		AND HUMAN SERVICES		-	M APPROVE D. 0938-039		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ATE SURVEY DMPLETED		
	345101		B. WING _	10	10/02/2015		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>		
ENFIELD	OAKS NURSING AN	ID REHABILITATION CENTER		208 CARY STREET ENFIELD, NC 27823			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE		
F 312 SS=D	483.25(a)(3) ADL ( DEPENDENT RES	CARE PROVIDED FOR	F 31	2	10/30/15		
	daily living receives	nable to carry out activities of the necessary services to ition, grooming, and personal					
	This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to provide the necessary foot care for 1 (Resident #1) of 2 sampled residents who required total assistance from staff for personal hygiene. Findings included: Resident #1 had diagnoses of Hypertension, Dementia, and Anxiety Disorder. The resident was coded on the most recent Quarterly			Enfield Oaks Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.			
	as totally depender and grooming. The had a focus area d 8/27/2105 that stat personal hygiene of maintaining of app Impairment, reside One of the interver	assessment dated 7/17/2015 at on staff for personal hygiene resident's current care plan ated as last reviewed on ed, "Requires assistance for haracterized by daily earance related to: Cognitive nt is resistive to care at times." ations for this focus area was to or hygiene and grooming.		Enfield Oaks Nursing and Rehabilitation Center¿s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Enfield Oaks Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute			
	#1 on 10/2/2015 at dirty white socks th of the sock. The so	s made of the feet of Resident 1:45PM. The resident had on at were soiled around the cuff ocks were removed by a nd revealed dry cracked		<ul> <li>Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</li> <li>F 312 483.25(a)(3) ADL Care provided for dependent residents</li> <li>Foot care was provided for resident #1 or</li> </ul>	n		
ABORATOR	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE		

Electronically Signed

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.

10/12/2015

		AND HUMAN SERVICES	-		O		APPROVEI 0938-039
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			B. WING _	B. WING			C 10/02/2015
NAME OF PROVIDER OR SUPPLIER ENFIELD OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 208 CARY STREET ENFIELD, NC 27823				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 312	The nursing assista 10/2/2015 at 1:45 F just finished providi further stated that t she needed to put I The Director of Nur 10/2/2015 at 3:25 F assistant should ha	ant was interviewed on PM. She stated that she had ing care for Resident #1. She he resident's feet were dry and lotion on them. rsing was interviewed on PM. She agreed the nursing ave changed the socks and put f Resident #1 during care prior	F 3	12	10-02-15 by NA #1 and clean socks applied to the resident¿s feet. The resident¿s feet were then checked Director of Nursing (DON) to ensure proper foot care had been provided #1. Resident # 1 was seen by the podiatrist on 10/8/15. A 100% foot care audit was initiated residents, to include resident #1 on 10/07/15 and completed on 10/09/1 the DON. All residents feet were so with warm soapy water, nail care provided, dried and lotion applied by DON and Treatment Nurse during t audit. Any areas of concern were immediately addressed by the DON 100% in-service was initiated on 10 by the DON and Staff Facilitator Ass for nursing assistants, to include NA providing proper ADL care, to includ care for the residents. All new nurs assistants will be trained during orientation by the Staff Facilitator regarding the need to provide proper care, to include foot care for the resi 100% inservice was initiated by the on 10/12/15 for all licensed nursing to include licensed agency nurses, providing nail care for residents or notifying the Social Worker (SW) of need to arrange podiatry consults for those residents who require podiatr In-services to be completed by 10/2 All new licensed nursing staff will be inserviced during orientation by the Facilitator regarding the need to pro- nail care for residents and notifying SW of the need to arrange podiatry consults for those residents who ref	by the by NA d for all 5 by baked y the he l. /07/15 sistant A#1, on de foot ing er ADL sidents. DON staff, on the br y care. 22/15 e Staff by de the	

Facility ID: 923153

If continuation sheet Page 2 of 6

		AND HUMAN SERVICES			C	FORM. MB NO.	10/15/2015 APPROVED 0938-0391	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
	345101			B. WING			02/2015	
NAME OF	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
ENFIELD	ENFIELD OAKS NURSING AND REHABILITATION CENTER			208 CARY STREET ENFIELD, NC 27823				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 312			F	312	podiatry care. Nursing assistants will provide ADI to include foot care, for all resident include dependent residents to en- residents are well groomed and m good personal hygiene. The nursin assistant will remove the resident if present and clean and examine daily during ADL care. Lotion will b applied to resident is feet during A daily by the assigned nursing assis Toe nails will be trimmed by the nu assistant as needed after ensuring resident does not have a diagnosis Diabetes. If the nursing assistant is unable to trim the toe nails due to thickening of nails or diagnosis of Diabetes, he or she will report the the licensed nurse who will trim the nails if able or notify the SW so tha podiatry consult can be arranged. Treatment Nurse will observe 10% resident is feet, to include resident the need to refer to the podiatrist v 8 weeks then monthly x 2 months Toe Nail Audit Tool. Audits will be conducted by the DON, MDS Nurs or Licensed Nurse to observe the assistants performing ADL care in nail care on 10% of the residents, week times 4 weeks, then weekly weeks, then monthly times 2 mont utilizing the QI ADL Care Audit Too which includes foot care. Any area concern will be addressed immedi re-education of staff. The Adminis will review and initial the ADL Care Tool and Toe Nail Audit Tool weekl weeks then monthly x 2 months.	ts to sure the aintain ng ,s socks the feet e DL care stant. ursing the s of s need to e toe at a The o of t #1, for veekly x using a se, and nursing cluding 3 x;s a times 4 hs ol, as of ately by trator e Audit		

Event ID: K7TM11

Facility ID: 923153

If continuation sheet Page 3 of 6

		AND HUMAN SERVICES			FO	ED: 10/15/2015 RM APPROVED NO. 0938-0391	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
	345101					10/02/2015	
NAME OF F	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ENFIELD	ENFIELD OAKS NURSING AND REHABILITATION CENTER				08 CARY STREET NFIELD, NC 27823		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	483.25(k) TREATMENT/CARE FOR SPECIAL		F3	312	The DON will compile audit results of th QI ADL Audit Tool and Toe Nail Audit To and present to the Quality Improvemen Committee for recommendations mont x 4 months. Identifications of potential trends will be used to determine the ner for further action and/or frequency of continued monitoring.	ool t hly	
F 328 SS=D			F3	328		10/30/15	
	by: Based on record re interviews the facilit necessary care and toe nails for 1 (Resi residents who requi for personal hygien Resident #1 had dia Dementia, and Anxi was coded on the n Minimum Data Set	NT is not met as evidenced eview, observation and staff ty failed to provide the d services for the grooming of ident #1) of 2 sampled ired total assistance from staff e. Findings included: agnoses of Hypertension, iety Disorder. The resident nost recent Quarterly assessment dated 7/17/2015 it on staff for personal hygiene,			F 328 483.25(k) Treatment/care for special needs Foot care was provided for resident #1 10-02-15 by NA #1 and clean socks we applied to the resident¿s feet. The resident¿s feet were then checked by t Director of Nursing (DON) to ensure proper foot care had been provided by #1. Resident # 1 was seen by podiatry 10/8/15. A 100% foot care audit was initiated for residents, to include resident #1 on	re he NA on	

Facility ID: 923153

If continuation sheet Page 4 of 6

		AND HUMAN SERVICES			F	FORM A	10/15/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
	345101		B. WING	B. WING			<i>,</i> )2/2015
	NAME OF PROVIDER OR SUPPLIER ENFIELD OAKS NURSING AND REHABILITATION CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 08 CARY STREET INFIELD, NC 27823		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 328	care plan had a foc on 8/27/2105 that s for personal hygien maintaining of apper Impairment, residen One of the interven provide total care for An observation was #1 on 10/2/2015 at resident were appro- and were thick curlis The Director of Nur- were interviewed on both confirmed that #1' s feet that day a needed podiatry se further stated that t come in quarterly b criteria for podiatry stated that an appor resident to receive Record review rever	oblity. The resident's current tous area dated as last reviewed tated, "Requires assistance e characterized by daily earance related to: Cognitive int is resistive to care at times." tions for this focus area was to or hygiene and grooming. a made of the feet of Resident 1:45PM. The toenails of the oximately a half an inch long ing into the skin. They had observed Resident and agreed the resident rvices. The Administrator he facility had a podiatrist ut Resident #1 did not fit the services. The Administrator intment would be made for the	F3	328	10/07/15 and completed on 10/09/15 the Director of Nursing (DON). All residents feet were soaked with warn soapy water, nail care provided, dried lotion applied by the DON and Treath Nurse during the audit. Any residents required podiatry care were placed of list for in-house podiatry to see on ne scheduled visit. Residents that did ne meet the criteria to see the in-house podiatrist had appointments made by Social Worker on 10/12/15 for outsid podiatry care. 100% in-service was initiated on 10// by the DON and Staff Facilitator for nursing assistants, to include NA#1, or providing foot care for the residents. new nursing assistants will be trained during orientation by the Staff Facilitat regarding the need to provide proper care for the residents. 100% inservice was initiated by the DON on 10/12/15 all licensed nursing staff, to include licensed agency nurses, on providing care for residents or notifying the Soc Worker of the need to arrange podiat consults for those residents who require podiatry care. In-services to be comp by 10/22/15. All new licensed nursing will be inserviced during orientation b Staff Facilitator regarding the need to provide nail care for residents and notifying the SW of the need to arrange podiatry consults for those residents and notifying the SW of the need to arrange podiatry consults for those residents and notifying the SW of the need to arrange podiatry consults for those residents and notifying the SW of the need to arrange podiatry consults for those residents and notifying the SW of the need to arrange podiatry consults for those residents and notifying the SW of the need to arrange podiatry consults for those residents and notifying the SW of the need to arrange podiatry consults for those residents and notifying the SW of the need to arrange podiatry consults for those residents and notifying the SW of the need to arrange podiatry consults for those residents and notifying the SW of the need to arrange podiatry consults for those residents and notifying the SW of the need	m d and ment is that in the ext iot y the le '07/15 on All d ator foot cial try uire bleted g staff by the co g nail cial try uire bleted g staff by the co g staff co g staff co g staff co	

Facility ID: 923153

If continuation sheet Page 5 of 6

		AND HUMAN SERVICES			F	FORMA	10/15/2015 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
	345101					10/02/2015	
NAME OF	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ENFIELD	O OAKS NURSING AN	D REHABILITATION CENTER			08 CARY STREET NFIELD, NC 27823		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 328	Continued From pa	ıge 5	F3	328	be applied if the skin is dry. Toe nails be trimmed as needed by the nursing assistant after ensuring the resident not have a diagnosis of Diabetes. If t nursing assistant is unable to trim the nails due to thickening of nails or diagnosis of Diabetes, he or she will report the need to the licensed nurse will trim the toe nails if able or notify t Social Worker so that a podiatry cons can be arranged. The Treatment Nu will observe 10% of resident;s feet, t include resident #1, for the need to re to the podiatrist weekly x 8 weeks the monthly x 2 months using a Toe Nail Tool. Audits will be conducted by the DON, MDS Nurse, and or Licensed N to observe the nursing assistants performing nail care, 3 x;s a week til 4 weeks, then weekly times 4 weeks monthly times 2 months utilizing the of Foot Check Audit Tool. Any areas of concern will be addressed immediate re-education of staff. The administration will review and initial the QI Foot Che Audit Tool and Toe Nail Audit Tool we x 8 weeks then monthly x 2 months. The DON will compile audit results of Foot Check Audit Tool and Toe Nail A Tool and present to the Quality Improvement Committee for recommendations monthly times 4 months. Identification of trends will determine the need for further action and/or change in frequency of require monitoring.	g does the e toe e who the sult irse to efer en Audit e Nurse mes , then QI ely by tor eck eekly f the Audit	

Facility ID: 923153

If continuation sheet Page 6 of 6