APR 2 5 2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2013
FORM APPROVED
OMB NO. 0938-0391

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 _____	03/28/2013

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

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to notify the physician of an	F 157	**Response Preface** Enfield Oaks Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality care of our residents. The plan of correction is submitted as written allegation of compliance. Enfield Oaks Nursing and Rehabilitation Center's response to this statement of deficiencies and plan of correction 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 submit documentation to statement of deficiencies through informal dispute resolution, formal appeal procedures and/or any other legal proceedings.	4/25/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/20/13

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.

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F 157	Continued From page 1 ultrasound test that was rescheduled to rule out a deep vein thrombosis (blood clot) for 1 (Resident #61) of 1 sampled resident with orders for an ultrasound for a specific date . Findings included: Resident #61 was admitted to the facility on 1/30/13 and readmitted on 3/7/13. Diagnoses on hospital return of 3/7/13 included a venous thromboembolism with deep vein thrombosis (blood clot) on the right subclavian vein. Review of a physician ' s verbal order, dated 2/21/13, revealed an order written as " Send resident to have ultrasound to right arm in the morning (2/22/13) to (rule out) blood clot. RE: edema to right arm and hand. Continue (antibiotic) therapy as long as PICC (percutaneously inserted central catheter) is patent." Review of a nurse note of 2/22/13 at 4:25 PM revealed in part: (Name of radiology group) rescheduled ultrasound to right arm. Resident made aware of rescheduling of ultrasound to Monday 2/25/13. A telephone interview was conducted with the Nurse # 1 on 3/28/13 at 2:46 PM. The nurse stated she received the rescheduled appointment and remembered she told the resident about the missed appointment and also told a family member when she came in later that evening, but didn't remember if she called the resident ' s physician. An interview was conducted with the resident ' s physician on 3/28/13 at 4:05 PM. The physician	F 157	The Physician was notified of Resident #61 ultrasound results on 2/25/13 by the charge nurse. A 100% audit of all resident's to include resident #61 ordered labs, x-rays, ultrasounds and appointments for the last 30 days were reviewed by the DON, treatment nurse, and MDS nurse initiated on 4/4/13 to ensure labs, x-rays, ultrasound, and appointments have been scheduled per physician's order and the MD has been notified of any labs, x-rays, ultrasound, and appointments that needed rescheduling. All identified areas of concern were immediately corrected by the DON. An inservice of all licensed nurses was initiated on 4/3/13 by the DON regarding notification to the physician of all rescheduled labs, x-rays, ultrasounds, and appointments with documentation in the medical records. All newly hired licensed nurses will be inserviced by the DON regarding notification to the physician of all rescheduled labs, x-rays, ultrasounds, and appointments with documentation in the medical records during orientation.	4/25/13

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F 157	Continued From page 2 stated he didn't remember receiving any call that the ultrasound couldn't be done on the day it was scheduled. The physician stated that if he were notified, he would have sent the resident to the hospital for the test and not have waited until 2/25/13. An interview was conducted with the Director of Nursing (DON) on 3/28/13 at 4:25 PM. The DON reported she expected the nurses would have called the physician when the ultrasound wasn't able to be done as scheduled.	F 157	Continued From page 2 The DON, MDS nurse, and treatment nurse will review all resident's to include resident # 61 physician orders 5x per week x4 weeks then 3 x per week x 4 weeks, then weekly x 4 weeks to ensure that all ordered labs, x-rays, ultrasounds, and appointments are scheduled per physician's order and the physician has been notified with documentation in the medical records of any labs, x-rays, ultrasounds, and appointments that have been rescheduled utilizing a MD Notification QI Tool. The Director of Nursing will compile audit results of the MD Notification QI Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance. A meal tray was retrieved by NA #1 and delivered to resident # 26 on 3/26/13.	4/25/13 4/25/13
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews the facility failed to provide a meal tray at the same time as the roommate for 1 of 2 residents (Resident#26) reviewed for a dignified, in-room dining experience. Findings included: Resident #26 was admitted on 09/20/12 with diagnoses that included Dementia. Review of the most recent Minimum Data Set (MDS) quarterly assessment dated 02/21/13, revealed the resident was moderately impaired for daily decision making. On 3/26/13 at 8:10 AM, NA#2 delivered and set	F 241		

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F 241	Continued From page 3 up a tray for the roommate of Resident #26. NA #2 then went out to the cart and looked for a tray for Resident #26. NA#2 informed NA#1 that there was not a tray on the cart for Resident #26. NA#2 left the hallway and did not return. On 3/26/13 at 8:44 AM NA#1 began to pick up the trays off the hallway. NA#1 went into the room of Resident #26 and discovered that Resident #26 had not received a tray for breakfast. NA#1 revealed that she had looked at B bed and saw a tray, and had assumed that A bed (Resident #26) has received a tray also. NA #1 then went to the kitchen to retrieve a tray for Resident #26. On 3/26/13 at 8:56 AM Resident #26 received a breakfast tray. NA #1 asked the resident if she was going to eat a little bit. Resident #26 then replied " Got to, I ' m hungry. " On 3/26/13 at 10:25 AM an interview was conducted with Nurse #1 who revealed that the person assigned to the hall was responsible for making sure that all residents on their hallway get their trays. Nurse #1 expected that the person helping pass the trays would make sure all trays were there, and if a tray was missing then the assigned person should be informed so the resident would get a tray. On 3/26/13 at 10:39 AM an interview was conducted with the Dietary Manager. The Dietary Manager revealed that for reasons unknown the computer did not print a ticket for Resident #26, therefore the line did not prepare a tray for the resident. The Dietary Manager revealed that she expected the NA that set up the trays for the	F 241	Continued From page 3 A 100% audit of meal tray delivery was conducted on 3/27/13 by the Facility Consultant, DON, Administrator, Accounts Payable Bookkeeper, Accounts Receivable Bookkeeper, Transportation coordinator, MDS Nurse, Social Worker, and Admissions Coordinator to ensure meal trays were provided at the same time for residents at the same table in the dining room and for residents in-room to include resident #26. There were no identified areas of concern. An inservice was initiated on 3/26/13 by the Director of Nursing with CNAs and license nurses regarding delivering meal trays at the same time for residents at the same table in the dining room and for residents in-room and obtaining a tray from dietary immediately if a meal tray is noticed missing. All newly hired CNAs and License Nurses will be inserviced regarding delivering meal trays at the same time for residents at the same table in the dining room and for resident's in-room and obtaining a tray from dietary immediately if a meal tray is noticed missing by the DON during orientation.	4/25/13

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F 241	Continued From page 4 residents to inform the kitchen if a tray was missing. On 3/26/13 during an interview at 11:16 AM, the Director of Nursing (DON) reported that she expected roommates to receive their trays at the same time. When the NA assisting reported to the assigned NA that the tray was not there, the situation should have been handled at that time by the assigned NA. She also expected that the NA would report the missing tray to the nurse, so they would be aware and help out with the situation.	F 241	Continued From page 4 A resident care audit of meal tray delivery will be conducted by the Staff Facilitator, Transport Coordinator and Dietary Manager 2x per week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months during breakfast, lunch, or dinner to ensure residents are delivered meal trays at the same time at the same table in the dining room and for in-room residents to include resident #26 utilizing a Resident Care Audit Meal Tray QI Tool. Any identified areas of concern will be corrected immediately by the Staff Facilitator, Transport Coordinator, Dietary Manager. The DON will review the resident care audit meal tray QI tools weekly for compliance. The Director of Nursing will compile audit results of the Resident Care Audit Meal Tray QI Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance.	4/25/13
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to provide a home-like environment by storing mechanical lifts and lift belts in the main dining room, using plastic-top folding tables with no covers for meals, using the manufactured packaging for juices and thickened liquids for residents to drink from, and the use of disposable clothing protectors during 3 of 3 meal observations. Findings included: A dining room observation on 3/26/13 at 12:10 PM revealed a mechanical lift was stored in the			

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F 252	Continued From page 5 dining room 4 feet from the table used by a resident. An additional mechanical lift was stored in front of a window in the dining room. Individual milk servings were provided in the small manufactured cartons as well as juice and thickened liquids. Some of the containers had straws and some did not. Lift belts were stored on top of the mechanical lifts and on the back of the dining room door exposed to the dining room. The residents' meals were served from the trays directly onto a white-colored plastic folding tables with no covers. The residents were provided disposable clothing protectors to be worn during their meal. Bingo equipment was stored on top of a piano. A breakfast meal observation was made of the main dining room on 3/26/13 at 7:52 AM. The mechanical lift remained in front of the window and had 2 green lift pads on top of the lift. There were 2 lift pads hanging off a rack on the dining room door. The additional mechanical lift was in the dining room stored by the piano. The bingo equipment remained on top of the piano. The residents were served the meal from the trays directly onto the white-colored plastic folding tables with no covers. The resident were provided disposable clothing protectors. Milk, juices, and thickened liquids were served to the residents from their containers. An additional meal observation was made of the main dining room on 3/27/13 at 12:30 PM. The observation revealed no changes to the room's environment. During an interview with the Minimum Data Set Coordinator on 3/27/13 at 12:42 PM, the nurse stated the dining room was not a homelike environment with the plastic tables	F 252	On 3/27/13 mechanical lifts in the dining room were removed by the MDS nurse. Lift belts were removed from the dining area by the MDS nurse on 3/27/13. Bingo equipment stored on top of piano was removed by the dietary manager on 3/27/13. Cloth table covers and center pieces were purchased and placed over the plastic-top folding tables in the dining room on 3/27/13 by the facility administrator. Additional cloth table covers were ordered by facility on 4/4/13. Additional drink ware was ordered by facility on 3/28/13. Cloth clothing protectors were purchased on 3/27/13 by payroll bookkeeper and provided for residents by CNA staff on 3/28/13. All disposable clothing protectors were no longer in use as of 3/29/13. A facility tour was completed by the administrator on 4/8/13 to ensure a homelike environment is provided for residents. Any items identified by the administrator as hindrance to homelike environment were directed to facility maintenance manager or home office support services for correction by 4/25/13.	4/25/13

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F 252	Continued From page 6 with no covers, and the mechanical lifts and lift pads in the dining room. The nurse stated the disposable clothing protectors were not homelike. During an interview and observation with the Administrator on 3/27/13 at 12:55 PM, the Administrator stated the dining area did not provide a homelike environment and expected changes needed to be made for the tables, equipment storage, clothing protectors, and drinkware.	F 252	Continued From page 6 100% In-servicing with CNAs, Nurses, Dietary department, Accounts Payable Bookkeeper, Accounts Receivable Bookkeeper, Transport Coordinator, Activities Director, Staff Coordinator, Admissions Coordinator, Social Worker, Maintenance Director and Administrator was initiated on 3/26/13 by the DON, MDS nurse and administrator regarding home-like environment of facility to include not storing mechanical lifts and lift belts in the main dining room, ensuring plastic-top folding tables have covers, not using manufactured packaging for juices and thickened liquids, and using cloth clothing protectors. All newly hired license nurses, CNAs, and Dietary Staff will be inserviced regarding home-like environment of facility to include not storing mechanical lifts and lift belts in the main dining room, ensuring plastic-top folding tables have covers, not using manufactured packaging for juices and thickened liquids, and using cloth clothing protectors by the DON during orientation.	4/25/13
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain 2 of 2 gas powered clothes dryers in clean condition; and the facility failed to properly seal 1 of 1 exit door in the main dining room and 1 of 1 exit door in a hall adjoining the main dining room that allowed light to show through. Findings included: 1) An observation was made of the laundry room on 3/27/13 at 9:40 AM. Observation of the drum of the left dryer revealed areas of baked on brown and tan matter throughout the drum. The dryer on the right revealed areas of baked on gray/tan matter and areas of brown matter baked onto the drum. The laundry aide reported she did not clean out the inside of the dryers drums, that			

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F 253	Continued From page 7 maintenance cleaned them. There were not records of a cleaning schedule of the drums available during the survey. During an observation of the dryers with the Maintenance Director on 3/27/13 at 10 AM, the Director reported he didn't clean the dryer drums, that laundry staff cleaned them. He stated the drums needed cleaned. At 3 PM on 3/27/13, an observation of the laundry room dryers was made with the Administrator. The Administrator reported she expected the dryer drums to have been clean. 2) Review of a pest visit report of 2/14/13 revealed a dining room exit door and a second hallway exit door were improperly sealed, both in need of door sweeps to prevent pest issues. Recommendation were made to seal all entry points (near the dining room). During an interview with the Maintenance Director 3/27/13 at 10:14 AM, the Director stated he had not completed the work on the recommendation, but should have done the repairs. An observation of the exit door from the dining room on 3/27/13 at 10:30 AM revealed a 1/2 inch gap between the floor and the bottom of the door. An observation of an exit door in the hall outside the dining room on 3/27/13 at 10:32 AM revealed a 1/4 inch gap between the floor and the bottom of the door which allowed daylight to show through. 3/27/13 at 1:10 PM. The Administrator stated she expected the Maintenance Director to have made the repairs at the time of the recommendations from the pest control vendor.	F252	Continued From page 7 The facility administrator and DON will review facility environment 3x per week x4 weeks, 2x per week x 4 weeks, then weekly x4 weeks to ensure tables with table cloths, no lifts or lift belts stored in dining room, drinks not in cartons, and cloth clothing protectors in use utilizing the Environmental QI tool. The facility administrator will compile audit results of the Environmental QI Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The administrator is responsible for overall compliance.	4/25/13
		F253	Dryer drums were cleaned by health care services facility manager on 3/27/13 to remove brown and tan matter. Exit door to dining room and exit door to hall outside dining room were properly sealed to prevent gaps by facility maintenance director on 3/28/13.	4/25/13

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record reviews, the facility failed to develop a plan of care for community discharge and had no discharge plan in place for 2 (Resident #19 and Resident #61) of 2 sampled residents who desired to return to the community. Findings included: 1) Resident #19 was admitted to the facility on 10/22/12 with diagnoses to include Depressive disorder, expressive language disorder, hypertension, Cerebrovascular Accident (stroke),	F253	Continued from page 8 100% audit of exit doors was completed on 4/12/13 by facility administrator to ensure exit doors were properly sealed and without gaps. All identified areas of concern were corrected by the Maintenance Director or home office support services by 4/25/13. 100% In-service of laundry staff was initiated on 4/08/13 by housekeeping and laundry district manager regarding dryer drum cleaning. All newly hired laundry staff will be inserviced regarding dryer drum cleaning by health care services district manager during orientation. The Maintenance Director was inserviced by the Administrator on 4/18/13 regarding ensuring exit doors are sealed properly. The facility administrator and DON will review facility 3x per week x4 weeks, 2x per week x4 weeks, then weekly x4 weeks to ensure exit doors without gaps, dryer drums clean, and work orders completed for equipment needing repair utilizing the Environmental QI tool.	4/25/13

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F 279	Continued From page 9 and hemiplegia. Review of the resident ' s Minimum Data Set (MDS) Admission assessment of 10/29/12, Section Q was documented as the resident participated in the assessment and the family or significant other. The resident's overall expectation was documented as "Expects to be discharged to the community ". The MDS documented a discharge plan was not put into place. Review of the resident ' s most recent Care plan of 1/28/13 revealed no problem was identified for the resident ' s discharge to the community. A Social Worker (SW) progress note of 10/29/12 revealed in part: completed 5-day admission assessment with the resident. Stated he felt depressed nearly everyday to wanting to return hope, was encouraged to accept care that's provided and participate in therapy. Offered for resident to see psychiatrists, resident has accepted. Referral will be made. Although resident would like to go home one day soon, he has adjusted to facility very well. Resident loves to social with other residents. There is no discharge plan in place at this time. During an interview with Resident #19 on 3/28/13 at 3:15 PM, the resident stated he needed to leave the facility because it was so depressing to him. He stated he lost a lot of function from the strokes when he was admitted to the facility, but has regained a lot of mental functioning and physical functioning since. The resident stated he wanted to go home or somewhere of lesser care that he could be stimulated to help improve	F253	Continued From page 9 All identified areas of concern will be corrected by housekeeping and the Maintenance Director. The facility administrator will compile audit results of the Environmental QI Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Administrator is responsible for overall compliance. Discharge planning was initiated and documented in the Social Progress notes for resident #19 on 3/26/13 by the Social Worker. Resident #19's care plan was updated by the Social Worker to reflect community discharge on 3/26/13. On 3/28/13 and 4/15/13 resident #61 was interviewed by the Social Worker regarding discharge planning and resident #61 does not have a desire to be discharged to the community at this time.	4/25/13
		F279		

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ENFIELD OAKS NURSING AND REHABILITATION CENTER	208 CARY ST ENFIELD, NC 27823

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F 279	Continued From page 10 his mind and have options of doing things. He stated he couldn't stand to be out in the nursing home crowd with the resident's yelling and throwing things. It made him more depressed and sometimes he felt like he wanted to cry. He stated no one was helping him here to find a lesser care environment. An interview was conducted with the SW on 3/26/13 at 3:28 PM. The SW reported the resident's mental status has improved since he came to the facility, but still had some short term memory loss. He was his own Responsible Party for decisions about his care since February 1, 2013. The last time the SW talked with the resident about his plans was in January 2013 for a quarterly assessment. The SW stated she hasn't spoken to him recently about going home. The SW stated she didn't care plan a discharge yet because there was not a discharge plan in place, but should have written one. The SW stated she felt the resident could go to an assisted living facility and should have looked for a lesser care facility for the resident for when he was ready. Record review revealed a physician's order of 11/16/12 for psychiatry evaluation for adjustment to placement in facility and stabilization of depressed mood. Resident #61 was admitted on 1/22/12 with orders for Celexa (an antidepressant medication) 20 mg. Review of a physician's order of 2/25/13, orders were given to discontinue Celexa and start Lexapro (an antidepressant medication) for depression . During an interview with Physical Therapy Assistant (PTA) #1 on 3/26/13 at 4:06 PM, the	F 279	Continued From page 10 100% interview with all current alert and oriented residents to include resident # 19 and resident #61 and with the resident representative for all non-alert and oriented residents regarding request for discharge to the community was initiated on 4/3/13 by the Social Worker. Care plans were updated and discharge planning was initiated for all residents that request to return to the community and documented in the social progress notes by the Social Worker by 4/25/13. An inservice was initiated with the MDS nurse, Administrator, Social Worker, and Admission Coordinator regarding the process for discharge planning on 4/8/13 by the Facility Consultant. Upon admission to the facility each resident or resident representative will be interviewed regarding discharge to the community by the Social Worker or Admission Coordinator with documentation in the social progress notes. The care plan will be updated immediately for	4/25/13

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F 279	Continued From page 11 PTA stated the resident would probably be able to dress and wash his upper body and do more for himself if he were motivated. An interview was conducted with the Administrator on 3/28/13 at 3:40 PM. The Administrator stated she expected the Social Worker would ,have developed a discharge plan for the resident. 2) Resident #61 was admitted to the facility on 1/30/13 and readmitted 3/7/13. Diagnoses for the resident included anxiety state, depressive disorder, Stage IV pressure ulcer, and paraplegia. A MDS admission assessment of 2/12/13 Section Q revealed the resident participated in the assessment and expected to discharge to the community. The assessment documented there was no active discharge planning in place. Review of a SW note of 2/1/13 revealed documentation that the resident was admitted from home with pressure ulcer stage IV, and paraplegia. Will monitor for adjustment to the facility and make plans with community resources as necessary. A SW note of 2/12/13 revealed documentation as: Discharge plan not in place at this time, as resident's wound heals, a discharge plan will be put in place at that time. Review of the resident ' s medical record revealed a Social History of 2/1/13 that documented "Discharge Plans" as "Stay is projected to be short-term.	F 279	Continued From page 11 all residents or resident representative request to return to the community. All residents to include resident #19 and resident #61 or all resident representatives will be re-interviewed regarding preferences to be discharged to the community by the Social Worker or MDS Nurse through the RAI process quarterly and annually unless requested not to be interviewed. The Administrator will review the social progress notes 2x per week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure residents have been interviewed and care plans have been updated utilizing a Discharge Planning QI Tool. The Administrator will follow up immediately for identified areas of concern. The Administrator will compile audit results of the Discharge Planning QI Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring.	4/25/13

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F 279	Continued From page 12 During an interview with the SW on 3/28/13 at 2:10 PM, the SW reported she didn't care plan a discharge because there was not a discharge plan in place, but should have written one. An interview was conducted with the Administrator on 3/28/13 at 3:40 PM. The Administrator stated she expected the Social Worker would .have developed a discharge plan for the resident.	F279	Continued From page 12 The Administrator is responsible for overall compliance.	4/25/13
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to obtain an ultrasound test to rule out a deep vein thrombosis (blood clot) as ordered causing a delay in notification of results of a blood clot for 1 (Resident #61) of one sampled resident with a deep vein thrombosis; and the facility failed to monitor for signs and symptoms of a deep vein thrombosis (blood clot) for 1 (Resident #61) of one sampled resident with swelling and warmth of the right arm Findings included: 1) Resident #61 was admitted to the facility on	F309	Resident #61 was assessed for signs and symptoms of DVT by hall nurse on 2/21/2013. Resident # 61 had an Ultrasound completed in-house by radiology group on 2/25/2013. The Physician was made aware of the findings of the ultrasound by the hall nurse on 2/25/2013. Order to send resident to ER for DVT was received by hall nurse on 2/25/2013 and resident # 61 was sent to hospital on 2/25/2013. A 100% audit of all residents to include resident #61 was completed to assess for acute changes to include signs and symptoms of DVT to include edema, warmth and pain by Facility Wound Care Consultant and the treatment nurse initiated on 4/1/2013. The MD was notified for all identified areas of concerns immediately by the treatment nurse.	4/25/13

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F 309	Continued From page 13 1/30/13 and readmitted 3/7/13. Diagnoses on hospital return of 3/7/13 included a venous thromboembolism with deep vein thrombosis (blood clot) on the right subclavian vein. Review of a physician ' s verbal order, dated 2/21/13, revealed an order written as " Send resident to have ultrasound to right arm in the morning (2/22/13) to (rule out) blood clot. RE: edema to right arm and hand. Continue (antibiotic) therapy as long as PICC (percutaneously inserted central catheter) is patent." Review of a nurse note of 2/21/13 at 9:42 PM revealed the resident's right arm was edematous (swollen) and slightly warm to touch. The nurse assessed the resident ' s PICC and it was intact and patent, the resident reported a slight burning sensation when the PICC line was flushed. The resident's arm was elevated on a pillow. The on-call physician was notified of the situation, and new orders were received to continue IV (intravenous) antibiotic while the PICC line was patent and send resident out for an ultrasound in the morning to rule out a blood clot. At 10 PM, resident tolerated the IV antibiotic without difficulty. PICC patent and flushing well. Resident stated she's experiencing less discomfort to her right arm than earlier. No signs or symptoms of respiratory distress noted. Resident continues to keep right arm elevated on a pillow. Will continue to monitor. Review of a nurse note of 2/22/13 at 4:25 PM revealed: (Name of radiology group) rescheduled ultrasound to right arm, (PICC line) patent and intact, no signs or symptoms of infection to	F309	Continued From page 13 An inservice was initiated on 04/03/2013 for all licensed nurses to include nurse #1 by the DON regarding monitoring acute changes to include signs and symptoms of DVT and notification to the physician and responsible party with documentation in the medical records. All newly hired licensed nurses will be inserviced by the DON regarding acute changes to include signs and symptoms of DVT and notification of the physician with documentation in the medical records during orientation. The DON, MDS nurse, and treatment nurse will review all nurses' progress notes weekly X 4, then biweekly X 4, and then monthly X 2 months for all identified acute changes in condition to include signs and symptoms of DVT to ensure that the resident s have been assessed, MD notified, and that acute changes in condition are documented in the progress notes	4/25/13

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F 309	Continued From page 14 insertion site, cleansed with aseptic (sterile) technique. Denies any pain or discomfort to right upper extremity this shift. Resident made aware of rescheduling of ultrasound to Monday 2/25/13. . A telephone interview was conducted with the Nurse # 1 on 3/28/13 at 2:46 PM. The nurse stated she received the rescheduled appointment and remembered she told the resident about the missed appointment and also told a family member when she came in later that evening, but didn't remember if she called the resident ' s physician. A nurse note written on 2/23/13 at 12:32 PM documented: resident remains on antibiotic therapy. PICC line to right arm remains intact, flushes well. No irritation or redness at site. Patient continues to have swelling in right arm, right arm is elevated, propped on pillow at this time. Right arm ultrasound has been scheduled as previously documented. No acute distress noted. Patient remained afebrile (no elevated temperature) during shift. A nurse note of 2/25/13 at 10:04 PM revealed: Resident was sent out to (name of hospital emergency room) at 6 PM per MD orders for positive reading of DVT (deep vein thrombosis, blood clot) to right arm. Nurse received call from (name of radiologist), that resident have DVT to right arm at 5 PM. Nurse also received call from (name of nurse from resident ' s physician ' s office). Nurse also informed (Physician ' s office nurse) that resident had a DVT to right arm. (Name of resident ' s physician) gave new orders to send resident out to ER. Resident was transported to (name of hospital ' s emergency	F309	Continued From page 14 each shift until resolved utilizing an Acute Change Assessment Monitoring QI Tool. All identified areas of concern will be corrected by the DON, MDS nurse and treatment nurse. The Director of Nursing will compile audit results of the Acute Change/Assessment Monitoring QI Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance.	4/25/13

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F 309	Continued From page 15 room) by EMS via stretcher. Resident was out of the facility for an appointment and returned back to facility at about 1 PM. (Name of radiology service) came to the facility about 1:30 PM and the ultrasound was done on the resident ' s right arm. About 2 PM, the X-ray technician came to the nurse with a preliminery report and stated to the nurse that the right arm axilla (arm pit) area was clotted. An interview was conducted with the resident ' s physician on 3/28/13 at 4:05 PM. The physician stated he didn't remember receiving any call that the ultrasound couldn't be done on the day it was scheduled. The physician stated that if he was notified, he would have sent the resident to the hospital for the test and not have waited until Monday. An interview was conducted with the Director of Nursing (DON) on 3/28/13 at 4:25 PM. The DON reported she expected the nurses would have called the physician when the ultrasound wasn't able to be done as scheduled. 2) Resident #61 was admitted to the facility on 1/30/13 and readmitted 3/7/13. Diagnoses on hospital return of 3/7/13 included a venous thromboembolism with deep vein thrombosis (blood clot) on the right subclavian vein. Review of a physician ' s verbal order, dated 2/21/13, revealed an order written as " Send resident to have ultrasound to right arm in the morning (2/22/13) to (rule out) blood clot. RE: edema to right arm and hand. Continue (antibiotic) therapy as long as PICC (percutaneously inserted central catheter) is			

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F 309	Continued From page 16 patent." Review of a nurse note of 2/21/13 at 9:42 PM revealed the resident's right arm was edematous (swollen) and slightly warm to touch. The nurse assessed the resident ' s PICC and it was intact and patent, the resident reported a slight burning sensation when the PICC line was flushed. The resident's arm was elevated on a pillow. The on-call physician was notified of the situation, and new orders were received to continue IV (intravenous) antibiotic while the PICC line was patent and send resident out for an ultrasound in the morning to rule out a blood clot. At 10 PM, resident tolerated the IV antibiotic without difficulty. PICC patent and flushing well. Resident stated she's experiencing less discomfort to her right arm than earlier. No signs or symptoms of respiratory distress noted. Resident continues to keep right arm elevated on a pillow. Will continue to monitor. Review of a nurse note of 2/22/13 at 4:25 PM revealed in part: (Name of radiology group) rescheduled ultrasound to right arm, (PICC line) patent and intact, no signs or symptoms of infection to insertion site, cleansed with aseptic (sterile) technique. Denies any pain or discomfort to right upper extremity this shift. A nurse note written on 2/23/13 at 12:32 PM documented: resident remains on antibiotic therapy. PICC line to right arm remains intact, flushes well. No irritation or redness at site. Patient continues to have swelling in right arm, right arm is elevated, propped on pillow at this time. Right arm ultrasound has been scheduled as previously documented. No acute distress			

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F 309	Continued From page 17 noted. Patient remained afebrile (no elevated temperature) during shift. A nurse note of 2/25/13 at 10:04 PM revealed in part: About 2 PM, the X-ray technician came to the nurse with a preliminary report (from an ultrasound) and stated to the nurse that the right arm.axilla (arm pit) area was clotted. Resident was sent out to (name of hospital emergency room) at 6 PM per MD orders for positive reading of DVT (deep vein thrombosis, blood clot) to right arm. Review of the resident ' s medical record revealed no documentation was completed regarding the conditions of the resident ' s right for 2/22/13 for the 11 PM to 7 AM shift and the 7 AM to 3 PM shift; on 2/23/13 for the 7 AM to 3 PM shift; no documentation for any shift on 2/24/13; and no documentation for the 7 AM to 3 PM shift on 2/26/13. An interview was conducted with the Director of Nursing (DON) on 3/28/13 at 4:25 PM. The DON reported she expected nurses to document on the condition of the resident ' s right arm every shift.			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F312	Resident #2 continues to be followed by dentist. Resident #2 was seen by dentist on 3/6/2013. Resident #2 was assessed by the DON and the MDS nurse on 4/3/2013 for oral care. No areas of concern with mouth care were noted.	4/25/13

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F 312	Continued From page 18 by: Based on observation, record review and staff interviews, the facility failed to provide complete oral care for 1 (Resident #2) of 1 sampled residents requiring extensive assistance for Activities of Daily Living (ADL's). Findings include: Resident #2 was admitted to the facility on 12/05/12. Cumulative diagnoses included cerebral vascular accident (CVA/stroke), dementia, and depression. Review of Resident #2 ' s annual Minimum Data Set (MDS) assessment, dated 01/07/13, indicated the resident was cognitively impaired, unable to make daily decisions, required extensive assistance with bathing and personal hygiene, and was impaired on both the right and left upper and lower extremities. Review of the Resident #2 ' s care plan, updated 01/07/13, revealed an area of need as a care deficit for teeth or oral cavity that could be seen by potential problems with the teeth and gums due to the resident ' s health condition. One of the interventions listed was to provide oral hygiene. An observation, on 03/27/13 at 8:00 AM, was made of the Resident #2 dressed and up in his wheelchair. When the resident spoke he was noted to have white paste like substance approximately the size of a quarter noted on the lower right teeth and gum area. An observation, on 03/27/13 at 9:55 AM, revealed Resident #2 to have a white paste like substance	F312	Continued From page 18 Resident #2 was referred for a dental consultation by the DON on 4/3/2013. 100% audit of all residents to include resident #2 was completed to assess for oral care to include need of dental consultation on 4/3/2013 by the DON and MDS nurse to ensure oral care was provided. All identified areas of concern were immediately addressed and corrected by the DON. An inservice was initiated on 3/28/2013 for all CNAs and licensed nurses to include NA #3 by the DON regarding providing oral care and notification to the nurse if there are areas of concern. All newly hired CNAs and licensed nurses will be inserviced by the DON regarding oral care during orientation. The staff facilitator, MDS nurse, and DON will review resident's oral care to include resident #2, 5 times a week x 4 weeks, and then weekly x 4 and then monthly x 2 to ensure all residents receive oral care utilizing an Oral Care Resident Care Audit QI Tool. All identified areas of concern will be correct by the Director of Nursing.	4/25/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	Continued From page 19 approximately the size of a quarter noted on the lower right teeth and gum area. The resident had stated he had had breakfast a little earlier. An observation, on 03/27/13 at 4:00 PM, revealed the Resident #2 to have a white paste like substance approximately the size of a quarter noted on the lower right teeth and gum area. An observation, on 03/28/13 at 7:55 AM, revealed the Resident #2 to have a white paste like substance approximately the size of a quarter noted on the lower right teeth and gum area. The resident stated he was waiting for breakfast. An observation, on 03/28/13 at 11:40 AM, was made of Resident #2 dressed and up in his wheelchair. The resident was noted to have a white paste like substance approximately the size of a quarter noted on the lower right teeth and gum area. An observation, on 03/28/13 at 11:45 AM, was made of Resident #2 with Nurse Aide (NA) #3. NA #3 confirmed the resident needed mouth care and indicated it should have been done this morning. NA #3 stated that she had assisted Resident #2 to brush his teeth last evening and reported during the brushing Resident #2 's gums had bleed a little. An observation, on 03/28/13 at 11:50 AM, was made of Resident #2 with Nurse #2. Nurse #2 confirmed the resident needed to have mouth care given. An interview, on 03/28/13 at 3:30 PM, was conducted with the Director of Nursing Services	F 312	The Director of Nursing will compile audit results of the Oral Care Resident Care Audit QI Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance.	

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F 312	Continued From page 20 (DNS). The DNS indicated she would have expected the staff to assist a resident who is unable to do oral care or to complete the care by his self. She continued she would have expected staff to notice a visual build up in the resident ' s mouth and provided care.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to identify, assess, and treat 3 unstageable pressure ulcers on 1 (Resident #61) of 2 sampled residents with pressure ulcers;. Findings included: Resident # 61 was admitted to the facility on 1/30/13 and readmitted to the facility on 3/7/13. Review of the hospital History and Physical of 2/26/13 revealed the resident the resident was being followed by the wound care center at the hospital for a stage IV sacral pressure ulcer and right ischial pressure ulcer. Additional diagnoses included paraplegia from the waist down to the	F 314	Resident #61 was provided foot care by the assigned CNA on 3/28/13 and will continue to receive foot care per facility policy. Resident #61 bilateral feet were assessed by the DON and Facility Consultant on 3/28/13 and by the Wound Care Consultants on 4/1/13, 4/2/13, and 4/3/13. The MD was notified of resident #61 bilateral feet unstageable pressure ulcers by the treatment nurse on 3/28/13. Resident # 61 was sent to the wound clinic on 4/5/13 related to unstageable feet pressure ulcers. Resident #61 unstageable feet pressure ulcers will continue to be treated per physician's orders. A 100% body assessment of all residents to include resident # 61 was completed by the treatment nurse, Wound Care Consultant, and RN Charge Nurse on 4/2/13. The MD was immediately notified of all identified areas of concern by the treatment nurse.	4/25/13

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F 314	Continued From page 21 lower extremities. Review of a Nurse Admission Assessment of 1/30/13 revealed a stage IV pressure ulcer of the right rear thigh that measured 2.7 cm (cubic centimeters) by 2.0 cm x 3.0 cm deep. The resident was also assessed as having had a stage IV pressure ulcer of the sacrum that measured 11.5 cm x 12.6 cm x 3.0 cm deep. An observation was made of the wound treatment for the resident ' s sacrum on 3/28/13 at 11:30 AM with the treatment nurse. When the resident was turned to her left side, her left outer ankle was exposed and a blackened area of 2.5 inches was noted over the bone. The treatment nurse stated she was unaware of the area. During additional observation of the resident ' s feet revealed the resident ' s left inner heel had a darkened, purple colored circular area. The treatment nurse reported the skin under the area was soft. Observation of the resident ' s right heel revealed a darkened, purple colored circular area. On the center to outer right heel was a dark purple colored area covered by dry peeling skin and also surrounded the area. The resident ' s feet were covered by multiple dry hardened peeling skin on her toes, tops of her feet, and bottoms of each foot. The treatment nurse reported she was unaware of the areas of the resident ' s heels. During an observation of the resident ' s right ankle and heels with the Director of Nursing (DON) on 3/28/13 at 11:45 AM, the DON reported the areas on the resident ' s heels were unstageable pressure ulcers and requested the resident ' s feet were thoroughly washed and	F 314	Continued From page 21 On 3/28/13 an inservice was initiated by the Director of Nursing with all CNAs and License Nurses regarding prevention intervention, routine skin check observation, reporting changes and abnormalities in residents to include skin abnormalities, foot care, notification of acute changes in condition to include skin condition, and skin alerts. An inservice with all licensed nurses was initiated on 4/18/13 by the DON regarding completing skin referral forms. All newly hired CNAs and License Nurses will be inserviced regarding prevention intervention, routine skin checks, observation and reporting changes and abnormalities in residents to include skin abnormalities, foot care, notification of acute changes in condition to include skin condition, skin alters, and skin referral forms by the DON during orientation. Skin checks on all residents to include resident # 61 will be completed by the CNAs daily during routine care. If any abnormalities are noted the CNA will complete a skin alert. Licensed nurses	4/25/13

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F 314	Continued From page 22 lotion applied.. During an observation of the resident ' s right ankle and heels with the DON and Nurse Consultant at 2:30 PM on 3/28/13, the blackened area of the right ankle was opened in a circular area with the top layer of skin removed. The discoloration of the heels remained. The DON and Nurse Consultant stated the heels were probably Stage IV pressure ulcers and the right ankle was a Stage II pressure ulcer. Review of the resident ' s medical record revealed no documentation was recorded for the areas on the resident ' s heels and ankle prior to the observation on 3/28/13. During an interview with NA #1 on 3/28/13 at 12:26 pm, the NA reported NAs were expected to wash resident's feet every day with their bath and the resident's feet did not look like they have been cared for in a long time. The NA stated NAs reported changes in residents ' skin to their nurse when discovered during a bath. An interview was conducted with the DON on 3/28/13 at 10:37 AM. The DON stated she expected NAs did skin checks to monitor for any red or opened areas or changes in residents ' skin. When they found any concerns, they were expected to notify the nurse and enter it into the point click care system. The DON reported there were no skin concerns documented in the point click care system and she was unaware of the condition of Resident #61 ' s feet.	F 314	Continued From page 22 will assess all residents with skin alerts, complete a skin referral form, and treat according to the MD order or facility protocol for all skin abnormalities noted. The treatment nurse will review the skin referral form and ensure the skin abnormality has been assessed and treated according to the MD order or facility protocol. The Treatment Nurse and RN Charge nurse will assess all residents to include resident #61 weekly x 4 weeks, Bi weekly x 4 weeks, and then Monthly x 2 months to ensure all skin abnormalities have been assessed and treated per physician's order or facility protocol utilizing a Skin Check QI Tool. Any identified areas of concern will be addressed immediately by the Treatment Nurse or RN Charge nurse. The DON will review the Skin Check QI Tools weekly x 4 weeks, Bi weekly x 4 weeks, and Monthly x 4 for completion. The Director of Nursing will compile audit results of the Skin Check Monitoring QI Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required.	4/25/13
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS			

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F 329	Continued From page 23 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to monitor and report to the physician the results of a narrow therapeutic margin medication (Coumadin) monitoring on 1 of 2 residents reviewed for Warfarin use, Resident #36 Findings include: Resident # 36 was admitted to the facility on	F319	Continued From page 23 Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance.	4/25/13
		F329	Resident #36 PT/INR was obtained on 4/11/13 and results were reported to the physician upon receipt on 4/12/13 by the Charge Nurse. Resident #36 PT/INR will continue to be monitored related to Coumadin use per physician's order and results will be reported to the physician immediately by the charge nurse. A 100% audit of all resident's to include residents on Coumadin and resident # 36 lab orders for the last 30 days to include PT/INRs was initiated by the Director of Nursing, treatment nurse, and MDS nurse on 4/4/13 to ensure labs have been drawn per physician's order on specific days and physician notified of results. All identified areas of concern were immediately corrected by the Director of Nursing. An inservice was initiated on 4/17/2013 for all licensed nurses by the Director of Nursing regarding notifying the physician timely of lab	4/25/13

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F 329	Continued From page 24 04/30/09 with cumulative diagnoses of hypertension, diabetes mellitus, previous history of cerebral vascular accident and previous bilateral (both lungs) pulmonary embolism [blood clot in the lung]. Record review of the physician ' s orders for March 2013, revealed the resident was on Coumadin. Lexicomp ' s Geriatric Dosage Handbook, 17th edition stated that the pharmacologic category of Warfarin was anticoagulant and a "high alert medication". "The Institute for Safe Medication Practices [ISMP] includes this medication among its list of drugs which have a heightened risk of causing significant patient harm when used in error." The Food and Drug Administration (FDA) had given its strongest warning on this medication known as a "U.S Boxed Warning which stated 'May cause major or fatal bleeding.' " Warfarin use is monitored and dosages adjusted by laboratory assay of PT (prothrobin time) and INR (international normalized ratio). Lexicomps Guide to Clinical Laboratory Medicine 3rd edition stated " Coumadin (Warfarin) therapy is associated with an increased PT. In fact, the PT along with calculation of the international normalized ration (INR) should be followed in every patient receiving Coumadin therapy. Adjustments in the Coumadin dose are based upon whether or not the INR is in the therapeutic range. " The reference range [INR] for patients not on anticoagulation is 0.8-1.2; the reference range for patients on Coumadin is 2.0-3.0 for the diagnosis of pulmonary embolism.	F 329	Continued From page 24 results, obtaining labs to include PT/INRs for Coumadin monitoring per physician order on specific days, and notifying the MD of refusals or any unsuccessful draws. All newly hired licensed nurses will be in serviced regarding notifying the physician timely of lab results, obtaining labs to include PT/INRs for Coumadin monitoring per physician order on specific days, and notifying the MD of refusals or any unsuccessful draws during orientation by the Director of Nursing. All new lab orders for all residents to include resident #36 to include PT/INR for Coumadin monitoring will be reviewed by the lab nurse and documented on the daily lab log daily. The Director of Nursing will review the daily lab log to ensure labs have been drawn timely per physician orders on specific days, physician notified immediately of results and Physician notified of refusals or unsuccessful lab draws utilizing a Laboratory Log Monitoring QI tool weekly x4 weeks then bi-weekly x4 weeks then monthly x 2 months. All identified areas of concern will be correct by the Director of Nursing.	4/25/13

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F 329	Continued From page 25 Record review of the resident's chart revealed that Warfarin 7.5 mg (milligrams) one tablet at bedtime was prescribed on 12/11/12. Laboratory results from 12/30/12 revealed an INR of 1.5 and a new order on 12/27/12 revealed the dose was increased to 8 mg daily; and recheck PT/INR on Monday (12/31/12). The INR drawn on 12/31/12 and reported on 01/01/13 was 4.2 [High]. The physician assistant (PA) on call ordered that the dose of Warfarin be held (not given) for 2 days, and recheck PT/INR the next day, 01/03/12. Record review of the MAR (medication administration record revealed the dose was held on 01/01/13 and 01/02/13,. Another blood draw was done on 01/03/13 with the results of 2.6 [High]. The resident refused the dose on 01/04/13. The physician was contacted and the 8 mg dose was resumed with instructions to recheck the PT/INR on the next lab day [which should have been January 7th 2013]. No results for 01/07/13 could be found. In an interview with evening RN supervisor on 03/26/13 at 3:50 PM, he stated that any day is the next lab day since all the nursing staff can do the phlebotomy. If the draws are done prior to 1:30 PM Monday through Friday, the driver for the laboratory will pick the specimen up. If it is after the lab driver comes or if it is a stat, the specimen can be driven to the hospital for assay. Record review of the chart revealed n 01/10/13 the physician discontinued a prophylactic dose of Aspirin 81 mg since Aspirin can elevate the PT/INR. The MAR revealed the resident continued on Warfarin 8 mg from a telephone order (TO) on 01/11/13, "Continue Coumadin 8 mg at bedtime, Recheck PT/INR in one week	F 329	Continued From page 25 The Director of Nursing will compile audit results of the Laboratory Log Monitoring QI Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nursing is responsible for overall compliance.	4/25/13

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F 329	Continued From page 26 (01/18/13), the reported for INR 1/11/13 was 2.7(High). There is some discrepancy of the order because on the duplicate final report says "recheck INR on Monday 01/14/13" This draw was not done and no clarification is noted on the telephone orders or nursing notes. The resident continued on 8 mg of Warfarin. An INR done at the hospital on 01/18/13 , because the error of a draw not done was discovered, revealed that the resident had an INR of 5.05 [High], the results were called to the facility at 7:01 PM and the dose was held, telephone order (TO) "Hold 8 mg dose tonight and repeat PT/INR on 01/19/13. No record of a PT/INR was found for 01/19/13. The dose on the 18th is held, but the MAR reflects that the 8 mg dose was given on the 19th and 20th and then the MAR is undocumented [blank] for 01/21/13 and 01/22/13. A telephone order on 01/23/13 revealed that the physician ordered a one time bolus dose of 10 mg for 01/23/13 because the INR was 1.8 [slightly low] [on Wednesday], resume the 8 mg dose on 01/24/113 and recheck PT/INR on Monday [01/28/13]. There was no record of a PT/INR done on 01/28/13. An INR value of 2.43 was posted for 01/29/13 and the assay revealed this was from the hospital, not the facility lab, so the specimen had been driven to the hospital when it was discovered that the Monday lab had not been drawn. The physician instructed to continue with the 8 mg of Warfarin and to recheck PT/INR in one week [02/06/13] The draw was done on 02/06/13 but the lab report said that the specimen volume was	F 329		

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F 329	Continued From page 27 insufficient to be tested. This was reported to the facility on 02/07/13 at 5:35 A.M but no redraw was done until 02/10/13 when the error was discovered. In an interview with the Director of Nursing on 03/27/13 at 11 AM, she stated that if the treatment nurse cannot get the draw, her expectation was that she or one of the RNs should be notified so they can try to get the specimen. The "insufficient specimen" notification should not be ignored but should be acted on as soon as it was received by the facility on the fax machine. A telephone order on 02/10/13 from the physician assistant (PA) indicated that the Warfarin dose should be held until the results from the PT/INR got back. A specimen was driven to the hospital on 02/10/13 and was reported back as 6.66 [High]. The orders were to hold the dose until Monday (02/11/13) and recheck PT/INR. Results of the assay drawn on 02/11/13 were again stated as "insufficient volume" but a redraw was not done. The dose continued to be 'held' from 02/10/13[Sunday] though 02/10/13 the next Monday. When another specimen was redrawn on 02/19/13 and the INR was reported as 1.1; a telephone order from the physician stated to resume the 8 mg dose and recheck PT/INR in one week [02/26/13]. The lab value for the draw on 02/26/13 was reported to have a PT/INR value of 4.7 [High]. The physician was advised and ordered the dose to be held and recheck on 03/01/13.	F 329		

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F 329	Continued From page 28 The recheck on 03/01/13 [Saturday] revealed the INR was reported as 2.3 [High], although the report was sent to the facility at 5:35 AM, it was not faxed to the attending physician until 03/04/13 and the lab slip says continue same dose (6 mg), the MAR reveals that the resident did not receive any Warfarin on 03/01/13 through 03/ 03/13 and a telephone order on 03/04/13 reveals that the dose should be decreased to 6 mg and recheck PT/INR in one week. There was no documentation for the conflict in the orders. There was no ' hold ' for the doses on 03/01/13 through 03/03/3. The recheck INR on 03/12/13 indicated the INR was at 2.1 and a telephone order stated "Continue Coumadin 6 mg daily and recheck in one week (03/19/13)." The recheck reported on 03/20/13 at 5:35 AM, revealed that the INR was elevated at 5.0 [High], the physician gave orders to hold the dose for 2 days and recheck on Friday (03/22/13). The MAR for this time period revealed that doses were held from 03/20/13 through 03/24/13 with for a total of four days rather than 2days. The INR reported from the hospital lab on 03/24/13 indicated that the INR was at 1.76 at 7:01 AM. The documentation on the lab slip reveals that the physician was not notified until 03/25/13 and the dose was further reduced to 5 mg daily. In an interview with the Director of Nursing and Administrator on 03/28/13 at 3:30 PM, they were unaware that lab draws were not done as ordered on specific days, that the physician was not always notified immediately of values, that if a	F364	The beans and peas that were exposed to prolonged heat on the steam table and stove top were immediately thrown away on 3/27/13 by the Dietary Manager. The steam table temperature was adjusted by the Dietary Manager on 3/27/13. Dietary staff was inserviced by the Dietary Manager regarding not exposing foods to prolong heat on the steam table and stove top and checking food temps on 4/16/13. All newly hired dietary staff will be inserviced regarding not exposing foods to prolong heat on the steam table and stove top and checking food temps during orientation. Food temperatures will be recorded by the cook twice during meal times, when the food is finished cooking and prior to serving and the food temperature will be recorded on the Food temperature Log. The Dietary Manager will review the Food temperature Log 3 x per week x 4 weeks then 2 x per week x 4 weeks then weekly x 4 week during breakfast, lunch, or dinner to ensure	4/25/13

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F 329	Continued From page 29 draw was unsuccessful the Director of Nursing should be notified immediately. F 364 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, SS=E PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to preserve the vitamin and mineral content of lima beans and peas by exposing it to prolonged heat on the steam table and stove top. Findings included: Food temperatures were taken at the steam table on 3/27/13 at 11:30 AM with the Dietary Manager. A calibrated thermometer inserted into a pan of lima beans registered at 202 degrees Fahrenheit on the A calibrated thermometer inserted into a pot of green peas on the stove top registered at 211 degrees Fahrenheit. The inside of the pot of peas had a darkened brown ring of 1/4 inch above the level of the peas. The liquid around the edge of the peas was bubbling. During an interview with the cook, the cook reported she had started heating the vegetables at 10:30 AM. An interview with the Dietary Manager on 3/27/13 at 11:45 AM, the Manager reported both vegetables were leftovers from the day before. The Manager stated the vegetables at those temperatures would no longer have had any	F364	Continued From page 29 food is not exposed to prolong heat on the steam table and stove top utilizing a Food Temp Monitoring QI Tool. All identified areas of concerns will be immediately corrected by the Dietary Manager. The Administrator will compile audit results of the Food Temp Monitoring QI Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The administrator is responsible for overall compliance. Kitchen can opener was cleaned by the dietary manager on 3/25/13. Butter pats stored on the top shelf of freezer were discarded by dietary manager on 3/25/13. 100% audit of the kitchen was completed by the Dietary Manager on 3/25/13 to ensure all equipment was clean and items were stored properly. There were no identified areas of concern.	4/25/13 4/25/13

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F 364	Continued From page 30 nutritive value and needed discarded.	F371	Continued From page 30 100% in-servicing with the dietary staff was initiated on 4/18/13 by the dietary manager regarding food storage and equipment cleanliness to include can opener cleanliness. All newly hired dietary staff will be inserviced regarding food storage and equipment cleanliness to include can opener cleanliness during orientation. The dietary manager and administrator will review the kitchen 3x per week x4 weeks, 2x per week x 4 weeks, then weekly x4 weeks for cleanliness of equipment to include can opener cleanliness and food storage utilizing dietary sanitation QI tool. The facility administrator will compile audit results of the dietary sanitation QI Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The administrator is responsible for overall compliance.	4/25/13
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain 1 of 1 can opener in clean condition, and failed to store 1 of 2 trays of butter pats free of splatter. Findings included: An observation was made of the kitchen freezer on 3/26/13 at 9:43 AM and revealed two rows of butter pats stored on the top shelf. One of the cardboard-type containers had splatters of brown matter inside the container and on the pats. At 9:45 AM on 3/26/13, an observation of the can opener revealed the blade had a thickened build up of dried gray/black matter the circumference of the blade. The face of the can opener had a build up of dried, gray/black matter behind the blade. During an interview with the Dietary Manager on 3/26/13 at 12:45 PM, the Manager stated staff were expected to clean the can opener after each			

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	345101	A. BUILDING _____ B. WING _____	03/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENFIELD OAKS NURSING AND REHABILITATION CENTER	208 GARY ST 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 371	Continued From page 31 use, and she did not expect staff to store foods with splatter in the freezer, and the tray of butter pats that were marked were expected to have been discarded. F 456 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE SS=E OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain 1 of 2 gas powered clothes dryers in safe operating condition. Findings included: An observation of the laundry room on 3/27/13 at 9:40 AM revealed two clothes dryers were used by the facility. The laundry aide reported she used both dryers. The lint filter on the left dryer was torn and hanging to the base of the dryer. The aide stated she reported the need for a new lint filter on Friday (3/22/13) last week to the Maintenance Director, but kept using the dryer. During an observation of the dryers with the Maintenance Director on 3/27/13 at 10 AM, the Director reported he was aware of the lint filter needing replaced on Friday (3/22/13), but has not done anything about it as of yet. At 3 PM on 3/27/13, during an observation of the laundry room dryers with the Administrator, the Administrator reported she expected the lint filter should have been ordered the day the	F456	A new lint filter was placed by maintenance director on 3/27/13. 100% audit was completed on 4/18/13 by Maintenance Manager and Administrator to ensure all laundry equipment to include all dryers are in safe operating condition. All identified areas of concern were addressed immediately by Maintenance Director. 100% in-service of laundry staff was initiated 4/08/13 by housekeeping and laundry district manager regarding lint screen cleaning and work order protocol. Maintenance director was inserviced by administrator on 4/18/13 regarding completion of work orders and fix of broken equipment in a timely manner. All newly hired laundry staff will be inserviced regarding lint screen cleaning and work order protocol during orientation by health care services district manager. 100% in-servicing with CNAs, Nurses, Dietary department, Therapy Department, Administrator, Maintenance Director, Admissions Coordinator, Social Worker, Activities Director, Staff Coordinator, Accounts Payable Bookkeeper, Accounts Receivable Bookkeeper, and Transport	4/25/13

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	345101	A. BUILDING _____ B. WING _____	03/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENFIELD OAKS NURSING AND REHABILITATION CENTER	203 CARY ST ENFIELD, NC 27823

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F 456	Continued From page 32 Maintenance Director was made aware of the tear, and the laundry staff should not have used the dryer with the defective lint trap.	F 456	Continued From page 32 Coordinator was initiated on 3/26/13 by the DON, MDS nurse, and administrator regarding work orders to be filled out immediately upon discovery of broken equipment. All newly hired CNAs, license nurses, and dietary aids will be in serviced regarding work orders to be filled out immediately upon discovery of broken equipment. The facility administrator and DON will review facility environment 3x per week x4 weeks, 2x per week x4 weeks, then weekly x4 weeks to ensure, lint filters on dryers in tact and work orders complete for equipment needing repair utilizing environmental QI tool. The facility administrator will compile audit results of the environmental QI Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The administrator is responsible for overall compliance.	4/25/13

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345101	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENFIELD OAKS NURSING AND REHABILITATION CENTER	208 CARY ST 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
K 050	Continued From page 1 alarms. 19.7.1.2 This STANDARD is not met as evidenced by: A. Based on observation on 04/18/2013 the staff interviewed did not know the fire drill procedure. 42 CFr 483.70 (a)	K 050	K050 Facility Maintenance Manger was inserviced on 4/30/13 by Facility administrator on fire drill protocol. An inservice of Administrator, Maintenance Manager, MDS Nurse, Admissions Coordinator, Social Worker, Accounts Payable Bookkeeper, Accounts Receivable Bookkeeper, Medical Records, Activities Coordinator, Licensed Nursing Staff, CNAs and Housekeeping Staff was initiated on 4/23/13 by Staff Coordinator regarding fire drill procedure. Facility administrator will review fire drill reports monthly x4 to ensure drills are held at unexpected times under varying conditions, at least quarterly on each shift. Staff Coordinator will audit staff on fire drill procedure 2x per week x4 weeks, weekly x4 weeks, then monthly x2 utilizing Fire Drill Protocol QI Tool. The Administrator will compile audit results of the Fire Drill Protocol QI Tool and present to the Quality Improvement Committee Meeting monthly. Subsequent plans of action will be developed by the Committee when required. Identification of any potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Administrator is responsible for overall compliance.	6/2/13
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: A. Based on observation on 04/18/2013 the laundry was sprinkled from the domestic water supply to the washing machines ,the valves are not supervised nor was the alarm switch wired. This area must be tied into the NFPA 13 system that covers the remainder of the facility. 42 CFr 483.70 (a)	K 056		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance	K 069		

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	345101	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/18/2013

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

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K 069	Continued From page 2 with 9.2.3, 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: A. Based on observation on 04/18/2013 the range hood inspection was out of date. 42 CFr 483.70 (a)	K 069	K056 Facility support services contacted by administrator 4/18/13 to discuss finding. 4/25/13 laundry room valves were supervised and alarm switch wired into NFPA 13 system by CTE, Inc. electrician. Sunland Fire Protection visited facility 5/14/13. Sunland to take sprinkler heads in laundry off domestic line and run to main fire line. K069 Kitchen range hood was inspected 4/23/13 by BFPE International. A 100% audit of equipment inspections initiated on 4/23/13 by facility administrator and current book of inspection records updated accordingly.	6/2/13 6/2/13