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 _____	03/30/2017

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 280 SS=G	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 280		5/6/17

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

Electronically Signed | 04/18/2017

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 _____	03/30/2017

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 280	Continued From page 1 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 280		

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 _____	03/30/2017

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 280	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and physician interviews the facility failed to include in the care plan range of motion exercises to the right lower extremity for 1 of 4 residents reviewed for range of motion. The resident developed a contracture of the right knee and an unstageable pressure ulcer to the end of the right stump. (Resident #11). The findings included: Resident #11 was admitted to the facility on 9/23/16 from the hospital after a right below the knee amputation. The resident was admitted to the facility with a knee immobilizer on the right lower extremity. The Care Area Assessment (CAA) dated 10/6/16 for Cognitive Loss/Dementia noted the resident had severe cognitive impairment and moderately impaired decision making skills and required cues and supervision. The CAA revealed the resident was dependent on staff for activities of daily living. A hand written Rehab Communication to Nursing form dated 11/11/16 written by the Physical Therapist noted exercises to include bilateral lower extremity therapeutic exercises ankle, knee, hip. The Short Term Goal was the patient would tolerate bilateral lower extremity therapeutic exercises 3 sets of 12 three times a week. A computer generated Rehab Communication to Nursing form dated 11/11/16 noted specific restorative interventions as follows: "Patient to tolerate both LE (lower extremity) sets of 12 to left ankle, knee, hip three times a week. The form contained the signature of MDS (Minimum Data Set) Nurse #1.	F 280	Enfield Oaks Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that this 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 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. F280 Resident #11 care plan was reviewed and revised on 4/12/17 to reflect the resident right lower extremity contracture by the Minimum Data Set (MDS)nurse. A therapy referral was completed on 3/27/17 for the contracture in resident #11 right lower extremity by the Director of Nursing. Resident #11 was picked up for therapy services on 3/27/17 related to the right lower extremity contracture. Resident #11 care plan was updated to reflect therapy services on 4/12/17 by 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 _____	03/30/2017

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 280	Continued From page 3 The range of motion exercises were added to the resident ' s Care Plan on 11/18/16 and read: Lower extremity therapeutic exercises to the left ankle, knee and hip 3 sets of 12 three times a week and was entered by MDS Nurse #1. The most recent Minimum Data Set Assessment (Quarterly) dated 2/15/17 noted the resident had severe cognitive impairment, required extensive assistance with bed mobility and was dependent on staff for transfers. The MDS noted the resident had functional limitation of range of motion of the lower extremity on one side. A nurse ' s note dated 3/3/17 at 10:45 AM revealed an order was received to discontinue the immobilizer to the right amputation site due to the area was completely healed and no supporting reason for the immobilizer. A nurse ' s note dated 3/14/17 at 1:30 PM noted the resident had an unstageable wound to the right stump that measured 0.9 centimeters (cm) by 0.7 cm with 100 percent dark brown adherent slough. A Wound Ulcer Flowsheet dated 3/14/17 revealed the physician was notified and an order received for Santyl ointment and Gentamycin cream to be applied daily. An X-ray report of the resident ' s right knee dated 3/20/17 revealed a fixed flexion contraction deformity of the right knee. On 3/29/17 at 10:53 AM during an observation of wound care for Resident #11, the Treatment Nurse stated the resident was discussed by the team and she was instructed to call the physician for an order to remove the knee immobilizer as	F 280	A 100% audit of all residents will be conducted by the staff facilitator including care plans for residents #11 and residents with contractures and/or ROM exercises to ensure that all areas of the care plan reflect the resident's individual needs by 5-6-17. 100% audit will be completed of all rehabilitation to nursing communication forms from 11/1/16 to 4/12/17 to ensure all areas of recommended treatment to include range of motion exercises were addressed on the resident care plans by the RN nurse and staff facilitator by 5/6/17. Any deficient care plans will be updated to reflect the resident by 5-6-17 by the staff facilitator. The interdisciplinary care plan team members (dietary manager, MDS coordinator, social services director and activities director will be re-educated on the requirements for completing a comprehensive care plan for each resident and to review and revise the care plan for each resident change as needed by the MDS consultant by 5-6-17. The MDS coordinator was inserviced on 4-12-17 by the staff facilitator regarding updating care plans. This in-service included that the care plan must be updated to reflect the resident to include contractures, pressure ulcers and ROM exercises. All treatment plan recommendations for all areas per the rehabilitation communication to nursing form, must be addressed on the care plan to include range of motion exercises which will in turn notify the restorative aide per the Kiosk in all areas to perorm	

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 _____	03/30/2017

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 280	Continued From page 4 the surgical incision to the stump had healed. The Treatment Nurse further stated the knee was now contracted and the pressure ulcer was a result of pressure to the end of the stump from resting on the pillow and bed. On 3/29/17 at 3:05 PM the Physical Therapy Assistant stated in an interview when the information on the Rehab Communication to Nursing was entered into the computer, the treatment information transferred over to a restorative nursing screen and this gave instructions to the RNAs (Restorative Nursing Assistants) for the care to be provided for the resident. On 3/29/17 at 3:09 PM the Physical Therapist was observed to provide diathermy for the resident and stated she evaluated Resident #11 yesterday and the resident ' s hamstring had shortened to the point the right knee could not be straightened. (Ultrasonic diathermy would generate deep heat within the body tissues for the treatment of some conditions such as pain and joint contractures.) The Physical Therapist stated contractures could develop very quickly. On 3/29/17 at 3:13 PM, NA (Nursing Assistant) #3 stated in an interview the resident ' s knee was straight when in the knee immobilizer. The NA stated she noted over the last 2 weeks the resident ' s knee was bent and when she tried to straighten out her knee the resident would tense up and would not let her straighten the leg. On 3/29/17 at 4:30 PM the Director of Nursing (DON) stated in an interview the current MDS Nurse was new and in November 2016 another nurse was doing the MDS assessments/care	F 280	restorative treatment. Pay close attention to the treatment area (example: bilateral, left, right) per the rehabilitation communication to nursing form to ensure it is accurately reflected on the resident care plan. An intervention task for refusal of the restorative treatment must also be addressed on the care plan. An audit will be completed of 10% of all rehab communication to nursing forms and residents with contractures and compare to the residents' care plans to include care plans for resident #11, weekly x8 weeks, then monthly x1month by the staff facilitator to ensure that the care plans accurately reflect the resident, and that all areas of treatment to include range of motion exercises per the rehab communication to nursing form are addressed on the care plan utilizing the QI Care Plan Audit Too. The MDS coordinator will be retrained by the staff facilitator by 5/6/17 and the care plan will be revised immediately by the MDS coordinator for any identified areas of concern. The Administrator or Director of Nursing will review and initial the QI Care Plan Audit Tool weekly x8 weeks then monthly x1 month for compliance and to ensure all areas of concern have been addressed. The Executive QI committee will meet monthly and review the QI Care Plan Audit Tools and address any issues, concerns and/or trends and to make changes as needed to include continued frequency of monitoring x3months.	

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 _____	03/30/2017

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 280	Continued From page 5	F 280		

plans. The DON stated the resident had a knee immobilizer until the surgical incision at the end of the stump healed and they kept the knee immobilizer on for a while. The DON further stated they got an order to discontinue the immobilizer so it would not cause pressure to the leg and stump. The DON continued and stated about one week ago the resident complained of leg pain so they got an order for an X-ray.

On 3/30/17 at 8:56 AM the Treatment Nurse stated in an interview they received a call from dialysis the resident had a reddened area on the right stump. The Treatment Nurse stated the next morning (3/14/17) she assessed the area and was able to straighten the knee a little. The Treatment Nurse stated the resident stated her leg hurt when she attempted to straighten the knee so she did not make further attempts to straighten the leg. The Treatment Nurse stated a therapy referral was not made until after the X-ray showed the contracture on 3/20/17.

On 3/30/17 at 9:27 AM, RNA (Restorative Nursing Assistant) #2 stated in an interview the resident ' s leg was straight when in the knee immobilizer. The RNA stated she came back to work after being off for 3 days and asked the nurse about the immobilizer and was told it had been discontinued. The RNA further stated the resident ' s knee was straight at that time but for approximately 2 weeks the knee was bent. The NA stated she was not told to do range of motion on the right stump and the resident would move the stump a little and she would let the resident do what she could do.

On 3/30/17 at 12:03 PM the Physical Therapist stated in an interview she discharged Resident

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 _____	03/30/2017

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 280	Continued From page 6 #11 from therapy to a restorative nursing program on 11/16/16 for therapeutic exercises to both lower extremities. On 3/30/17 at 12:49 PM RNA #2 stated in an interview she never did range of motion to the right lower extremity and did range of motion according to what was in the kiosk for restorative nursing to do. The RNA was observed to pull up the information on Resident #11 in the kiosk and the instructions stated lower extremity exercises to the left ankle, knee and hip 3 sets of 12. There was no information regarding exercises to the right lower extremity (hip and knee). On 3/30/17 at 1:37 PM the Director of Nursing stated in an interview the physical therapy assistant did not yet have computer access in November 2016 and wrote the communication on paper and the information was later entered into the computer. On 4/3/17 at 11:40 AM the Physician that cared for the resident in the facility stated in an interview the resident ' s right knee contracture was firm and fixed. The Physician stated he saw the resident on Saturday (4/1/17) and made a referral to the orthopedist.	F 280		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 314		5/6/17

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 _____	03/30/2017

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 314	Continued From page 7 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and physician interviews the facility failed to prevent an unstageable pressure ulcer to the end of a resident ' s stump (below the knee amputation) by failing to assess and identify pressure to the end of the stump for 1 of 4 residents reviewed for pressure ulcers (Resident #11). The findings included: Resident #11 was originally admitted to the facility on 9/23/16 from the hospital after a right below the knee amputation and was admitted to the facility with a knee immobilizer on the right lower extremity. Other diagnoses included cerebrovascular accident (stroke), diabetes, end stage renal disease with dialysis, anxiety and depression. The Care Area Assessment for Pressure Ulcer (CAA) dated 10/6/16 noted the resident required total assistance with bed mobility that put the resident at risk for pressure ulcers. The CAA noted the resident had severe cognitive impairment and moderately impaired decision making skills that required cues and supervision. The resident ' s Care Plan dated 11/16/16 noted	F 314	F314 Resident #11 skin was assessed on 4-7-17 by the treatment nurse with observation of all skin abnormalities documented on the skin check sheet. There were no new wounds observed on resident #11. A foam wrap was placed on resident#11 right below the knee amputation on 4-12-17 by the Director of Nursing (DON) to prevent direct pressure to the stump. An amputee stump cover sleeve and relevator (a device used to lift the stump to decrease direct pressure) was ordered on 4-18-17 by the administrator for the resident's right below the knee amputation. 100% audit will be completed by the corporate Wound Care Director by 5/6/17 of all residents at high risk for pressure ulcers, and with contractures to include resident #11 to ensure appropriate preventive measures to prevent pressure ulcers are in place. The Corporate Wound Care Director, treatment nurse and MDS nurse will correct identified areas of concern during the audit by implementing	

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 _____	03/30/2017

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 314	Continued From page 8 the resident was at risk for skin breakdown related to cognitive impairment and immobility. The interventions were to ensure appropriate pressure relieving devices were in place during repositioning, pad bony prominences with pillows or foam products as needed to protect susceptible areas for skin breakdown. The most recent Minimum Data Set (MDS) Assessment dated 2/15/17 revealed the resident had severe cognitive impairment, required extensive assistance for bed mobility and was at risk for pressure ulcers. The MDS revealed the resident had no healed or unhealed pressure ulcers. A nurse ' s note dated 3/3/17 at 10:45 AM revealed an order was received to discontinue the immobilizer to the right amputation site due to area completely healed and no supporting reason. Review of the clinical record revealed no skin assessments after the right knee immobilizer was removed until 3/14/17. On 3/29/17 at 3:13 PM, NA (Nursing Assistant) #3 stated in an interview that since the knee immobilizer was removed she kept the resident ' s stump and leg elevated on pillows. On 3/29/17 at 4:07 PM, NA #4 stated in an interview when she worked with Resident #11 the resident would complain that her leg hurt so she put it on a pillow. The NA stated she had done this since the knee immobilizer was removed. The Treatment Nurse stated in an interview on 3/29/17 at 10:53 AM a dialysis nurse called the	F 314	appropriate preventive measures and updating the resident care guide and care plan to reflect the preventive measure. 100% head to toe assessments were completed on 3-29-17 by DON, staff facilitator and treatment nurse on all residents to include resident #11 to ensure all identified skin abnormalities to include wounds, non-ulcer skin conditions and contractures have been assessed, MD/RP (Responsible Person), appropriate interventions implemented to include therapy referrals, and documentation in the medical record for all identified areas of concern by 4/13/17. 100% audit was completed on 4/13/17 by the DON of wound ulcer flow sheet and flow sheet of non-ulcer skin conditions to ensure all residents with wounds and non-ulcer skin conditions have a current assessment with appropriate interventions, MD/RP notification and documentation in the medical record. The treatment nurse will initiate appropriate wound ulcer flow sheet of non-ulcer skin conditions for all identified areas of concern by 4/13/17. 100% audit will be completed of all progress notes from 3/1/17 to 4/12/17 by 5/6/1 by the DON, MDS nurse and staff facilitator to ensure all identified documentation of a skin abnormality to include wounds, non-ulcer skin conditions or contractures have been assessed, MD/RP notifications done, appropriate interventions implemented and documentation done in the medical records. The DON, MDS nurse and staff facilitator will correct all identified areas of concern durng the audit.	

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 _____	03/30/2017

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 314	Continued From page 9 facility and reported the resident had a reddened area with intact skin to the end of her stump. The Treatment Nurse stated she assessed the area the next morning (3/14/17) and the resident had some slough to the area. A nurse ' s note written by the treatment nurse dated 3/14/17 at 1:30 PM revealed Resident #11 had an unstageable wound to the right stump that measured 0.9 centimeters (cm) by 0.7 cm with 100 percent dark brown adherent slough. The note revealed the physician was notified and orders received for Santyl ointment and Gentamycin cream 0.1 percent, dry dressing and 4 by 4 gauze for padding, wrap with kerlix and secure with medipore tape and change dressing daily. There was no documentation in the clinical record of any pressure ulcers for Resident #11 prior to 3/14/17. An X-ray report of the resident ' s right knee dated 3/20/17 revealed a severe fixed flexion contraction deformity to the right knee. The resident ' s Care Plan updated on 3/22/17 noted ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to cognitive impairment and immobility. The interventions included the following: Treatments as ordered, ensure appropriate pressure relieving devices in place during repositioning and bunny boots to feet/heels and weekly wound assessments. On 3/29/17 at 10:53 AM prior to an observation of wound care, resident #11 was observed lying in bed with a bunny boot on the end of the right	F 314	100% of Nurse Aides to include NA #3, NA#4 and licensed nurses, including agency staff, to include the treatment nurse will be in-serviced by 5/6/17 by the DON and staff facilitator regarding observation and reporting of any new or worsening contractures, decline in ADLs, pain, inability to straighten legs, resistance to ROM, skin abnormalities and new or worsening wounds to the nurse immediately when observed. The nurse must assess the resident immediately and complete a rehabilitation referral for all new identified contractures and decline in ADLs and complete a skin referral for all new or worsening pressure ulcers or non-ulcer skin conditions and implement appropriate treatment to address the pain, contracture, skin abnormality and decline in ADLS and notify the MD/RP. 100% of licensed nurses to include the treatment nurse will be in-serviced by the DON and staff facilitator regarding anytime a device is removed to include knee immobilizers, the skin should be assessed and findings documented in the medical records. Upon notification of a skin abnormality to include reddened areas, the nurse being notified must assess the area immediately with notification to the MD/RP and implementation of appropriate intervention and documentation in the medical record. All newly hired licensed nurses and nursing assistants will be in-serviced during orientation by the staff facilitator regarding observation and reporting of any new or worsening contractures, decline in ADLs, pain and inability to	

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 _____	03/30/2017

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 314	Continued From page 10 lower extremity that was flexed at the knee. The knee was flexed and the end of the stump made contact with the bunny boot which was resting on a pillow. During the wound care on 3/29/17 at 10:55 AM the Treatment Nurse stated the resident ' s stump incision had healed and the staff discussed the resident in the morning meeting and decided to remove the knee immobilizer as the surgical wound had healed. The Treatment Nurse stated the resident ' s knee was now contracted and the wound was caused by pressure from the end of the stump resting on the bed. The Treatment Nurse stated they put a bunny boot over the stump when the resident was in bed and had ordered an air mattress for the resident. On 3/29/17 at 4:30 PM an interview was conducted with the Director of Nursing (DON) and the nurse consultant. The DON stated Resident #11 had a knee immobilizer on the right leg until the surgical incision on the stump healed. The DON further stated the treatment nurse called the physician and got an order to discontinue the immobilizer so it would not cause a pressure area to the resident ' s stump or leg. The DON stated from the time the knee immobilizer was removed, the staff elevated the resident ' s right leg on a pillow. The DON continued and stated about one week ago the resident complained of increased pain of the right lower extremity and they got an X-ray that also revealed osteoarthritis. On 3/30/17 at 10:30 AM the physical therapist was observed to perform diathermy on the resident ' s right knee. (Ultrasonic diathermy would generate deep heat within the body tissues for the treatment of some conditions such as pain and joint contractures.) The bunny boot was	F 314	straighten legs, resistance to ROM, skin abnormalities and new or worsening wounds to the nurse immediately when observed. The nurse must assess the resident immediately and complete a rehabilitation referral for all identified contractures and decline in ADLs and complete a skin referral for all new or worsening pressure ulcers or non-ulcer skin conditions and implement appropriate treatment to address the pain, contracture, skin abnormality and decline in ADLs and notify the MD/RP. All newly hired licensed nurses will be in-serviced by the staff facilitator during orientation regarding anytime a device is removed to include knee immobilizers, the skin should be assessed and findings documented in the medical records. Upon notification of a skin abnormality to include redden area, the nurse being notified must assess the area immediately with notification to the MD/RP and implementation of appropriate intervention and documentation in the medical records. The MDS nurse and/or staff facilitator will complete head to toe skin assessments on 10% of residents to include resident #11 to ensure preventive interventions are in place to prevent pressure ulcers per the resident care guide/care plan, all skin abnormalities wounds, non-ulcer skin conditions and contractures have been identified, assessed, MD/RP notification, appropriate interventions implemented and documentation in the medical records utilizing the Skin Assessment QI Tool weekly x8 weeks then monthly x1month.	

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 _____	03/30/2017

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 314	Continued From page 11 observed on the right stump with the knee flexed and the end of the stump pressing into the bunny boot. On 3/30/17 at 3:30 PM the Staff Development Coordinator (SDC) provided four skin audit tools for Resident #11 for the month of March 2017. The first three skin audit tools for March 2017 were observed to be blank and the SDC stated the forms had not been filled out. The fourth skin audit tool was dated 3/14/17 and revealed no new skin issues. The SDC stated this one had been completed on the afternoon of 3/14/17 after the unstageable area to the resident ' s right stump had been identified and treatment initiated and there were no new skin issues at the time of the assessment. On 4/3/17 at 11:40 AM an interview was conducted with the physician that cared for Resident #11 in the facility. The Physician stated the resident ' s right knee contracture was firm and fixed and with the way it was flexed it would be difficult to keep the pressure off of the area and would need to keep the limb on a pillow to keep the pressure off.	F 314	The MDS nurse and/or staff facilitator will address any identified areas of concern immediately during the audit by ensuring interventions are in place, skin abnormalities identified are assessed with MD/RP notification, implement appropriate interventions, document in the medical record, and/or provide retraining with the CNA, license nurse and/or treatment nurse, to include agency staff, as appropriate. The DON will review and initial the skin assessment weekly x8 weeks then monthly x1 month for completion and to ensure all areas of concern have been addressed. The Executive QI committee will meet monthly and review the Skin Assessment QI Tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x3 months.	
F 317 SS=G	483.25(c)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE (c) Mobility. (1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. This REQUIREMENT is not met as evidenced	F 317		5/6/17

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 _____	03/30/2017

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 317	Continued From page 12 by: Based on observation, record review, staff and physician ' s interview, the facility failed to provide range of motion and failed to assess the right lower extremity for a possible contracture for 1 of 4 sampled residents reviewed for range of motion, resulting in a contracture to the right knee. (Resident #11). The findings included: The resident was originally admitted to the facility on 9/23/16 from the hospital after a right below the knee amputation and admitted with a knee immobilizer on the right lower extremity. Other diagnoses included cerebrovascular accident (stroke), diabetes, end stage renal disease with dialysis, anxiety and depression. The Care Area Assessment (CAA) for Cognitive Loss/Dementia dated 10/6/16 noted the resident had severe cognitive impairment, moderately impaired decision making skills that required cues and supervision and was dependent on staff for activities of daily living. The CAA for Behavioral Symptoms dated 10/6/16 noted the resident had refused showers and skin assessments during the 7 day look back period. The Care Plan for Resident #11 initiated on 10/7/16 noted the resident was resistive to treatment and care and refused showers and skin assessment. The intervention was to leave the resident and return in 5-10 minutes if the resident refused care. A Rehab Communication to Nursing form dated 11/17/16 noted Resident #11 was anxious/fearful. The treatment approaches included the following exercises: Bilateral lower extremity therapeutic exercises to ankle, knee and hip. The short term	F 317	A Therapy referral was completed on 3/21/17 for the contracture in resident #11 right lower extremity by the Director of Nursing (DON). Resident #11 was picked up for therapy services on 3/27/17 related to the right lower extremity contracture. The MD saw resident #11 on 4/4/17 with no new orders. 100% audit was completed of all rehabilitation to nursing communication forms from 11/1/16 to 4/12/17 by 5/6/17 by the RN and staff facilitator and compared to restorative evaluation and treatment plan, restorative summary sheets, resident care plan, actual documentation or restorative treatment being provided in the electronic medical records, and for decline in participation of restorative program, pain or new or worsening contracture with MD notification and/or therapy referral to ensure all areas of recommended treatment to include range of motion exercises were being provided per therapy recommendations. Residents will be referred back to therapy by 5/6/17 by the RN nurse and staff facilitator for all identified areas of concern during the audit. 100% head to toe assessments were completed on 3/29/17 by the DON, staff facilitator and treatment nurse on all residents to include resident #11 to ensure all identified skin abnormalities to include wounds, non-ulcer skin conditions and contractures have been assessed, MD/RP notification, appropriate interventions implemented to include therapy referrals and documentation in the medical	

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 _____	03/30/2017

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 317	Continued From page 13 goals included the following: The patient would tolerate bilateral lower extremity therapeutic exercises 3 sets of 12. The form was signed by Physical Therapist #1 and Restorative NA (Nursing Assistant) #1. A Restorative Nursing Evaluation and Treatment Plan dated 11/18/16 under Treatment Plan C read: "Specific Restorative Intervention(s): Patient to tolerate both LE" (lower extremities) "3 sets of 12 to left ankle, knee and hip." A Care Plan initiated on 11/18/16 listed the focus as the resident required assistance/potential to restore or maintain maximum function of self-sufficiency for mobility characterized by the following functions: positioning, locomotion/ambulation related to right below the knee amputation. The goal was to maintain or increase range of motion. The interventions included: Lower extremity therapeutic exercises to left ankle, knee and hip 3 sets of 12. If resident did not participate in restorative range of motion program, document reason. There was no information regarding range of motion to the right lower extremity (right hip and knee). The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 2/15/17 noted the resident had severe cognitive impairment, required extensive assistance with bed mobility and was dependent on staff for transfers. A nursing progress note dated 3/3/17 at 10:45 AM noted an order was received to discontinue the knee immobilizer to the right amputation site due to the area completely healed. A nursing progress note dated 3/20/17 at 4:00 PM	F 317	records. The treatment nurse will notify the MD/RP, initiate appropriate interventions to include therapy referrals and document in the medical record for all identified areas of concern. 100% of restorative aides to include restorative NA #1 and restorative NA #2 will be in-serviced by the 5/6/17 by the staff facilitator regarding following the restorative treatment plan, report any refusal to restorative nurse and if there is an area the restorative aide was in-serviced by rehabilitation but not on the treatment plan, notify the MDS nurse or DON immediately. Report to the hall nurse and MDS nurse immediately and document refusal or decline in participation of restorative program, new or worsening of contractures and pain. The MDS nurse was in-serviced on 4/12/17 by the staff facilitator regarding checking daily for rehab communication to nursing, making sure the restorative treatment plan recommended by therapy is put in place timely and addresses all areas (bilateral, left, right), ensuring all areas are also addressed on the care plan which will notify the restorative aide per the kiosk all areas to perform restorative treatment plan to include range of motion, and ensuring all residents with a noted physical decline in restorative participation are assessed and referred back to therapy. 100% of nurse aides to include NA #3,NA #4 and license nurses to include the treatment nurse, including agency license nurses and NAs, will be in-serviced by 5/6/17 by the staff facilitator	

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 _____	03/30/2017

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 317	Continued From page 14 revealed the resident had new orders to obtain an X-ray of her left knee related to pain and contraction. A radiology report dated 3/20/17 of a right knee X-ray for Resident #11 under Impression read: "Severe flexion contraction deformity of right knee." A nursing progress note dated 3/21/17 revealed the X-ray results revealed a severe flexion contraction deformity of the right knee. Review of the restorative nursing treatment record for March 2017 revealed the resident resisted/ refused range of motion 16 out of 30 days. On the other days in March 2017 it was documented in the column named active range of motion, 10-15 minutes of range of motion was provided for Resident #11. There were no nurse ' s notes that the resident resisted range of motion exercises and the physician ' s orders revealed no further referrals to therapy. On 3/29/17 at 3:05 PM the Physical Therapy Assistant (PTA) stated in an interview when the physical therapist wrote the recommendations for restorative nursing, the PTA put the information in the computer and transferred over to the restorative nursing screen for them to view the instructions. On 3/29/17 at 3:09 PM the Physical Therapist stated in an interview she evaluated Resident #11 on 3/28/17 and the resident had a lot of anxiety and flexed everything when touched and was hypersensitive to touch. The Physical Therapist stated the right hamstring had shortened to the point where the right knee could not be	F 317	regarding observation and reporting of any new or worsening contractures, decline in ADL, pain, inability to straighten legs, resistance to ROM, skin abnormalities and new or worsening wounds to the nurse immediately when observed. The nurse must assess the resident immediately and complete a rehab referral for all identified contractures and decline in ADLs and complete a skin referral for all new or worsening pressure ulcers or non-ulcer skin conditions and implement appropriate treatment to address the pain, contracture, skin abnormality and decline in ADLs and notify the MD/RP. All newly hired license nurses and nursing assistants will be in-serviced during orientation by the staff facilitator regarding observation and report of any new or worsening contractures, decline in ADL, pain and inability to straighten legs, resistance to ROM, skin abnormalities and new or worsening wounds to the nurse immediately when observed. The nurse must assess the resident immediately and complete a rehab referral for all identified contractures and decline in ADL and complete a skin referral for all new or worsening pressure ulcers or non-ulcer skin conditions and implement appropriate treatment to address the pain, contracture, skin abnormality and decline in ADLs and notify the MD/RP. The staff facilitator will review 10% of all residents, to include resident #11, rehab communication to nursing forms and compare to restorative evaluation 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 _____	03/30/2017

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 317	Continued From page 15 straightened. The Therapist further stated contractures could develop very quickly. On 3/29/17 at 3:13 PM an interview was conducted with one of the NAs assigned to care for the resident. NA #3 stated during care she noted the resident ' s knee was straight when in the knee immobilizer and when first removed from the immobilizer. The NA stated she noted the knee was bent for the last 1½ to 2 weeks. The NA stated she would try to straighten the knee and the resident would tense up and would not let her straighten the leg so she would stop. On 3/29/17 at 4:30 PM the Director of Nursing (DON) stated in an interview Resident #11 was admitted to the facility with a knee immobilizer to the right lower extremity until the stump healed. The DON stated they discussed the immobilizer in their morning meeting and the treatment nurse called the physician for an order to discontinue the immobilizer as the surgical site was completely healed and so it would not cause pressure to the remaining leg. The DON did not explain why the knee immobilizer had been on since the resident ' s admission to the facility. The DON stated about one week ago the resident was complaining of increased pain of the right lower extremity so they got an order for an X-ray. On 3/30/17 at 8:56 AM the Treatment Nurse stated in an interview that a dialysis nurse called on 3/14/17 and reported a reddened area on the end of the resident ' s stump. The Treatment Nurse stated the staff had elevated the right knee and leg on pillows since the knee immobilizer was removed. The Treatment Nurse stated when the resident returned from dialysis she assessed the area and the resident would only allow her to	F 317	treatment plan, restorative summary sheets, resident care plan and actual documentation of restorative treatment being provided in the electronic medical records to ensure all areas of recommended treatment to include range of motion exercises are being provided per therapy recommendations and the MD has been notified and/or therapy referral completed for any notice decline in participation of restorative, pain or new or worsening contracture using a Restorative Treatment Plan QI tool weekly x8 weeks, then monthly x1 month. The staff facilitator will implement appropriate interventions and in-service the MDS nurse or restorative aide for any identified areas of concern during the audit. The MDS nurse and/or staff facilitator will complete head to toe skin assessments on 10% of residents to include resident #11 to ensure preventive interventions are in place to prevent pressure ulcers per the resident care guide/care plan, all skin abnormalities to include wounds, non-ulcer skin conditions and contractures have been identified, assessed, MD/RP notification, appropriate interventions implemented to include therapy referrals and documentation in the medical records utilizing the Skin Assessment QI Tool weekly x8 weeks then monthly x1 month. The MDS nurse and/or staff facilitator will address any identified areas of concern immediately during the audit by ensuring interventions are in place, skin abnormalities identified are assessed with MD/RP notification, implement appropriate interventions to include	

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 _____	03/30/2017

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 317	Continued From page 16 straighten the right knee a little. The Treatment Nurse stated the resident complained her leg hurt and the resident tensed up so she did not make any further attempts to straighten the leg. The Treatment Nurse further stated the resident ' s treatment to the area was every day and the resident would tense up and would not allow her to straighten the right knee. The Treatment Nurse stated she did not report this to the physician and did not make a referral to therapy regarding the resident not straightening the knee. The Treatment Nurse further stated she did not realize the resident could not straighten the right leg at the knee. On 3/30/17 at 10:10 AM the Physical Therapist was observed to perform diathermy on the right knee of Resident #11. (Ultrasonic diathermy would generate deep heat within the body tissues for the treatment of some conditions such as pain and joint contractures.) There was not a pillow under the resident ' s right stump. The right knee was observed to be flexed with the end of the stump pressing into the mattress. A bunny boot was also in place on the end of the stump. The Physical Therapist stated the staff had been elevating the end of the resident ' s amputated leg on pillows and any elevation of the hip or knee could shorten the hamstring and cause or worsen contractures. The therapist stated she removed the pillow this morning and told the staff to not elevate the extremity on pillows. On 3/30/17 at 11:27 AM an interview was conducted with the Director of Nursing (DON). The DON stated when the treatment nurse did the wound assessment on 3/14/17 and was unable to straighten the resident ' s right knee, she would expect the nurse to call the physician	F 317	therapy referrals, document in the medical record and/or provide retraining with the CNA, license nurse, and/or treatment nurse as appropriate, to include agency license nurse and NAs. The DON will review and initial the Skin Assessment QI Tool and the Restorative Treatment Plan QI Tool weekly x8 weeks and then monthly x1 month for completion and to ensure all areas of concern have been addressed. The Executive QI committee will meet monthly and review the Restorative Treatment Plan QI Tool and the Skin Assessment QI Tool and address any issues, concerns and/or trends and to make changes as needed to include continued frequency of monitoring x3 months.	

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 _____	03/30/2017

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 317	Continued From page 17	F 317		

and make him aware and to obtain further instructions.

On 3/30/17 at 12:03 PM the Physical Therapist stated in an interview she evaluated Resident #11 on 9/26/16 and addressed functional mobility of the lower extremities and discharged the resident to nursing with a restorative program on 11/17/16. The Physical Therapist further stated Restorative NA #1 was instructed in range of motion exercises to both lower extremities, left hip, knee and ankle and right hip and knee as the resident had a below the knee amputation on the right. The Physical Therapist also stated the Physical Therapy Assistant usually was the one to enter the treatment into the computer. The Physical Therapist stated when the knee immobilizer was removed, a therapy referral would have been made only if the staff saw a problem. The Physical Therapist stated there had been no further therapy referrals until 3/23/17 when she received a referral for the resident ' s contracture.

On 3/30/17 at 12:49 PM an interview was conducted with Restorative NA (RNA) #2. The RNA stated the resident ' s leg was straight when in the knee immobilizer. The RNA stated she was off for several days and when she returned to work, the knee immobilizer was off and the nurse told her the immobilizer had been discontinued. The RNA stated initially the resident ' s knee was straight but for approximately the last 2 weeks the knee was bent. The RNA further stated when she touched the resident she would say: "Oh, Oh, Oh" and tense up. The RNA stated she and RNA #1 rotated the restorative nursing care. RNA #2 stated she never did range of motion to the right hip or knee and performed the care that was in the computer. RNA #2 was observed to pull up

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 _____	03/30/2017

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 317	Continued From page 18	F 317		

the restorative information in the kiosk and the directions were for lower extremity exercises to left ankle, knee and hip 3 sets of 12. The RNA pulled up a screen where she documented "refused" when the resident resisted and refused her range of motion. There were no instructions to provide range of motion exercises to the right hip or knee in the kiosk.

On 3/30/17 at 12:57 PM RNA #1 stated in an interview that therapy would show the RNA who was working what the restorative NAs were supposed to do for a resident. RNA #1 stated she tried to do range of motion to the resident ' s right knee but about half the time the resident would not allow her to do it. RNA #1 further stated she did not tell anyone the resident resisted range of motion to the right knee. When asked if she had discussed the treatment plan for Resident #11 with RNA #2 the RNA stated she had not and that range of motion was the same for everybody.

On 3/30/17 at 1:37 PM the Director of Nursing stated in an interview the MDS nurse was responsible for the RNAs and they were without a MDS nurse for a while. The DON stated she covered restorative for a while. The DON stated she had not been told Resident #11 resisted her range of motion exercises and she would expect the Restorative NAs to let someone know so they could see what else the resident needed. The DON stated the Physical Therapy Assistant did not have computer access when he first started working at the facility and filled out a paper communication form for the referral to restorative. The DON could not explain why the range of motion to the right hip and knee was not in the kiosk for the restorative nurses to see.

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 _____	03/30/2017

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 317	Continued From page 19 On 4/3/17 at 11:40 AM the Physician that cared for Resident #11 in the facility stated in an interview he assumed the person who did the amputation put on the knee immobilizer but he was not sure of the reason. The Physician stated in his experience the resident ' s knee contracture was not a common event and this resident ' s contracture was firm and fixed. The Physician stated he did not remember being contacted regarding the resident resisting range of motion exercises or the inability of the resident to straighten the right leg. When asked what he would expected the staff to do when the resident resisted range of motion exercises and the right knee started to contract, the Physician stated: "You can ' t make people do what they don ' t want to do." The Physician stated he saw the resident on 4/1/17 and had made a referral for the orthopedic surgeon to see the resident regarding the right knee contracture.	F 317		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323		5/6/17

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 _____	03/30/2017

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 323	Continued From page 20 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews the facility failed to secure loose toilet safety frames for 4 of 5 toilets observed (Shower Room #1, Shower Room #2, Bathroom #2 and Bathroom #3) for resident use in the main hallways and failed to store a cleaning chemical in a secured spot away from resident bathrooms in 1 of 3 bathrooms (Bathroom #2). The findings included: 1. An observation was made on 3/27/17 at 2:57 PM of Shower Room #1. There was a toilet safety frame attached to the back of the toilet secured under the seat. The arms were wobbly and bent outwards when touched. (The toilet safety frame attaches to the frame of the toilet where the toilet seat attaches and the arms extend next to the side of the toilet) An observation was made on 3/28/17 at 9:05 AM of Shower Room #1. The arms were wobbly and bent outwards when touched. An observation was made on 3/28/2017 at 9:15 AM of Bathroom #2 on middle hall. The toilet safety frame consisted of only one arm. The arm	F 323	Shower Room #1, Shower Room #2, Bathroom #2 and Bathroom #3 loose toilet frames were repaired on 3/28/17 by the maintenance director. The cleaning chemical bottle in the bathroom between rooms 11 and 13 was removed on 3/28/17 by the housekeeping supervisor. Facility rounds were made to include 100% shower rooms and bathrooms for loose equipment to include loose toilet frames and for unsecured cleaning chemicals on 4/12/17 by the Director of Nursing. Work orders were completed for any identified loose equipment and all observed unsecured cleaning chemicals were immediately removed on 4/12/17 by the Director of Nursing. An in-service will be initiated by the staff facilitator with all staff to include Nurse Aides, license nurses (to include agency license nurses and NAs), housekeeping, maintenance, dietary, activities, payroll, medical records, therapy and social worker regarding broken, defective, unsafe equipment to include loose toilet	

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 _____	03/30/2017

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 323	Continued From page 21 was loose and the screw was observed as loose on the leg of the safety frame. An observation was made on 3/28/17 at 9:20 AM of Bathroom #3. The toilet safety frame had two arms attached to the back of the toilet secured under the seat. The arms were observed to be wobbly and bent outwards when touched. An observation was made on 03/28/2017 at 9:43 AM of Shower Room #2. The toilet safety frame attached to the back of the toilet was secured under the toilet seat. The arms to the frame were observed to be loose when touched. An observation was made on 3/28/17 at 3:10 PM of Shower Room #1, Shower Room #2, Bathroom #2 and Bathroom #3. The toilet safety frame arms on the toilets in each of the rooms were observed to be wobbly and bending outwards when touched. An observation was made on 3/29/17 at 10:11 AM of Shower Room #1, Shower Room #2, Bathroom #2 and Bathroom #3. The toilet safety frame arms on the toilets in each of the rooms were observed to be wobbly and bending outwards when touched. Record review for Resident #55 identified that the resident had been admitted to the facility on 3/17/17 with a diagnosis of fracture of the left femur and difficulty walking. The Admission Minimum Data Set Assessment identified Resident #55 as cognitively intact with a Brief Interview for Mental Status score of 15. He was continent of his bowel and bladder. During a resident interview on 3/27/17 at 2:23 PM	F 323	safety frames, must be red tagged and reported to maintenance immediately and completion of work order. The white copy goes to the maintenance director and the yellow copy goes to the administrator. Chemicals must be secured away form residents to include in residents' bathroom. If chemicals are observed, remove the chemical immediately. Do not leave chemicals in a cabinet if the cabinet cannot be locked immediately. If there is a lock on a cabinet, ensure the cabinet is locked and not left open. If the lock is not working properly or is missing, report it to maintenance and a work order must be done immediately. All newly hired nursing assistants and license nurses will be in-serviced during orientation by the staff facilitator regarding broken, defective, unsafe equipment to include loose toilet safety frames must be red tagged and reported to maintenance immediately and completion of work order. The white copy goes to the maintenance director and the yellow copy goes to the administrator, Chemicals must be secured away from residents to include in resident's bathroom. If chemicals are observed, remove the chemical immediately. Do not leave chemicals in a cabinet if the cabinet cannot be locked immediately. If there is a lock on a cabinet, ensure the cabinet is locked and not left open. If the lock is not working properly or is missing, report to the maintenance director and a work order must be done immediately. The staff facilitator will monitor all areas of the facility to include all shower rooms 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 _____	03/30/2017

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 323	Continued From page 22 Resident #55 stated he used the toilet down the hall and the handles (toilet safety frames) next to the toilet were loose. During a follow up interview with resident #55 on 03/28/2017 at 11:05 AM he stated that he used the toilet in Shower Room #1 daily. He stated the arms next to the toilet in Shower Room #1 made him feel unsafe and that he could possibly fall. During an interview with Nursing Assistant #3 on 3/28/17 at 3:25 PM she stated that Resident #55 was able to take himself to the toilet and used Shower Room #1 on his hallway. During an observation and interview on 3/29/17 at 10:16 AM with the Maintenance director he stated the handles needed to be tightened. During an observation and interview with the Administrator on 03/29/2017 at 10:37 AM he observed Bathroom # 2 and stated the bolt on the safety frame arm was loose and needed to be tightened. He stated the arms on the safety frames should not be loose. 2. On 3/27/17 at 10:15 AM during the initial tour of the facility, one bottle of liquid cleaner with the name of "TB Cide Quant" was observed in an unlocked cabinet in a hall bathroom between rooms 11 and 13. (This was a shared bathroom used by the residents on the hall as the resident rooms did not have bathrooms.) The bottle of cleaner contained a label that read: "Keep out of reach of children." The label on the bottle also gave instructions to wash the area with soap and water if solution came in contact with the skin, avoid contact with eyes or clothing and if swallowed, contact poison control immediately for treatment.	F 323	bathrooms for loose/unsafe equipment to include loose toilet frames and unsecured chemicals weekly x8 weeks, then monthly x1 month utilizing Facility Map QI Tool. Any defective, loose or unsafe equipment will be red tagged, maintenance will be notified and a work order will be completed immediately during the audit and all unsecure chemicals will be immediately removed. The administrator will review the Facility Map QI Audit Tool weekly x8 weeks, then monthly x1 month for completion and to ensure all areas of concern were addressed. The Executive QI committee will meet monthly and review the Facility Map QI Audit Too. and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x3 months.	

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 _____	03/30/2017

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 323	Continued From page 23 On 3/28/17 at 1:00 PM the bottle of cleaner was again observed in the unlocked cabinet in the same bathroom. On 3/28/17 at 2:23 PM an observation of the shared bathroom in the hall between rooms 11 and 13 was made with the Housekeeping Manager. A bottle of "TB Cide Quant" cleaner was observed in an unlocked cabinet in the bathroom. The Housekeeping Manager stated chemicals should not be stored in the resident ' s bathrooms. The Housekeeping Manager stated sometimes after the housekeeping staff left for the day, the staff would go in and get a cleaner off the cart and hide it in the bathroom. On 3/28/17 at 2:27 PM the Director of Nursing (DON) stated in an interview that the housekeeping staff usually left between 2:30 PM and 3:30 PM and the housekeeping cart was kept outside the laundry door and the cleaning supplies locked up on the cart. The DON further stated after the housekeeping staff left the nursing staff had a key and would go and get cleaning supplies from the cart if they had a spill they needed to clean up and the staff were supposed to return the supplies to the housekeeping cart.	F 323		
F 328 SS=E	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including	F 328		5/6/17

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 _____	03/30/2017

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 328	Continued From page 24	F 328		

to prevent complications from the resident's medical condition(s) and

(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments

(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 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 _____	03/30/2017

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 328	Continued From page 25 this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to securely store 7 of 11 full oxygen cylinders observed in an unlocked outdoor shed. The findings included: During an observation on 3/28/17 at 1:51 PM the resident smoking area was observed. A shed adjacent to the facility was observed to hold 7 full oxygen cylinders and 6 empty oxygen cylinders in a wooden rack. There was no door or lock observed on the shed holding the oxygen cylinders, a small no smoking sign was posted above the shed. During an interview on 3/28/17 at 1:55 PM Nurse #1 stated that oxygen cylinders for residents were stored outdoors. In an interview on 3/28/17 at 2:00 PM nursing assistant #2 revealed resident oxygen tanks were stored outside in the shed with a no smoking, sign posted. She stated the oxygen cylinders were not locked up, as the residents did not go that far along the building. During an interview with the Director of Nursing (DON) on 3/28/17 at 3:25 PM she stated the oxygen cylinders were stored out back in a small	F 328	A locked door was placed on the outdoor shed housing the full oxygen cylinders by the maintenance director on 3/28/17. 100% audit was completed on 4/11/17 by the Director of Nursing (DON) throughout the facility to include outdoors to ensure all oxygen tanks were securely stored. There were no concerns identified during the audit. All license nursed to include nurse #1, nurse aides to include NA #2 (to include agency license nurses and NAs) and the maintenance director will be in-serviced on oxygen cylinder storage by 5/6/17 by the staff facilitator. This in-service will include that there are two doors and a lock on the shed that the full and empty oxygen tanks are stored in. Ensure that the lock is replaced when the cylinders are replaced, removed or anytime entering the shed. A key has been placed on each nurses' key ring. Ensure all single oxygen cylinders are securely stored in residents' rooms or within other areas of the facility in a holder. All newly hired license nurses and nurse aides will be	

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 _____	03/30/2017

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 328	Continued From page 26 cabinet that could not be locked. She revealed the front face of the cabinet was missing and could not be locked. The DON indicated she would have the maintenance man secure the oxygen cylinders that day. In an interview on 3/28/17 at 3:30 PM the Administrator stated he would expect that the oxygen cylinders were secured and would be secured right away. In an interview on 3/30/17 at 2:13 PM the facility consultant indicated the facility had always stored the oxygen cylinders in the outside shed. The facility was not able to provide a policy on oxygen cylinder storage.	F 328	in-serviced during orientation by the staff facilitator regarding there are two doors and a lock on the shed that the full and empty oxygen tanks are stored in. Ensure the lock is replaced when cylinders are replaced, removed or anytime entering the shed. A key has been placed on each nurses' key ring. Ensure all single oxygen storage cylinders are securely stored in resident's room or within other areas of the facility in a holder. The staff facilitator Assistant will complete facility rounds to include the outdoor shed to ensure that all oxygen cylinders are securely stored weekly x8 weeks and then monthly x1 month utilizing the Facility Map QI Audit Tool. The staff facilitator Assistant will secure the oxygen cylinder and provide retraining to staff for any identified areas of concern during the audit. The administrator or director of nursing will review and initial the Facility Map QI Audit Tool weekly x 8 weeks, then monthly x1 month for completion and to ensure all areas of concern have been addressed. The Executive QI committee will meet monthly and review the Facility Map QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x3 months.	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency	F 431		5/6/17

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 _____	03/30/2017

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 27	F 431		

drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
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.

(h) Storage of Drugs and Biologicals.
(1) 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

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 _____	03/30/2017

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 28 have access to the keys. (2) 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 review and staff interviews, the facility failed to store unopened insulin in the refrigerator and date vials of insulin and insulin pens stored on the medication cart for 1 of 2 medication carts and failed to date an opened vial of (Purified Protein Derivative, a tuberculin screening test) for 1 of 1 medication refrigerator. The findings included: 1. The package insert for Humalog Insulin provided instructions to store unopened vials of Humalog Insulin in the refrigerator and once opened discard in 28 days. The facility policy provided by the facility ' s consulting pharmacy, revised on 2/1/17 listed instructions to store Humalog Insulin in the refrigerator and when opened, date and initial the vial and discard in 28 days. On 3/29/17 at 1:19 PM an observation of the medication cart for residents in rooms on unit 1 of the facility was made with the Staff Development Coordinator (SDC). There was one unopened bottle of Humalog Insulin stored on the medication cart. The SDC stated the Insulin	F 431	The undated and unopened insulins and undated Purified Derivative Vials (PPD vials) were immediately pulled from the medication carts by the staff facilitator and returned to pharmacy per policy on 3/28/17. All medications returned to pharmacy were reordered by the staff facilitator on 3/28/17. 100% audit will by conducted by 5/6/17 by the treatment nurse of the medication rooms, and all medication carts to ensure there are no open undated medications to include insulins and multi dose vials to include PPD medications that are required to be dated when opened and no unopened insulins were stored in the medication carts. The treatment nurse will return all observed open undated medications to include insulins and PPD medications that requires to be dated when opened and medications not stored appropriately per package insert to include insulins by 5/6/17. All medications returned to the pharmacy will be reordered by the treatment nurse 5/6/17.	

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 _____	03/30/2017

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 29 should be stored in the refrigerator until opened. On 3/29/17 at 1:40 PM the Director of Nursing stated she had just completed an in-service last week on medication storage with her regular staff but they used some agency nurses that were not present for the in-service. On 3/30/17 at 8:24 AM the Director of Nursing stated in an interview that unopened insulin should be kept in the refrigerator until opened. 2. The package insert provided instructions that unopened refrigerated Levemir Insulin was good until the expiration date on the vial and once opened could be used for 42 days. The facility policy for medication storage from the facility ' s consulting pharmacy, revised on 2/1/17 provided instructions to refrigerate unopened Levemir insulin, date and initial when opened, and discard after 42 days. On 3/29/17 at 1:19 PM an observation of the medication cart for residents on unit 1 of the facility was made with the Staff Development Coordinator (SDC). There was one vial of unopened Levemir Insulin stored on the medication cart. There was not a date on the insulin to indicate when the bottle was removed from the refrigerator. The SDC stated Insulin should be stored in the refrigerator until opened. On 3/29/17 at 1:40 PM the Director of Nursing stated she had just completed an in-service last week on medication storage with her regular staff but they used some agency nurses that were not present for the in-service.	F 431	An in-service will be initiated by the Director of Nursing by 5/6/17 with 100%of licensed nurses to include agency nurses regarding insulin storage to include all insulin products will be refrigerated prior to first use, insulin vials should be dated upon opening and unused portions discarded within 28 days, insulin pens should be dated upon first use and discarded within the timeframe recommended by the manufacturer, expiration of opened mulit-dose vials to include all multi-dose vials of injectable medications and vaccines shall be dated by the designated staff person at the time that the seal is broken and the first dose is drawn. Subsequently, the following expiration dates shall be observed: PPD 30 days. All newly hired license nurses and agency nurses will be in-serviced during orientation by the staff facilitator regarding insulins storage to include all insulin products will be refrigerated prior to first use, insulin vials should be dated upon opening and ususd portions discarded within 28 days, insulin pens should be dated upon first use and discarded within the timeframe recommended by the manufacturer and expiration of opened multi-dose vials to include all multi-dose vials of injectable medications and vaccines shall be dated by the designated staff person at the time that the seal is broken and the first dose drawn. Subsequently, the following expiration dates shall be observed: PPD 30 days.	

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 _____	03/30/2017

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 30 On 3/30/17 at 8:24 AM the Director of Nursing stated in an interview that unopened insulin should be kept in the refrigerator until opened and dated when opened. 3. The package insert for Toujeo Insulin Pens provided instructions to store unopened pens in the refrigerator and opened pens at room temperature and discard 42 days after the first use. The facility policy for medication storage provided by the facility ' s consulting pharmacy, revised on 2/1/17 listed instructions to refrigerate unopened Toujeo Insulin pens and once opened store at room temperature, date and initial the pen and discard after 42 days. On 3/29/17 at 1:19 PM an observation of the medication cart for residents on unit 1 of the facility was made with the Staff Development Coordinator (SDC). There was one Toujeo Insulin pen stored on the medication cart and contained a yellow label that read expires in 42 days after opened. There was not a date on the insulin pen to indicate the day the pen was opened. The SDC stated the insulin pen should be stored in the refrigerator until ready to be used. On 3/30/17 at 8:24 AM the Director of Nursing stated in an interview that insulin was to be dated when opened. 4. The package insert for PPD (skin test for tuberculosis) noted a vial of PPD which had been punctured and in use for 30 days should be	F 431	The treatment nurse will check all medication carts and medication room weekly x8 weeks, then monthly x1 month to ensure there are no open undated medications to include multi-dose vials to include PPD medications and insulins that are required to be dated when opened and no un unopened insulins are stored in the medication carts utilizing a Medication Cart/Room QI Audit Tool. Retraining will immediately be conducted by the DON with the hall nurse for any identified areas of concern during the audit. The DON will initial and review the Medication Cart/Room QI Audit Tools weekly x8 weeks and then monthly x1 month for completion and to ensure all areas of concern have been addressed. The Executive QI committee will meet monthly and review the Medication Cart/Room QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed to include continued frequency of monitoring x3 months.	

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 _____	03/30/2017

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 31 discarded because oxidation and degradation may have reduced the potency. The facility policy for medication storage provided by the facility ' s consulting pharmacy, revised on 2/1/17 listed instructions to discard PPD 30 days after opening. On 3/29/17 at 1:19 PM an observation of the medication refrigerator with the Staff Development Coordinator revealed one vial of PPD was opened and approximately one third of the medication was left in the vial. There was not a date on the bottle to show when the bottle of medication had been opened. The SDC stated the bottle of PPD should have been dated when opened. On 3/30/17 at 8:24 AM, the Director of Nursing stated in an interview the medication should have been dated when opened.	F 431		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other	F 520		5/6/17

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 _____	03/30/2017

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 32 individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place. This failure was related to F431 being cited on an annual recertification of 5/12/16 and on the current recertification survey. The facility's continued failure during the recertification survey showed a pattern of the facility's inability to sustain an effective QAA program. Findings Included:	F 520	The administrator, DON and QI nurse will be 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 by 5/6/17. The Administrator, DON and QI nurse will be educated by the corporate consultant by 5/6/17 regarding the QA process to include identifying issues that warrant development and establishing a system to	

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 _____	03/30/2017

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 33 This tag is cross referenced to: F431: Based on observation, record review and staff interviews, the facility failed to store unopened insulin in the refrigerator and date vials of insulin and insulin pens stored on the medication cart for 1 of 2 medication carts and failed to date an opened vial of (Purified Protein Derivative, a tuberculin screening test) for 1 of 1 medication refrigerator. The facility was cited for F431 on the current recertification survey for failing to store unopened insulin in the refrigerator and date vials of insulin and insulin pens stored on the medication cart and failing to date an opened vial of (Purified Protein Derivative, a tuberculin screening test). F431 was cited during the May 2016 recertification survey for failing to maintain medication room refrigerators between the temperatures of 36 degrees Fahrenheit and 46 degrees Fahrenheit. During an interview with the Quality Assurant nurse on 3/30/17 at 2:00 PM she stated the most likely cause as to medications being outdated and opened medications not being labeled with opened dates was because the facility relied on a lot of agency nursing and there is no stability with the staff.	F 520	monitor the corrections and implement changes when the expected outcome is not achieved. The QI nurse will complete a 100% audit of previous citation action plans within the past year to include medication storage to ensure that the QI committee has maintained and monitored interventions that were put into place. Action plans will be revised and updated and presented to the QI committee by the MDS nurse by 5/6/17 for any concerns identified. All data collected for identified areas of concern to include medication storage and current citations will be taken to the Quality Assurance committee for review monthly x4 months by the Quality Improvement Nurse. The Quality Assurance committee will review the data and determine if plans of correction 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 QI nurse. 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 medication storage and all current citations are followed and maintained quarterly x2.	

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 _____	03/30/2017

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 34	F 520	The results of the monthly Quality Assurance meeting minutes will be presented by the administrator and/or DON to the Executive Committee quarterly x2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	