active Diagnoses section of the MDS did not include anxiety. The resident reported having trouble falling asleep 2-6 days out of 7.<br><br>A review of the psychiatry consult progress note of 2/29/16 revealed the history of present illness included insomnia, anxiety and dementia.<br><br>An interview was conducted with the MDS Nurse on 5/12/16 at 10:15 AM. The nurse stated that the diagnoses section of the MDS would prepopulate and the diagnosis for anxiety had been missed by the previous MDS nurse. | F 278 | F 278<br>ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br>The Last Minimum Data Set (MDS) assessments completed for resident # 21, resident #14, resident #45, resident #30, Resident #23 and resident #50 were reviewed and the proper modifications were made to ensure that the assessments accurately reflected the residents condition, to include Section I and Section M, by the MDS Nurse on 5/31/16.<br>A 100% audit of the last completed MDS assessment for all residents to include resident # 21, resident #14, resident #45, resident #30, Resident #23 and resident #50 was initiated by Trained MDS Nurse on 5/26/16 to ensure coding of the minimum data set accurately reflects the residents condition to include the coding for Section I and Section M. The audit to be completed by 5/23/16. For all identified areas of concern, a modification or significant correction of prior assessment (Quarterly/Comprehensive) will be completed by the facility MDS Nurse by 6/03/16. | |

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 278 | Continued From page 5<br><br>An interview was conducted with the Director of Nursing on 5/12/16 at 10:38 AM. She stated it was her expectation that the MDS nurse verify the diagnoses that were prepopulated and ensure the MDS was coded accurately.<br><br>#2. Resident # 45 was admitted to the facility 8/20/15 with diagnoses that included dementia, anxiety, depression, adult failure to thrive, and other mental disorders due to known physiological condition.<br><br>A review of the care plan created 12/4/15 indicated the use of psychotropic drugs/use of antidepressant and antianxiety with a goal that the resident will show minimal/no side effects of medications taken. Relevant interventions were included.<br><br>The most recent quarterly Minimum Data Set (MDS) of 3/1/16 indicated the resident was cognitively intact. The assessment indicated the resident reported feeling down, depressed or hopeless 2-6 days out of 7 and exhibited verbal behaviors and behavior not directed toward others 1-3 days out of 7. He was listed as receiving antianxiety and antidepressant medications 7 out of 7 days. The Active Diagnoses section of the MDS did not include anxiety and depression.<br><br>A review of the March 2016 physician's orders revealed Resident #45 was currently receiving Zoloft 75 milligrams (mg) daily for depression and anxiety and Klonopin (a medication used to treat | F 278 | The MDS Nurses, Social Worker (SW), Dietary Manager (DM), and Activities Director (AD) will be re-inserviced on proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual by the MDS Consultant to be completed by 5/25/16. Teleconference on MDS completion will be viewed by the Care Plan Team to include MDS Nurse, SW, DM, and AD by 5/26/16.<br>When coding the MDS assessment the MDS Nurses 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 50% of completed Minimum Data Set (MDS) assessments to include Section I and Section M and any subsequent MDS assessments completed for residents #21, #14, #45, #30, #23, and #50 will be conducted weekly x 4 weeks, then 25% bi-weekly x 4 weeks, then 25% monthly x 1 month by the DON and QI Nurse to ensure compliance and accuracy utilizing a QI MDS Audit Tool. All identified areas of concern will be addressed immediately by the DON with retraining of appropriate staff as indicated and by the MDS nurse with modification or significant correction of the MDS Assessment. The Administrator will review and initial the QI MDS Audit Tool weekly x 4 weeks, then bi-weekly x 4 weeks then monthly x 1 months.<br>The results of the MDS Audit Tool will be compiled by the Administrator and presented to the Quality Improvement | |

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 278 | Continued From page 6<br>anxiety) 1 mg every night.<br><br>A review of the psychiatry consult note from 3/31/16 revealed the chief complaint/nature of presenting problem as anxiety, insomnia and dementia.<br><br>An interview was conducted with the MDS Nurse on 5/12/16 at 10:15 AM. The nurse stated that the diagnoses section of the MDS would prepopulate and the diagnosis for depression and anxiety had been missed by the previous MDS nurse.<br><br>An interview was conducted with the Director of Nursing on 5/12/16 at 10:38 AM. She stated it was her expectation that the MDS nurse verify the diagnoses that were prepopulated and ensure the MDS was coded accurately.<br><br>#3. Resident # 30 was admitted 4/8/16 with diagnoses that included hypertension, arthritis, chronic pain syndrome, anxiety, depression and psychosis.<br><br>Her admission Minimum Data Set (MDS) of 4/15/16 indicated she was severely cognitively impaired and reported moods that included having little interest or pleasure in doing things, feeling down or depressed, feeling hopeless, feeling bad about self, feeling she had let herself or family down and was having trouble concentrating on things such as reading the newspaper or watching TV 2-6 days out of 7. The assessment indicated Resident #30 had delusions (misconceptions or beliefs that are | F 278 | Committee monthly x 3 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring. | |

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 278 | Continued From page 7 | F 278 | | |

firmly held, contrary to reality). She was noted to have received antipsychotic, antianxiety and antidepressant medication 7 out of 7 days. The Active Diagnoses section of the MDS did not include anxiety, depression, and psychosis.

A review of the care plan created 4/15/16 indicated concerns with ineffective coping: resident acts sad/depressed related to change of environment (recent admission to facility). The goal specified the resident will demonstrate reduced sadness/depression through the next review. Interventions included to encourage verbalization of feelings and praise/reward resident for demonstrating consisted desired/acceptable behavior. A second care plan created 4/15/16 identified feelings of sadness, anxiety, uneasiness, depression characterized by ineffective coping, low self-esteem, tearfulness, motor agitation and withdrawal from care. The goal was for the resident to show physical sign of stress being alleviated, have improved mood state happier, calmer appearance, no signs and symptoms of depression anxiety or sadness through the next review. Interventions included encouraging the resident to attend group activities and providing emotional support to the resident as needed.

A review of physician orders for April 2016 revealed Resident #30 was receiving Lorazepan (a medication used to treat anxiety) 0.5 milligrams (mg) three times a day, Cymbalta (a medication used to treat depression) 60 mg every morning, and Risperdal (a medication used to treat certain mental/mood disorders) 0.5 mg every morning and 1 mg at bedtime.

An interview was conducted with the MDS Nurse

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 278 | Continued From page 8<br>on 5/12/16 at 10:15 AM. The nurse stated she was new to the position and had missed capturing the diagnosis for Resident #30.<br><br>An interview was conducted with the Director of Nursing on 5/12/16 at 10:38 AM. She stated it was her expectation that the MDS nurse ensure the MDS was coded accurately for each resident.<br><br>#4. Resident #21 had been admitted to the facility on 5/15/2015. Diagnoses included: fracture of the femur neck, dehydration, Escherichia coli in the urine, urinary tract infection, gastroesophageal reflux disease (GERD), hyperlipidemia, hypertension, iron deficiency anemia and dementia.<br><br>A quarterly minimum data set (MDS) assessment dated 8/22/2015 included diagnoses of Escherichia coli and dehydration.<br>A quarterly MDS assessment dated 10/28/2015 included diagnoses of hip fracture, Escherichia coli and dehydration.<br>A quarterly MDS assessment dated 1/26/2016 included diagnoses of Escherichia coli and dehydration.<br><br>The most recent physician note dated 1/27/206 indicated Resident #21's past medical history included a left hip fracture and urosepsis.<br><br>Resident #21's most recent annual MDS assessment was dated 4/25/2016. Resident #21's | F 278 | | |

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 278 | Continued From page 9 | F 278 | | |

active diagnoses included hip fracture, Escherichia coli, and dehydration.

An interview was conducted with the MDS nurse on 05/12/2016 at 10:11 AM. The nurse stated the diagnoses section of the MDS would prepopulate and Resident #21's diagnoses of hip fracture, Escherichia coli and dehydration should not have been included on these assessments.

An interview with the director of nursing (DON) was conducted on 5/12/2016 at 10:38 AM. The DON stated the MDS software the facility used prepopulated the diagnoses section of the MDS assessment. The DON stated the MDS nurse should double check the assessment for accuracy. The DON stated is was her expectation for the MDS to be accurate.

#5. Resident #23 had been admitted to the facility on 6/28/2011. Diagnoses included Hemiplegia, neurogenic bladder, colostomy status and hip amputation status.

Resident #23's most recent annual MDS assessment dated 11/10/2015 indicated Resident #23 was alert and oriented and required extensive assistance with bathing and limited assistance with hygiene and was independent after set up with other ADLs. The assessment indicated upon admission, Resident #23 had one Stage III pressue ulcer (PU) and one Stage IV PU.

Resident #23's most recent quarterly MDS assessment dated 2/10/2016 indicated Resident #23 continued to have two Stage IV PUs. The assessment also indicated Resident #23 had two

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 278 | Continued From page 10 | F 278 | | |

Stage IV PUs which had healed.
An interview with the treatment nurse was conducted on 5/11/2016 at 3:30 PM. The nurse stated Resident #23 had been admitted with one PU on his right heel and one large pressure ulcer on the buttocks. The nurse stated Resident #23 continued to have the same pressure ulcers since admission, the wounds had improved but had not yet completely healed.
An interview was conducted with the MDS nurse on 05/12/2016 at 10:11 AM. The nurse stated the wound section of the MDS had been miscoded.

An interview with the DON was conducted on 05/12/2016 at 10:38 AM the DON stated it was her expectation for the MDS to be accurate and for the MDS nurse to double check the assessment for accuracy.

#6. Resident #50 had been admitted to the facility on 11/27/2015. Diagnoses included a chronic ulcer of the foot, anemia, thyroiditis, quadriplegia, hypertension, diabetes and osteoarthritis.

Resident #50's admission MDS assessment dated 12/09/2015 indicated Resident #50 was alert and oriented. Required extensive assist with ADLs and only required supervision with eating and locomotion, continent of urine and occasionally incontinent of bowel. Indicated upon admission, Resident #50 had two Stage III pressure ulcers (PU) and one Stage IV PU. Resident #50's most recent quarterly MDS assessment dated 2/12/2016 indicated Resident #50 had two Stage III PU and one Stage IV PU. The assessment also indicated Resident #50 had two Stage III PU and one Stage IV PU which had healed.

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 278 | Continued From page 11<br>An interview with the treatment nurse was conducted on 5/11/2016 at 3:35 PM. The nurse stated Resident #50 had been admitted with three pressure ulcers and continued to have the same three pressure ulcers as the ulcers had not yet completely healed.<br>An interview was conducted with the MDS nurse on 05/12/2016 at 10:11 AM. The nurse stated the wound section of the MDS had been miscoded.<br><br>An interview with the DON was conducted on 05/12/2016 at 10:38 AM the DON stated it was her expectation for the MDS to be accurate and for the MDS nurse to double check the assessment for accuracy. | F 278 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). | F 279 | | 6/6/16 |

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 279 | Continued From page 12<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record review the facility failed to develop a care plan for the use of psychotropic medications for 1 of 5 residents (Resident #30) reviewed for unnecessary medications.<br><br>Findings included:<br>Resident # 30 was admitted 4/8/16 with diagnoses which included depression, anxiety and psychosis.<br><br>A review of orders for April 2016 orders revealed Resident #30 was receiving Lorazepam (a medication used to treat anxiety) 0.5 milligrams (mg) three times a day, Cymbalta (a medication used to treat depression) 60 mg every morning, and Risperdal (a medication used to treat certain mental/mood disorders) 0.5 mg every morning and 1 mg at bedtime.<br><br>Her admission Minimum Data Set (MDS) of 4/15/16 indicated she was severely cognitively impaired and reported moods that included having little interest or pleasure in doing things, feeling down or depressed, feeling hopeless, feeling bad about self, feeling she had let herself or family down and was having trouble concentrating on things such as reading the newspaper or watching TV 2-6 days out of 7 days of the assessment period. The assessment indicated Resident #30 had delusions (misconceptions or beliefs that are firmly held, contrary to reality). She was noted to receive antipsychotic, antianxiety and antidepressant | F 279 | 279 DEVELOP COMPREHENSIVE CARE PLANS<br>The care plan for resident #30 was reviewed and update by MDS Nurse on 5/23/16 to reflect the use of psychotropic medications.<br>A 100 % audit of all residents□ care plans was conducted by Administrative Nurses on 5/31/16, including care plans for resident #30 to ensure comprehensive care plans have been developed per the most recent comprehensive assessment. The care plans were updated for any identified areas of concern by utilizing CAA□s from last comprehensive assessment, progress notes, medication administration records, and treatment records to ensure the care plans address the residents□ current medical, nursing, mental, and psychosocial needs to include care plan for psychotropic medications as indicated by Treatment Nurse/DON on 5/31/16.<br>The Care Plan Team (CPT) to include the MDS Nurse, Social Worker, Dietary Manager, and Activity Director were educated on care planning requirements, per instructions provided in the MDS 3.0 RAI Manual by MDS Consultant and on 5/23/16.<br>When creating a resident□s care plan, the CPT will ensure that the care plan describes the services that are furnished that attain or maintain the resident□s highest practible physical, mental, and | |

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 279 | Continued From page 13<br>medication 7 out of 7 days of the assessment period. The Care Area Assessment Summary indicated the use of psychotropic drug use and the care plan decision was coded as a yes.<br><br>A review of the care plan created 4/15/16 indicated concerns with ineffective coping related to observations of the resident acting sad/depressed as a result of her recent change of environment (recent admission to the facility). There were no goals or interventions documented regarding the use of the antipsychotic medication.<br><br>An interview was conducted with the MDS nurse on 5/12/16 at 10:15 AM. She stated that residents who were receiving psychotropic medications should have a care plan that addressed the potential side effects of such medications. She reviewed the current care plans for Resident #30 and stated they did not include interventions related to the ordered medications and their potential side effects.<br><br>An interview was conducted with the Director of Nursing on 5/12/16 at 12:27 PM. She stated it was her expectation that all residents receiving psychotropic medications be care planned for potential side effects of their medications. | F 279 | psychosocial well-being to include creating a care plan for psychotropic medication use. The DON, QI Nurse, and Treatment Nurse will review all resident care plans to include resident #30 in comparison to triggered Care Area Assessments on all subsequent comprehensive assessments, 24 hour reports, shift change notes, progress notes, current interventions, and physician telephone orders Monday through Friday x 4 weeks, then an audit of 10% of care plans weekly x 4 weeks, and then 10% of care plans monthly x 1 month to ensure that care plans reflect the residents current medical, nursing, mental, and psychosocial needs, to include care plans for psychotropic medication use, utilizing a QI Care Plan Audit Tool. The MDS Nurse will immediately update the care plan for all identified areas of concerns and the DON will provide retraining of the CPT member as indicated. The Administrator will review and initial the QI Care Plan Audit Tool weekly x 8 weeks then monthly x 1 months to ensure compliance.<br>The Administrator will compile the results of the QI Care Plan Audit Tool and present to the QI Executive Committee monthly x 3 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring. | |
| F 431 SS=F | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of | F 431 | | 6/6/16 |

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 14<br>a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>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.<br><br>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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interview the facility failed to store refrigerated medications between 36 degrees and 46 degrees Fahrenheit (F) for one of one medication | F 431 | F 431 Drug Records, Label/Store Drugs & Biologicals.<br><br>1. All medications were removed from | |

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 15<br>refrigerators.<br><br>Findings included:<br><br>An observation of the medication storage refrigerator was made with Nurse #1 on 5/11/2016 at 10:34 AM. The nurse indicated the medication refrigerator thermometer read 32 degrees F. The refrigerator contained a pneumonia vaccine package which indicated the medication should be stored between 36-46 degrees F, Regranex (a topical medication to promote wound healing) indicated the medication should be stored between 36-46 degrees F, hepatitis vaccine package which indicated the medication should be stored between 36-46 degrees F, flu vaccine package which indicated the medication should be stored between 35-46 degrees F, Toujeo insulin syringe package which indicated the medication should be stored between 36-46 degrees F, Novolog 70/30 and Novolog flexpen packages which indicated "keeping in a cold place avoid freezing" and Perforomist nebulizer treatments indicated the packages should be stored between 36-77 degrees F.<br><br>Review of the May 2016 medication refrigerator temperature log revealed four entries had been made. One entry on 5/3/16 noted 30 degrees F and one entry on 5/5/16 noted 34 degrees F. The refrigerator log indicated the medication refrigerator temperatures should be 36-46 degrees F.<br><br>An interview with the Director of Nursing (DON) was conducted on 5/11/2016 at 10:37 AM. The DON stated it would be her expectation for refrigerators to be checked daily and to notify | F 431 | the medication room refrigerator and disposed of on 5/24/16 by the Director of Nursing (DON). Replacement medications were ordered by the DON on 5/24/16. The Medication refrigerator locked in the medication room was replaced on 5/12/16 by the Maintenance Director. The new refrigerator was adjusted to the proper temperature setting Maintenance Director on 5/12/16.<br><br>2. 100% audit of all refrigerators in the facility to include the Medication Room refrigerator was completed by the Director of Nursing on 5/27/16 using a QI Refrigerator Temperature Monitoring Tool to ensure all temperatures were within the appropriate range for the refrigerators designated use. No further Issues were noted with any refrigerator temperatures during the audit.<br><br>3. 100% in-service was initiated by the DON on 5/12/16 for all licensed nurses to include agency nurses regarding the need to check the thermometers in the medication room refrigerator twice daily (in the morning and in the evening), to ensure that the temperature remains within the appropriate range. All newly hired licensed nursing staff will be inserviced by the Staff Facilitator during orientation on the need to check the thermometers in the medication room refrigerator twice daily (in the morning and in the evening) to include the medication refrigerator to ensure that the temperature remains within the appropriate range. | |

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 16<br>maintence if the refrigerator temperatures were not in range. | F 431 | 4. It is the responsibility of the assigned licensed floor nurse to check the medication refrigerator, located in his or her assigned area twice daily, in the morning and in the evening, to ensure the refrigerator temperature remains within the appropriate range and then document the temperature on the Refrigerator Temperature Log. Any refrigerators found to have a temperature reading outside of the appropriate temperature range will be addressed immediately by the licensed floor nurse by adjusting the temperature control knob and rechecking the temperature within 30 minutes. The licensed floor nurse will document the new temperature on the Refrigerator Temperature Adjustment Log if it is within the acceptable range. If after adjusting the refrigerator□s temperature control knob, the temperature remains outside of the appropriate temperature range the licensed floor nurse will immediately contact the Maintenance Director so that that the refrigerator can be replaced or repaired. The DON, QI Nurse, Treatment Nurse, and MDS Nurse, will monitor the temperature and adjustment logs on all the refrigerators for complete documentation and to ensure temperatures are within range in the facility to include the medication refrigerator using a Refrigerator Temperature and Adjustment Monitoring QI tools Monday through Friday x 4 weeks, weekly x 4 weeks, then monthly x 1 months. Any identified concerns will be addressed with reeducation of licensed nursing staff and or adjustment of | |

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 17 | F 431 | temperature in the refrigerator as needed. The Administrator will review and initial the Refrigerator Temperature and Adjustment Monitoring QI tools weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed.<br><br>The Administrator will compile the results of the QI Refrigerator Temperature and Adjustment Monitoring Tool and present to the Executive QI Committee monthly x 3 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring. | |
| F 520 SS=F | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>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.<br><br>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.<br><br>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 | F 520 | | 6/6/16 |

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 520 | Continued From page 18<br>requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to implement, monitor and revise as needed the action plan developed to correct deficiency in the area of accuracy of assessments (F 278) cited during the recertification survey of 6/11/2015. As a result, a deficiency in the area of inaccurate assessments was cited again on the current survey.<br>The findings included:<br>The tag is cross referenced to: F 278: Based on observations and staff interviews the facility failed to accurately code Minimum Data Set (MDS) for 5 of 15 residents (Resident #12, #29, #24, #62, and #31) whose MDS's were reviewed. During the recertification survey on 5/12/2016 the facility was cited for failing to code the MDS correctly for 4 of 17 residents reviewed for diagnoses (Residents #21, #14, #45 and #30), and 2 of 2 residents reviewed for wound assessments (residents #23 and #50).<br>On 5/12/2016 at 11:18 AM, an interview was conducted with the Director of Nursing (DON), and the Administrator. The Administrator stated the facility had corrected the problems of inaccurate MDS assessments when the deficiency was found last year, but there had been staff turnover in that position since then. She indicated she had been made aware there were inaccurate assessments this year. She | F 520 | F520<br>The Administrator, DON and QI Nurse were educated by the corporate consultant on the QI process, to include implementation of Action Plans, Monitoring Tools and the Evaluation of the QI process, and modification and correction if needed on 5/27/16. The Administrator, DON and QI Nurse were educated by corporate consultant on the QA process to include identifying issues that warrant development and establish a system to monitor the corrections and implement changes when the expected outcome is not achieved. Completion date 5/27/16.<br>The Facility consultant completed 100% audit of previously citation action plans within the past year to include accuracy of assessments to ensure that the QI committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QI Committee by the administrator on 6/01/16 for any concerns identified.<br>All data collected for identified areas of concerns to include accuracy of assessments and current citations will be taken to the Quality Assurance committee | |

| 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 _____ | 05/12/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ENFIELD OAKS NURSING AND REHABILITATION CENTER | 208 CARY STREET 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 520 | Continued From page 19<br>stated when a facility had turnover in staff, things were going to be missed. | F 520 | for review monthly x 3 months by the Quality Improvement Nurse. The Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the director of nursing.<br>The Executive Committee Quarterly meeting minutes will be reviewed and initialed by the Facility Consultant to ensure implemented procedures and monitoring practices to address interventions, to include accuracy of assessments and all current citations are followed and maintained Quarterly x 2.<br>The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring. | |