PRINTED: 05/14/2018 FORM APPROVED OMB 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	
		345101	B. WING			C 22/2018	
	ROVIDER OR SUPPLIER OAKS NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 208 CARY STREET ENFIELD, NC 27823			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 558 SS=D	S483.10(e)(3) The rig services in the facility accommodation of re preferences except wendanger the health cother residents. This REQUIREMENT by: Based on observation and resident interview maximize a residents for 3 of 5 residents (reviewed for side rails independence for bed) The findings included 1. Resident #30 was 6/23/17 and had a diachronic pain. A bed rail evaluation of following for Resident oriented to person, ploor long term memory independent with deceived mobility. The resident oriented to have the side for his own safety or oprovided feeling of satunder the risks section Recommendation for Risks and benefits, all resident.	sident needs and hen to do so would or safety of the resident or is not met as evidenced in, record review and staff vs the facility failed to potential for bed mobility esident # 30, #24, and #21), s, resulting in loss of mobility.	F 58	Enfield Oaks Nursing and Rehabilita Center acknowledges receipt of the Statement of Deficiencies and proporthis Plan of Correction to the extent this Summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of reside The Plan of Correction is submitted a written allegation of compliance. Enfi Oaks Nursing and Rehabilitation Cer response to this Statement of Deficiencies not denote agreement with the Statements of Deficiencies nor does constitute an admission that any deficiency is accurate. Further, Enfie Oaks Nursing and Rehabilitation Cer 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 leg proceeding. F558 The process that led to this deficience was the facility failed to maximize a residents potential for bed mobility of 5 residents reviewed for side rails,	nts. is a eld ter ncies it d ter es e e e e e e e e e e e e e e e e e e	4/16/18 (X6) DATE	

04/13/2018

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.

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345101	B. WING		0.	C 3/22/2018		
NAME OF PE	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	0.	5/22/2016		
	to the Little of the Little			208 CARY STREET				
ENFIELD (DAKS NURSING AND R	EHABILITATION CENTER		ENFIELD, NC 27823				
240.45	CUMMA DV C	FATEMENT OF DEFICIENCIES			FOTION	0/5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 558	Continued From pag	e 1	F 55	58				
	Assessment (Quarte the resident was cog extensive assistance limited range of motio extremities.	imum Data Set (MDS) rly) dated 2/9/18 revealed nitively intact, required with bed mobility and had on of both upper and lower e Plan did not include		resulting in loss of independence mobility. On 3/22/18 resident #24 and resulting were re-evaluated for use of beet the Director of Nursing (DON). Appropriate alternatives were in bed rails were installed until appart	sident #30 d rails by itiated and propriate			
	information regarding			potential for bed mobility for res and resident #30. Risks/benefits temporary use of bed rail was re	ident #24 s of			
	hand and forearm. T the resident's bed. took the side rails off	d with a splint on his right here were no side rails on The Resident stated the staff his bed and now he could f in the bed and wanted to be side of the bed.		with resident #24 and resident # DON and informed consent obta rails were correctly installed and maintained according to manufa recommendation and the bed di are appropriate for resident size	#30 by the ained. Bed d acturer⊡s imensions			
	A second bed rail everevealed the following place and time. Safe short or long term me independent with demedium with paresis weakness and total combility. Resident has have side rails raised safety or comfort. Not #7 Other read: "PT/C treat. Has plateau (si services due to resid of bed. Paralysis with noted contracture to movement to (L) (left	aluation dated 3/20/18 g: Resident alert to person, ty awareness deficit. No		weight. Side rails were within cle proximity to mattress with no gat for entrapment. On 4/9/18 100% audit of all resiremoval of bed rails to include refinitiated by the Director of Nursito ensure resident has been proassessed for the use/removal of and that appropriate alternatives initiated prior to removing bed ramaximize residents potential for mobility and prevent loss of indeduring bed mobility. Audit was con 4/12/18. All areas of concern immediately addressed by the EON 4/9/18 resident #21 was re-efor use of bed rails by the DON.	dents with esident #30 was ng (DON) operly f bed rails is had been ails to bed ependence completed in were DON.			
	Benefits/risks explair On 3/21/18 at 11:07	ned to resident on 3/20/18.		Appropriate alternatives were in bed rails were installed until appalternative could be obtained to potential for bed mobility for res	itiated and propriate maximize			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			, 50.25.	_			С
		345101	B. WING			0.3	3/22/2018
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	72272010
					08 CARY STREET		
ENFIELD	OAKS NURSING AND	REHABILITATION CENTER			NFIELD, NC 27823		
(V4) ID	STIMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(YE)
(X4) ID PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 558	Continued From p	age 2	F t	558			
	#2. The PTA state	d when Resident #30 had the			Risks/benefits of temporary use of bed	rail	
	bed rails he could	use them to turn himself. The			was reviewed with resident #21 by the		
	PTA further stated	the resident had gotten to the			DON and informed consent obtained.	Bed	
	point he could use	e the side rail to sit on the side			rails were correctly installed and		
	of the bed to eat a	meal with contact guard			maintained according to manufacturer	□s	
		TA stated this meant she could			recommendation and the bed dimension	วทร	
		ttended but would have to keep			are appropriate for resident size and		
		safety and he was able to do			weight. Side rails were within close		
		ites at a time. The PTA stated			proximity to mattress with no gaps or r	isks	
		very important for the resident			for entrapment.		
		out the rails he was total assist			On 3/28/18 an in-service on Bed Rails		
		The PTA stated with the bed could use the left hand on the			was initiated by the Facility Nurse Consultant with all licensed nurses,		
		ht arm around the rail to pull			Minimum Data Set nurse, Treatment		
	himself over.	nt ann around the rail to pair			Nurse, Staff Facilitator, Admissions,		
					Maintenance Director and DON in rega	ards	
	On 3/21/18 at 2:20	DPM an interview was			to use of bed rails to include:		
		e Administrator and the Director			Assessing the resident for the risk	of	
	of Nursing (DON).	The DON stated a trapeze bar			entrapment from bed rails prior to		
	had been ordered	for the resident 2-3 weeks ago			installation under the Bed Rail Evaluat	ion	
	but had not come	in at this time.			in Point Click Care (PCC) a. Entrapment: an event in which a		
	On 3/23/18 at 10:	30 AM an interview was			resident is caught, trapped or entangle	ed in	
	conducted with the	e Physical Therapist (PT) who			the space in or about the bed rail		
		lent #30. The PT stated the			2. The facility must attempt to use		
		ok his arms around the side			appropriate alternatives prior to installi		
		and help pull himself over or lift			a side or bed rail (trapeze bar, low bed	ls,	
		o relieve pressure. The PT			frequent monitoring, activities)		
		upational therapy had			Appropriate alternatives must be i	n	
		rapeze bar but she was not			place before removing a side rail.		
		nad enough grip pressure in his			4. Review the risks and benefits of b	ed	
		par. The PT stated she had not			rails with the resident or resident		
		aluate the resident for the use of			representative and obtain informed		
	bed.	he rails being removed from the			consent 5. Ensure the rail is installed per the		
	beu.				manufactures recommendations and		
	On 3/23/18 at 11-0	05 AM an interview was			specifications		
		e Administrator and the facility '			6. Ensure the bed rail is compatible	with	
		nt. The Nurse Consultant stated			the mattress and bed frame and that the		

Facility ID: 923153

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
			A. BOILDI	NG		,	2		
		345101	B. WING				22/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
ENEIEI D	JAKS NIIDSING AND B	REHABILITATION CENTER		208 CARY STREET					
LIVI ILLD	DANS NONSING AND IN	CHABIETATION CENTER		Е	NFIELD, NC 27823				
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 558	Continued From pag	ge 3	F 558						
	when the bed rail ini	tiative came out, the facility			dimensions are appropriate for the				
		to assess residents with bed			residents size and weight				
	rails and to remove t	the bed rails for the residents			7. Inspect regularly the mattress and				
	that were at risk for e	entrapment. The Nurse			bed rail for the possibility of entrapmen	t			
		ated when the guidelines			8. Maintenance monitors bed rails				
	_	staff was told to re-assess			regularly to ensure they are installed				
		look at what alternatives			correctly and/or have not shifted or loos	ed or loosen			
		educate the residents and			over time.				
			Appropriate documentation in PCC with use of had rails under OI	,					
	resident s bed fails	were removed on 1/19/16.			with use of bed rails under QI Restraint/Enabler Progress Note				
					10. Resident is care planned for use o	f			
	2. Resident #24 was	admitted to the facility on			bed rails				
		iagnosis of congestive heart			200.000				
	failure and adult failu	-			No licensed nurses, QI nurse, Minimun	า			
					Data Set Nurse (MDS), Treatment Nurs	se,			
	A side rail evaluation	n dated 12/6/17 noted the			Staff Facilitator, Admissions, Maintena	nce			
	_	ent was alert to person, place			Director and Director of Nursing (DON)				
		dependent with decision			will be allowed to work until in-service of				
		gth within normal perimeters.			Bed Rails has been completed. In-serv	ice			
	Range of motion and				will be completed by 4/16/18.				
	•	with bed mobility. Resident			All newly hired licensed nurses, QI nurs	se,			
		sire to have side rails raised own safety/comfort. Used side			Minimum Data Set Nurse (MDS), Treatment Nurse, Staff Facilitator,				
	rails for care with sta	•			Admissions, Maintenance Director and				
		½ side rails right and left.			Director of Nursing (DON) will be trained				
		ke appropriate decisions on			by the Staff Facilitator on Bed Rails du				
	his preferences.	The special section is a second secon			orientation to include:	3			
	•				1. Assessing the resident for the risk	of			
	The most recent Min	nimum Data Set (MDS)			entrapment from bed rails prior to				
	-	erly) dated 1/30/18 revealed			installation under the Bed Rail Evaluati	on			
	_	gnitively intact and required			in Point Click Care (PCC)				
	extensive assistance	e with bed mobility.			a. Entrapment: an event in which a				
	The	Discoundated at 4/04/40			resident is caught, trapped or entangle	d in			
		e Plan updated on 1/31/18			the space in or about the bed rail				
		as at risk for decline in ability			2. The facility must attempt to use	20			
		e bed related to generalized nd pain in the knees. There			appropriate alternatives prior to installing a side or bed rail (trapeze bar, low bed:	-			
		on the Care Plan regarding			frequent monitoring, activities)	J,			

OLITILIT	OT OIL WEDIOTILE &	MEDIO/ (ID CEITVICE)				T T	7. 0000 000 1
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDI	. •0 _		(С
		345101	B. WING			03/	22/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ENFIELD	OAKS NURSING AND RI	EHABILITATION CENTER			08 CARY STREET		
				Е	NFIELD, NC 27823		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		DATE
		•			DEFICIENCY)		
F 558	Continued From page	e 4	F:	558			
	side rails.				Appropriate alternatives must be i	n	
					place before removing a side rail.		
	On 3/20/18 at 1:44 P				4. Review the risks and benefits of b	ed	
	observed lying in bed. There were no bed rails on the bed and the right side of the bed was against the wall. The Resident stated he had side rails on				rails with the resident or resident		
					representative and obtain informed consent		
		Il himself over but they took			5. Ensure the rail is installed per the		
	•	e bed and now he could no			manufactures recommendations and		
	longer do this. The Resident stated he was getting therapy.				specifications		
					6. Ensure the bed rail is compatible v	vith	
					the mattress and bed frame and that the		
	There was not a bed rail assessment on the				dimensions are appropriate for the		
	record to show when	the bed rails were removed			residents size and weight		
	from the resident 's b	ped.			7. Inspect regularly the mattress and		
					bed rail for the possibility of entrapmer	it	
	On 3/21/18 at 11:07 i				Maintenance monitors bed rails		
	-	ical Therapy Assistant (PTA)			regularly to ensure they are installed		
		Resident #24 could use the self from side to side and			correctly and/or have not shifted or loo over time.	sen	
	needed the side rails				9. Appropriate documentation in PC0	_	
	Ticeded the side rails	for bed mobility.			with use of bed rails under QI	,	
	On 3/21/18 at 1:10 P	M an interview was			Restraint/Enabler Progress Note		
		occupational Therapist who			10. Resident is care planned for use of	of	
		was a functional quadriplegic			bed rails		
	and could use the sid	le rails to turn from side to					
	side.						
					Monitoring:		
	On 3/23/18 at 10:30 I				10% audit of all residents with use and		
		hysical Therapist who			removal of bed rails to include resident		
		lent and stated the resident ils to turn from side to side			#21, resident #24 and resident #30 will		
		elf up in the bed when his			completed by the Quality Improvement nurse (QI)/Staff Facilitator weekly x 8		
	feet touched the foot	•			weeks, then monthly x 1 month utilizing	ו	
		was not asked to do an			the Bed Rail Audit Tool to ensure:	đ	
		eed for side rails prior to the			The resident was assessed for the	;	
		ved from the resident 's bed.			risk of entrapment		
					Bed Rail Assessment is completed	t	
	On 3/23/18 at 11:05 A	AM an interview was			accurately in PCC		
	conducted with the A	dministrator and the facility '			The facility attempted use of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		345101	B. WING		0	C 03/22/2018	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			0	
				208 CARY STREET			
ENFIELD (DAKS NURSING AND R	EHABILITATION CENTER		ENFIELD, NC 27823			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 558	when the bed rail initistaff was instructed to rails and to remove the that were at risk for econsultant further state came out the facility of the residents and to lead to the family members. The resident of the family members of the family members of the family members. The resident of the family members of the family	The Nurse Consultant stated intive came out, the facility of assess residents with bed the bed rails for the residents intrapment. The Nurse ated when the guidelines staff was told to re-assess ook at what alternatives educate the residents and The Administrator stated the were removed on 1/19/18. The admitted to the facility on moses to include diabetes, and disease. Her annual MDS) assessment dated the recognition was intact, and the assistance with 1 staff for the dated 1/29/2018 reveled the distribution of the facility with decision making. Her the facility with resident and the person place and time in short or long-term memory the with decision making. Her the face of motion (ROM) and the distribution of the face of motion (ROM) and the distribution of the face of the f	F 5	appropriate alternatives prior to a bed rail (trapeze bar, low beds monitoring, activities) 4. Appropriate alternatives we and in place prior to removal of the first benefits of bed rails with the resist resident representative and obtainformed consent 6. The rail is installed per the manufactures recommendations specifications and is compatible mattress and bed frame and that dimensions are appropriate for resize and weight 7. Appropriate documentation with use of bed rails under QI Restraint/Enabler Progress Note 8. Resident is care planned for bed rails The DON will review the Bed Rail Tool weekly x 8 weeks, then more month to ensure all areas of contaddressed. The Quality Improvement (QI) N forward the results of the Bed Rail Tool to the Executive QI Commit monthly x 3 months. The Execut Committee will meet monthly x 3 and review the Bed Rail Audit To determine trends and / or issues need further interventions put in and to determine the need for fully or frequency of monitoring. The Administrator and Director of will be responsible for the impler of corrective actions to include a	re initiated ped rails. Its and ident or ain. and with the esident in PCC in use of ail Audit in ail Audit in the exity of a months pol to a that may into place in the rand of Nursing mentation ill 100%		
	on 11/27/17.	·		audits, in services, and monitoring to the plan of correction.			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED C		
345101 B. WING			
NAME OF PROVIDER OR SUPPLIER ENFIELD OAKS NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 208 CARY STREET ENFIELD, NC 27823	03/22/2018		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 558 Continued From page 6 The Care Plan for Resident #21 dated 2/6/2018, did not address side rails. On 3/19/2018 at 2:13 PM, Resident #21 stated in an interview the facility had removed her quarterly bed side rails and she wanted to keep them on her bed. The resident stated she could hold onto the rails to reposition herself in the bed, turn over in the bed, and help herself sit up in the bed. The resident stated the staff had come around and asked her about the rails and at that time her bed rails were left on the bed. Sometime after, the staff came around again and removed her rails. On 3/21/2018 at 9:08 AM an interview was conducted with the nursing assistant (NA #1). The NA stated Resident #21 had told her she could help more with care if she had her side rails on the bed, and wished she had side rails. On 3/21/18 at 10:35 AM, an interview was conducted with NA #2. The NA stated Resident #21 was alert and oriented and required extensive assistance from staff for activities of daily living (ADLs), but was not total care, as she could help with part of her care. The NA stated Resident #21 told him she wanted the side rails to turn on her side and help her sit up on the side of the bed. On 3/22/2018 at 10:04 AM an interview was conducted with the Physical Therapist (PT). The PT stated resident #21 needed tactile (touching) and verbal prompting for bed mobility, that involved the therapist physically touching the resident and prompting her on which part of her bed body to move. The PT stated she was not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345101	B. WING			03/	22/2018
	ROVIDER OR SUPPLIER DAKS NURSING AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 208 CARY STREET ENFIELD, NC 27823		08 CARY STREET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD B		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558 F 656 SS=D	mobility. On 3/23/2018 at 11:00 conducted with the Ad Nurse Consultant. The bed rail initiative was instructed to assefor risk of entrapment new guidelines came told to re-asses the realternatives could be residents and families.	5 AM, an interview was dministrator and facility's ne Administrator stated when was introduced, the facility ess residents with bed rails, with bed rails. When the out, the facility was then esidents and look at what used and to educate		558 656			4/16/18
	§483.21(b) Comprehe §483.21(b)(1) The fact implement a comprehe care plan for each resident rights set fort §483.10(c)(3), that incobjectives and timeframedical, nursing, and needs that are identificant assessment. The complement of the following (i) The services that a comparison or maintain the reside physical, mental, and required under §483.2 (ii) Any services that wunder §483.24, §483. provided due to the reunder §483.10, includit treatment under §483. (iii) Any specialized services implementation of the factorial of the f	cility must develop and lensive person-centered sident, consistent with the sthat §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial led in the comprehensive aprehensive care plan must lent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not lesident's exercise of rights ling the right to refuse 1.10(c)(6).					

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		345101	B. WING			03/	22/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ENFIELD	OAKS NURSING AND R	EHABILITATION CENTER			08 CARY STREET NFIELD, NC 27823			
24.0.15	CUIMMA DV CT	TATEMENT OF DEFICIENCIES	- 15		·		0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656	findings of the PASAI rationale in the reside (iv)In consultation wit resident's representa (A) The resident's go desired outcomes. (B) The resident's prefuture discharge. Facwhether the resident's community was asselocal contact agencie entities, for this purpo (C) Discharge plans in plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on record revised for psychot #8 and #32). The findings included A psychotropic medic substance that change in alterations in perceior behavior and incluantianxiety medication. 1. Resident #8 was a 1/13/17 and had a distance that change in alterations in perceior behavior and incluantianxiety medication.	a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-als for admission and eference and potential for cilities must document is desire to return to the seed and any referrals to estand/or other appropriate obse. In the comprehensive care in accordance with the in paragraph (c) of this is not met as evidenced diew and staff interviews the die psychotropic medications. Plan for 2 of 5 residents ropic medications (Resident dies antipsychotic and ens.	F	656	F656 The process that led to this deficiency was the facility failed to include psychotropic medications in a resident care plan for 2 of 5 residents reviewed. On 3/21/18, resident #8 Care Plan was updated for use of psychotropic medications to reflect a patient-centere care plan that includes measureable go and objectives to attain or maintain resident #8 highest practicable physical mental and psychosocial well-being by Minimum Data Set Coordinator (MDS). On 4/6/18, resident #32 Care Plan was updated for use of psychotropic medications to reflect a patient-centere care plan that includes measureable go	ed pals al,		
	rationale in the reside (iv)In consultation with resident's represental (A) The resident's good desired outcomes. (B) The resident's profuture discharge. Fact whether the resident's community was asselucal contact agencie entities, for this purpor (C) Discharge plans in plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on record revision facility failed to includin a resident 's Care reviewed for psychot #8 and #32). The findings included A psychotropic medic substance that changin alterations in perceor behavior and incluantianxiety medication. 1. Resident #8 was a 1/13/17 and had a diabehaviors and anxiet	ent's medical record. In the resident and the tive(s)- als for admission and eference and potential for cilities must document is desire to return to the seed and any referrals to is and/or other appropriate ose. In the comprehensive care in accordance with the in paragraph (c) of this If is not met as evidenced itew and staff interviews the depsychotropic medications is a chemical great proper medications (Resident desire). It is a chemical great proper medical great proper medical and results eption, mood, consciousness desire antipsychotic and medical great proper medical and medical great proper medical			The process that led to this deficiency was the facility failed to include psychotropic medications in a resident care plan for 2 of 5 residents reviewed. On 3/21/18, resident #8 Care Plan was updated for use of psychotropic medications to reflect a patient-centere care plan that includes measureable go and objectives to attain or maintain resident #8 highest practicable physical mental and psychosocial well-being by Minimum Data Set Coordinator (MDS). On 4/6/18, resident #32 Care Plan was updated for use of psychotropic	ed pals al, ded		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		Ι,	c
		345101	B. WING				22/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ENEIEI D	UVKS NIIBSING VND 1	REHABILITATION CENTER			08 CARY STREET		
LINI ILLD	OANO NONOINO AND I	REHABIEHATION GENTER		Е	NFIELD, NC 27823		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC 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 656	Continued From pag	ge 9	F	656			
		ligrams) twice a day."	'	000	mental and psychosocial well-being by		
		psychotic medication used to			Minimal Data Coordinator (MDS).		
	1	There was also an order on			On 4/9/18, 100% audit of Care Plans o	f all	
		ecrease the resident 's Ativan			residents utilizing psychotropic medica		
	(Ativan is an antian)				was initiated by the MDS nurse to inclu		
	, , , , , , , , , , , , , , , , , , , ,				resident #8 and resident #32 to ensure		
	The resident 's Car	e Plan dated 8/2/17 noted the			resident⊡s Care Plan is patient centere	ed	
	resident had anxiety	related to anxiousness and			and reflects usage of psychotropic		
	restlessness while s	sitting in a wheelchair. The			medication to include measureable goa	als	
		clude care for a resident on			and objectives. Audit was completed of	า	
	antipsychotic or anti	ianxiety medications.			4/11/18. All areas of concern were		
					immediately addressed by the Minimal		
	The Annual Minimu	, ,			Data Nurse (MDS).		
		12/20/17 revealed the resident			On 4/11/18, an in-service on MDS Care		
	_	e impairment and received an nti-anxiety medications for 7			Plans related to Psychotropic Medication was completed by the Administrator with		
	days of the 7 day as				the MDS Coordinator and Director of	.11	
	days of the r day as	sacasment period.			Nursing (DON) in regards to MDS Care	ا د	
	The resident 's Car	e Plan reviewed on 12/27/17			Plans related to Psychotropic Medication		
	did not include care				to include:		
	antipsychotic or anti	ianxiety medications.			1. MDS should ensure that care plan	S	
	. ,	•			reflect the resident□s mental, physical		
		essment for Cognitive Loss			and psychosocial status to include	ĺ	
		a deficit in memory, judgment,			psychotropic medications use	ĺ	
		d thought processes related to			Any resident utilizing psychotropic		
		due to dementia. The CAA for			medication must be care planned for us	se	
		cations noted a diagnosis of			of the medication to include name of		
	anxiety with an-anxi	lety medications.			medication being utilized, possible side	:	
	On 2/22/19 at 12:56	S PM an interview was			effects, goals, and target behaviors. 3. Resident Care Plan is resident		
		Director of Nursing (DON).			centered and goal oriented with clearly		
		rved to review the Care Plan			measurable time frames and approach		
		stated there was a care plan			Care plans must be updated timely		
		ot for antipsychotic or			when there are changes in mental,	'	
	antianxiety medicati				physical and psychosocial status		
	.,				5. Care guides should be updated ar	ıd	
	On 3/23/18 at 1:50	PM the Administrator stated in			placed in resident room with any chang		
	an interview she tho	ought Care Plans were an					
	issue due to change	es in staff within the facility.			All newly hired licensed nurses, MDS	ĺ	

Facility ID: 923153

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	LTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		345101	B. WING _			C 03/22/2018		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	22/2010	
					08 CARY STREET			
ENFIELD	OAKS NURSING AND RI	EHABILITATION CENTER			NFIELD, NC 27823			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	TE ACTION SHOULD BE COMPLETIC DATE		
F 656	2. Resident #32 was facility on 2/13/18 wit Unspecified Psychos known physiological of Major Depressive Dis Unspecified Dementia Disturbance. Review of the doctor revealed Resident #3 Risperidone 2mgs., 1 dementia and psychological of Review of Resident #2/19/18, revealed the antipsychotic medical During an interview of facility Minimum Data stated she did not pure medication) in the calit. During an interview of Administrator stated for a care plan to include the state of the care plan to include the care plan to inclu	originally admitted to the h diagnoses including is not due to a Substance or condition, Bipolar Disorder, sorder, Single Episode and a with Behavioral 's orders for March 2 had a doctor 's order for mg. by mouth at bedtime for exis. 32's 's Care Plan dated re was no care plan for tion. n 3/22/18 at 1:02 PM, the Set (MDS) Coordinator	F	656	Nurse and Director of Nursing will be trained during orientation by the Staff Facilitator in regards to MDS Care Plar related to Psychotropic Medications to include: 1. MDS should ensure that care plan reflect the resident smental, physical and psychosocial status to include psychotropic medications use 2. Any resident utilizing psychotropic medication must be care planned for urof the medication to include name of medication being utilized, possible side effects, goals, and target behaviors. 3. Resident Care Plan is resident centered and goal oriented with clearly measurable time frames and approach to an experience of the experience of the property of the medication to include the experience of the	s se es y nd ges. h ill ent s, ure as t d		
	the reason the reside	nt was on the medication.			then monthly x 1 month utilizing the Ca Plan Audit Tool to ensure all residents utilizing psychotropic medication have patient-centered care plan that include name of psychotropic medication being utilized, possible side effects, target behaviors, measureable goals and objectives to attain or maintain residen highest practicable physical, mental and	a s g t		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345101	B. WING			l	22/2018
	ROVIDER OR SUPPLIER DAKS NURSING AND RE	EHABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 18 CARY STREET NFIELD, NC 27823		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758 SS=D	CFR(s): 483.45(c)(3)(c) §483.45(e) Psychotror §483.45(c)(3) A psychaffects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a compreheresident, the facility management of the compreheresident, the facility management of the compreheresident of the com	chotropic Meds/PRN Use (e)(1)-(5) ppic Drugs. hotropic drug is any drug that associated with mental rior. These drugs include, drugs in the following		758	the MDS nurse. The Administrator will review the Care Plan Audit Tool weekly x 8 weeks, then monthly x 1 month to ensure all areas of concern are addressed. The Quality Improvement (QI) Nurse w forward the results of the Care Plan Au Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 month and review the Care Plan Audit Tool to determine trends and/or issues that ma require further interventions to be put in place and to determine the need for further and/or frequency of monitoring. The Administrator and Director of Nursi will be responsible for the implementati of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	of ill dit ns ny nto ing on	4/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345101	B. WING		C 03/22/2018
NAME OF PROVIDER OR SUPPLIER ENFIELD OAKS NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 208 CARY STREET ENFIELD, NC 27823	03/22/2010
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 758	unless the medication specific condition as	e 12 re not given these drugs n is necessary to treat a diagnosed and documented	F 75	8	
	drugs receive gradua behavioral interventic contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs po	neffort to discontinue these nts do not receive ursuant to a PRN order			
	diagnosed specific co in the clinical record; §483.45(e)(4) PRN of are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the PR beyond 14 days, he of	rders for psychotropic drugs Except as provided in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and			
	drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of This REQUIREMENT by: Based on record revinterviews, the facility for the use of Seroqui	er evaluates the resident for of that medication. is not met as evidenced lew, staff and physician 's failed to provide a diagnosis el for 1 (Resident #8) of 5 r psychotropic medications.		F758 The process that led to this deficiency was the facility failed to provide appropriate diagnosis for the use of Seroquel for 1 of 5 residents reviewed On 4/10/18 100% audit of all residents	ı.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		345101	B. WING _		0	C 3/22/2018
NAME OF PROVIDER OR SUPPLIER ENFIELD OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 208 CARY STREET ENFIELD, NC 27823	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 758	1/13/17 and had a behaviors and anx A physician 's order Seroquel 50mg (m. Seroquel 50mg (m. Seroquel is an antitreat mental illness. The resident 's Caresident had anxier restless while sitting interventions included a process of anxiety. Doctor) of changes woice and assure in Antipsychotic meditation and behavior." In a communication 8/3/17, the facility 'requested a diagnory physician 's respoor "restlessness with A communication of facility 's consulting read: Restlessness as the indication for (Center for Medical approved diagnosidated 9/18/17 read Seroquel."	dmitted to the facility on diagnosis of dementia with iety. er dated 7/22/17 read: "Start illigrams) twice a day." psychotic medication used to describe the replan dated 8/2/17 noted the sty related to anxiousness and g in a wheelchair. The ded the following: Document y and notify MD (Medical stranger and the resident of her safety. Cations were not included in the Plan. er dated 8/3/17 read: Seroquel D (twice a day) for agitation and form to the physician dated as consulting pharmacist posis for Seroquel. The last dated 8/16/17 read:	F7	with psychotropic medication resident #8 was initiated by Administrator to ensure all receiving psychotropic medical diagnos completed on 4/12/18. All and concern were immediately at the Director of Nursing (DO) On 4/10/18 the supporting rediagnosis for resident #8 us antipsychotic medication was the DON from the Medical Enthe electronic record of residupdated by Medical Record On 4/11/18 100% audit for a with antipsychotic medication completed by the consultant to ensure an appropriate diaplace to support antipsychouse. There were no new coron 4/11/18 an in-service was the DON with all licensed number of Minimum Data Set nurse (M. Facilitator, and Quality Improved (QI) in regards to Medication, and Quality Improved (QI) in regards to Medication to 1. When a resident is admireadmitted to the facility it is responsibility to review all mensure each medication to in psychotropic medications has appropriate supporting medin place. If there is not a supporting the contact the referring hospital an updated diagnosis list. 2. It is the nurse sepondation as supporting medical as supporting medical contact the referring hospital and supporting medical contact the referring medical contact the r	the residents lication have sis. Audit was areas of addressed by (N). medical se of as obtained by Director and ident #8 d. all residents ons was at pharmacists agnosis was in otic medication encerns noted. as initiated by urses, MDS), Staff rovement dical se of include: mitted or include ave dical diagnosis porting and include ave dical diagnosis porting and include and include ave dical diagnosis porting and include and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345101	B. WING		C 03/22/2018
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/22/2016
	10 7.52.1 0.1 00. 1 2.2.1			208 CARY STREET	
ENFIELD OAKS NURSING AND REHABILITATION CENTER					
				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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 758	Continued From page	· 14	F 75	8	
F 758	12/20/17 revealed the cognitive impairment antipsychotic medicat assessment period ar on a routine basis. The resident 's Care 12/27/17 did not incluantipsychotic medicat. The Care Area Assess Loss dated 1/3/18 revealed ficit in memory, jud thought processes redue to dementia. The Medications noted a canti-anxiety medication. On 2/6/18, the pharm reduction of the Seroet to once a day at bedti and the order was care. On 3/23/18 at 11:46 A (DON) stated in an infordered the Seroquel smearing and eating they did not have a period because the resident medication had been she had asked the phediagnosis for the Seroen not provide one.	e resident had severe and received an ion for 7 days of the 7 day and received the medication. Plan last reviewed on de information regarding ions. Sment (CAA) for Cognitive realed the resident had a gment, decision making and ated to brain deterioration. CAA for Psychotropic diagnosis of anxiety with ons. acist recommended a dose quel from 25mg twice a day ime, the physician agreed rried out. AM the Director of Nursing terview the physician due to the resident her feces. The DON stated sychiatric evaluation done mellowed out and the effective. The DON stated ysician for another oquel but the physician did	F 75	all new medication orders to include psychotropic medications. If the physicions not list a supporting medical diagnosis the nurse must contact the physician and request appropriate diagnosis. 3. The physician may elect to discontinue medication if not indicated that time. No licensed nurses, Director of Nursin Staff Facilitator, QI nurse, MDS Nurse be allowed to work until in-service on Medical Supporting Diagnosis for use Psychotropic Medication has been completed. In-service will be completed 4/16/18. All newly hired licensed Nurses, Director of Nursing, Staff Facilitator, MDS Nurse and QI nurse will be trained by the Staff Facilitator during orientation in regards Medical Supporting Diagnosis for use Psychotropic Medication to include: 1. When a resident is admitted or readmitted to the facility it is the nurse responsibility to review all medications ensure each medications have appropriate supporting medical diagnosi in place. If there is not a supporting diagnosis on admission the nurse sho contact the referring hospital or facility an updated diagnosis list. 2. It is the nurse □s responsibility to	g, will of ed by tor se, aff s to of
	Seroquel for Residen he did not have anoth	M an interview was nysician that ordered the t #8. The Physician stated her diagnosis and did not aluation was necessary as		obtain a supporting medical diagnosis all new medication orders to include psychotropic medications. If the physical does not list a supporting medical diagnosis the nurse must contact the	

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345101	B. WING _			C 03/22/2018
NAME OF P	ROVIDER OR SUPPLIER	0.0101		STREET ADDRESS, CITY, STAT		03/22/2018
				208 CARY STREET		
ENFIELD	OAKS NURSING AND R	EHABILITATION CENTER		ENFIELD, NC 27823		
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F 758	Continued From pag	e 15	F 7	758		
F 758	the medication had b	e 15 peen effective but they had I Dose Reductions) of the	F 7	physician and request diagnosis. 3. The physician m discontinue medication that time. Monitoring 10% audit of all resid psychotropic medication resident #8 will be concerned all residents of medication therapy h supporting diagnosis then monthly x 1 more concern will be immedited the DON. The DON Plan Audit Tool week monthly x 1 month to concern were address 100% audit for all residents of medication therapy h supporting diagnosis then monthly x 1 month to concern were address 100% audit for all residents antipsychotic medication completed by the commonthly x 3 months to appropriate diagnosis support antipsychotic consultant pharmacistic DON and/or Administic following each audit. Immediately address concern. The Quality Improver forward the results of Tool and the Pharma on Antipsychotic Medicated Plan Audit Tool Care Plan Audit Tool	ents utilizing tion to include impleted by the QI are Plan Audit Tool on psychotropic ave appropriate weekly x 8 weeks inth. All areas of diately addressed will review the Carly x 8 weeks, then ensure all areas of diately addressed will review the Carly x 8 weeks, then ensure all areas of diately addressed will review the Carly x 8 weeks, then ensure all areas of diately addressed will review the carl areas of the medication use. The box will provide facilitation with report the DON will any areas of the Care Plan Audications to the tee monthly x 3 we QI Committee withs and review the	to by ee of ts The ty III dit it viII e

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED			
		345101	B. WING			C	
NAME OF D	POVIDED OD SLIDDI IED	345101	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	03/22/2018	
NAME OF PROVIDER OR SUPPLIER				208 CARY STREET	_		
ENFIELD OAKS NURSING AND REHABILITATION CENTER				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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 758	Continued From page	e 16	F 7	Consultant Audit on Antipsyche Medications to determine trend issues that may need further in put into place and to determine for further and/or frequency of The Administrator and Director will be responsible for the impl of corrective actions to include audits, in-services, and monitor to the plan of correction.	ds and/or nterventions e the need monitoring. r of Nursing lementation e all 100%		