ATEMENT O PLAN O	of deficiencies Foortection	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(x2) Multiple Construction A. Bulding			(X3) DATE SURVEY COMPLETED	
		345101	B. WNG			03	128/2013	
	omoer or supplier Oaks nursing and re	EHABILITATION CENTER		20	eet address, city, state, zip come 18 Cary St NFIELD, NG 27823			
(X4) ID PREFIX YAG	(CACH DEFICIENC)	atement of deficiencies y must be preceded by full LSC identifying information)		ID FROMBERS PLAN OF C PREFX - (EACH CORRECTIVE ACTIVE TAG CROSS-REFERENCED TO THE DEFICIENCY		Dee	COMPLETION DATE	
F 157 SS=D	A facility must immed consult with the resid known, notify the resid or an interested familiaccident involving the injury and has the pointervention; a significantly find the clinical complications significantly (i.o., a mexisting form of treatment); or a decisine resident from the \$483.12(a). The facility must also and, if known, the resident rights under regulations as specifithis section. The facility must receive the address and pholegal representative the address and pholegal representative.		F	157	Response Preface Enfield Oaks Nursing and Rehabilitation Center acknowle receipt of the statement of deficiencies and proposes this proposes this proposes this proposes this proposes that sure of findings is factually correct an order to maintain compliance wapplicable rules and provisions quality care of our residents. The of correction is submitted as wallegation of compliance. Enfiel Nursing and Rehabilitation Centersponse to this statement of deficiencies and plan of correct does not denote agreement with statement of deficiencies nor denote agreement with statement of deficiencies nor deficiency is accurate. Further, Oaks Nursing and Rehabilitation Center reserves the right to subto documentation to statement of deficiencies through informal diresolution, formal appeal proceed.	olan of mmary and in old in ol	4/25/13	

Any deficiency statement budge with an extertak (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the pationis. (See instructions.) Except for mushing homes, the findings stated above are disclossable 90 days following the date of survey whether or not a plan of correction is provided. For mushing homes, the above findings and plans of correction are disclossable 14 days following the date those documents are made evaluable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		(XI) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER:	1	(x2) multiple construction A. Buloho			SURVEY LUTEO
		345101	D. YANG			03/28/2013	
ENFIELD	SUMMARY ST	EHABILITATION CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	to PREF	20 E	ECT ADDRESS, CITY, STATE, ZIP CODE 8 CARY ST NFIELD, NC 27823 PROVIDERS PLAN OF CORRECTION 1 (JACH CORRECTIVE ACTION SHOULD	02	COMPLETION EXA
PRÉFIX YAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		Cross referenced to the appropr Deficiency)	INTE	DATE
F 167	deep vein thrombosi #61) of 1 sampled re ultresound for a spec Findings included: Resident #61 was at 1/30/13 and readmit hospital return of 3/7 thromboembolism without the first thromboembolism without color on the right for the first thromboembolism without color on the right for the first thromboembolism without color on the right for the first thromboembolism without color of a physician color of the first thromboembolism without color of a physician of the first thromboembolism of thromboembolism of the first thromboembolism of thromboembolism o	vas rescheduled to rule out a s (blood clot) for 1 (Resident sident with orders for an elific date. Imilited to the facility on led on 3/7/13. Diagnoses on /13 included a venous lith deep vein thrombosis ght subclavian vein. In 's verbal order, dated order written as "Send assound to sight arm in the lift (rule out) blood clot. RE: and hand. Continue	F	157	The Physician was notified of Resident #61 ultrasound results 2/25/13 by the charge nurse. A 100% audit of all resident's to include resident #61 ordered laterays, ultrasounds and appointment for the last 30 days were review the DON, treatment nurse, and nurse initiated on 4/4/13 to ensilabs, x-rays, ultrasound, and appointments have been scheduper physician's order and the Mibeen notified of any labs, x-rays, ultrasound, and appointments tineeded rescheduling. All identifiareas of concern were immediated corrected by the DON. An inservice of all licensed nurse was initiated on 4/3/13 by the Coregarding notification to the physician of all rescheduled labs rays, ultrasounds, and appointment with documentation in the med records. All newly hired licensed nurses will be inserviced by the physician of all rescheduled labs rays, ultrasounds, and appointments will be inserviced by the physician of all rescheduled labs rays, ultrasounds, and appointmentation in the med records during orientation.	os, x- ents ed by MDS ure lied D has hat ied tely s, x- ents i DON s, x- ents	4/25/13

	OT ASTIMENIALITY A	MUPOLOVIO OFFICIO	· · · · · · ·			O11110	, 000000
STATEMENT (of deficiencies correction	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILO		CONSTRUCTION	(X3) PATE SURVEY COMPLETED	
		345101	B. WANG	·		03/	28/2013
	ovider or supplier Daks nursing and ri	ehabilitation center		20	et address, city, state, 2/p code 8 oary st NFIELD, NO 27823		
(X4) IO 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 D Cross-Referenced to the Appropri Ceficency)		OVIE COMPETION (xt)
F 167	stated he clidn't reme the ultrasound couldr scheduled. The phys notified, he would hat hospital for the test a 2/25/13. An interview was con hursing (DON) on 3// reported she expecte called the physician v able to be done as so 483,15(a) DIGNITY / INDIVIDUALITY The facility must pro- manner and in an en- enhances each resid full recognition of his	mber receiving any call that it be done on the day it was itelian stated that if he were we sent the resident to the not not have walled until ducted with the Director of 28/13 at 4:25 PM. The DON of the nurses would have when the ultrasound wasn't cheduled. NO RESPECT OF mote care for residents in a eviconment that maintains or earl's dignity and respect in		· 167	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		4/25/13
-	Based on observation interviews the facility at the same time as residents (Resident#In-room dining exper Findings included: Resident #26 was as	imitted on 09/20/12 with			monthly, Subsequent plans of ac will be developed by the Commi when required, identification of potential trends will be used to determine the need for action and/or frequency of continued monitoring. The Director of Nur- is responsible for overall compli	ttee any sing	
	(MDS) quarterly assi revealed line residen for delly decision ma	ecent Minimum Data Set eament dated 02/21/13, I was moderately impalied			A meal tray was retrieved by NA and delivered to resident # 26 o 3/26/13.	. #1	4/25/33
i		,	1		1		1

PRINTED: 04/12/2013 FORM APPROVED OMB_NO. 0938-0391

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	of deficiencies F correction	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DAT	O. 0930-0391 E SURVEY PLETEO
		345101	A. WING		02	128/2013
	ROWDER OR SUPPLIER OAKS NURSING AND R	EHABILITATION CENTER		reet address, city, state, zip code 208 Cary 8t Enfield, NC 27823		
(X4) IO PREFIX TAG	(EACH DEFICIENC	AYEMENT OF DEFICIENCIES Y MAST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX YAG	Providers plan of correc (each corrective action shot cross-heferenced to the appr deficiency)	JLD BE	COMPLETION DATE
F 241	up a tray for the roon #2 then went out to the for Resident #26. N/ there was not a tray on NA#2 left the hallway. On 3/26/13 at 8:44 A the trays off the hallway. On 3/26/13 at 8:44 A the trays off the hallway. Resident #26 had no breakfast. NA#1 rev. B bed and saw a tray bed (Resident #26) h#1 then went to the k Resident #26. On 3/26/13 at 8:66 A breakfast tray. NA # was going to eat a till replied " Got to, 1' m. On 3/26/13 at 10:25 conducted with Nurse person assigned to the making sure that all right trays. Nurse #1 helping pass the tray were there, and if a trassigned person sho resident would get a On 3/26/13 at 10:39 conducted with the D. Manager revealed the computer did not print therefore the line did resident. The Dietan	amate of Resident #26. NA the carl and looked for a tray that Informed NA#1 that on the cart for Resident #28. If and did not return. M NA#1 began to pick up that into the so and discovered that the received a tray for the tr	F 24	Continued from page 3 A 100% audit of meal tray del was conducted on 3/27/13 by Facility Consultant, DON, Administrator, Accounts Paya Bookkeeper, Accounts Receiv Bookkeeper, Transportation coordinator, MDS Nurse, Soci Worker, and Admissions Coordinator, MDS Nurse, Soci Worker, and Admissions Coordinator, MDS nurse, Soci Worker, and Admissions Coordinator, MDS nurse, Soci Worker, and In the Gining room for residents in-room to Incluresident #26. There were no identified areas of concern. An inservice was initiated on by the Director of Nursing will and license nurses regarding delivering meal trays at the same in the dining room and for rein-room and obtaining a tray dietary immediately if a mean oticed missing. All newly his CNAs and License Nurses will inserviced regarding deliveritarys at the same time for reat the same table in the dining and for resident's in-room are obtaining a tray from dietary immediately if a meal tray is missing by the DON during orientation.	ble able al dinator ovided s at the n and de 3/26/13 th CNAs ame e table sidents from I tray is ed be ng meal sidents ng room ad	4/25/13

PRINTED: 04/12/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 Statement of Deficiencies And Plan of Correction (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DAYE SURVEY COMPLETED A. BUILDING 345101 B. WING 03/28/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, SYAYE, ZIP CODE 208 CARY ST ENFIELD OAKS NURSING AND REHABILITATION CENTER ENFIELD, NC 27823 PROVIDERS PLAN OF CORRECTION

(BACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY) (X4) 10 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG (X6) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC (DENTIFYING INFORMATION) Continued From page 4 4/25/13 F 241 Continued From page 4 F 241 A resident care audit of meal tray residents to inform the kitchen if a tray was delivery will be conducted by the Staff Facilitator, Transport On 3/26/13 during an interview at 11:16 AM, the Coordinator and Dletary Manager 2x Director of Nursing (DON) reported that she per week x 4 weeks, then weekly x 4 expected roommates to receive their trays at the weeks, then monthly x 2 months same time. When the NA assisting reported to during breakfast, lunch, or dinner to the assigned NA that the tray was not there, the ensure residents are delivered meal situation should have been handled at that time trays at the same time at the same by the assigned NA. She also expected that the NA would report the missing tray to the nurse, so table in the dining room and for inthey would be aware and help out with the room residents to include resident situation. #26 utilizing a Resident Care Audit 483.15(h)(1) F 252 Meal Tray QI Tool. Any Identified SAFE/CLEAN/COMFORTABLE/HOMELIKE areas of concern will be corrected ENVIRONMENT immediately by the Staff Facilitator, Transport Coordinator, Dietary The facility must provide a safe, clean, Manager. The DON will review the comfortable and homelike environment, allowing the resident to use his or her personal belongings resident care audit meal tray Qi tools to the extent possible. weekly for compliance. The Director of Nursing will compile This REQUIREMENT is not met as evidenced audit results of the Resident Care Audit Meal Tray QI Tool and present Based on observations, resident and staff interviews, the facility failed to provide a to the Quality Improvement home-like environment by storing mechanical lifts Committee Meeting monthly. and lift belts in the main dining room, using Subsequent plans of action will be plastic-top folding tables with no covers for meals, developed by the Committee when using the manufactured packaging for juices and required. Identification of any thickened liquids for residents to drink from, and potential trends will be used to the use of disposable clothing protectors during 3 determine the need for action of 3 meal observations. ł Findings included: and/or frequency of continued monitoring, The Director of Nursing A dining room observation on 3/25/13 at 12:10

PM revealed a mechanical lift was stored in the

is responsible for overall compliance.

CENTER	RS FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D; 04/12/2013 M APPROVED 0, 0938-0391
AND PLANO	of deficiencies F correction	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .		сонятлистюн	(X3) DAY	E SURVEY PLETED
L		345101	B. WING			١.,	
Name of P	ROVIDER OR SUPPLIER			STR	EEY ADORESS, CITY, STATE, 21P CODE	1 03	/28/2013
ENFIELD	OAKS NURSING AND RE	HABILITATION CENTER		2	08 CARY SY NFIELD, NC 27823		
(X4) IÓ PREFIX YAG	(EACH DEFICIENCY	ntenent of deficiencies I must be preceded by full sc identifying reformation	PREF TAG	'IX	Providents Plan of Correction (Kach Corrective Action Should B Cross-Referenced to the Appropri/ Deficiency)	g \YG	COMPLETION DATE
F 252	dining room 4 feet froi resident. An additional in front of a window in milk servings were pre manufactured certons thickened liquids. Sor straws and some did in on top of the mechanisthe dining room door of the residents; meals the dining room door with no covers. The redisposable clothing profit meal. Bingo equipal a plano. A breakfast meal observation and had 2 green lift passion and had 2 green lift passion and had 2 green lift passion door. The additional meal dining room stored equipment remained o residents were served directly onto the white-tables with no covers, provided disposable of juicos, and thickened it residents from their conservation revealed in environment. Durings and mining modes est considered the nurse sit conservation revealed in environment. Durings and mining modes est considered the nurse sit conservation revealed in environment.	in the lable used by a sal mechanical lift was stored the diding room. Individual oxided in the small as well as juice and me of the containers had not. Lift bolts were stored call lifts and on the back of exposed to the dining room, were served from the trays oldered plastic folding tables as identify and the saldents were provided otectors to be worn during alpment was stored on top of exposed for the window disconting the saldents were provided otectors to be worn during alpment was stored on top of the 26/13 at 7:52 AM. The end in front of the window disconting to the window disconting the plane. The golf a rack on the dining one mechanical lift was in by the plane. The the meat from the trays colored plastic folding. The resident were oithing protectors. Milk, equids were served to the intainers.	i-	262	On 3/27/13 mechanical lifts in the dining room were removed by the MDS nurse. Lift belts were remove from the dining area by the MDS nurse on 3/27/13. Bingo equipme stored on top of piano was removed by the dietary manager on 3/27/11. Cloth table covers and center piece were purchased and placed over the plastic-top folding tables in the diaground on 3/27/13 by the facility administrator. Additional cloth take covers were ordered by facility on 4/4/13. Additional drink ware was ordered by facility on 3/28/13. 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 use as of 3/29/13. A facility tour was completed by the administrator on 4/8/13 to ensure homelike environment is provided residents. Any items identified by administrator as hindrance to homelike environment were direct to facility maintenance manager of home office support services for correction by 4/25/13.	ed nt ed 3. es he he hling ole th d	4/25/13

TATEMENT (of deficiencies	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CMB NO. 0938-0	
WO PLAN OF	CONRECTION	IOENTIFICATION NUMBER:	A DULDING_		COMPLETED
	······	346101	D. WANG		03/28/2013
	Ovider or Supplier DAKS Hursing and F	REHABILITATION CENTER	20	EET ADDRESS, CITY, STAYE, ZIP CODE 8 CARY ST VFIELD, NO. 27823	- OURUZUIO
(X4) ID PREFIX TAG	(EACH DEFICIEN	Tayement of deficiencies oy must be preceded by full resc identifying information	IO PREFIX TAG	Providers Plan of Correction (Each Corrective action Shorad Cross-Referenced to the appropri Deficiency)	BE CONSTR
į	Continued From pag with no covers, and pads in the cining ro	ge 6 the mechanical lifts and lift rom. The nurse stated the	F 252	Continued From page 6	4/25/13
	disposable ciothing ;	protectors were not homelike.		100% in-servicing with CNAs, Nu Dietary department, Accounts	rses,
1	During an Interview	and observation with the		Payable Bookkeeper, Accounts	
	Administrator on 3/2 Administrator stated	7/13 at 12:55 PM, the the dining area did not		Receivable Bookkeeper, Transpo	
- 1	Drovide a homelike e	and aming area are not		Coordinator, Activities Director,	,
- 1	changes needed to t	oe made for the tables.		Coordinator, Admissions Coordin	• •
	equipment storage, o	clothing protectors, and	1 1	Social Worker, Maintenance Dire	
	drinkware.			and Administrator was initiated	
SS=E	483.15(h)(2) HOUSE MAINTENANCE SEI	KEEPING &	1	3/26/13 by the DON, MDS nurse administrator regarding home-lift	
00-4	MANAGE OF	(VICES	1 1	environment of facility to include	
]:	The facility must prov	bne gnkgoskevort ablv		storing mechanical lifts and lift b	
[4	mainionance service	s necessary to maintain a		in the main dining room, ensurin	
	sanitary, orderly, and	comfortable interior.		plastic-top folding tables have co	
1				not using manufactured packaging	, š
-	This REQUIREMENT	f is not met as evidenced		for juices and thickened liquids,	and
] [py:			using cloth clothing protectors.	
١,	Based on observatio	ins and staff interviews, the		newly hired license nurses, CNAs	, and
- 13	aciny isiao to maint	ain 2 of 2 gas powered in condition; and the facility	1 1	Dietary Staff will be inserviced	
ļf	ailed to properly sea	1 1 of 1 exit door in the main		regarding home-like environmen	nt of
- 10	lining room and 1 of	1 exil door in a hall adjoining		facility to include not storing	
Įt.	he main dining room	that allowed light to show		mechanical lifts and lift belts in t	
	hrough. Indings included:		1 1	main dining room, ensuring plass	
l'	mange mondada;			top folding tables have covers, nusing manufactured packaging for	4
1) An observation wa	as made of the laundry room		Juices and thickened liquids, and	1
C	in 3/27/13 at 9:40 At	A. Observation of the drum		using cloth clothing protectors b	
l a	nd lan maller throug	led areas of baked on brown shout the drum. The dryer areas of baked on gray/tan		DON during orientation.	,
i n	natter and areas of b	rown maller baked onto the			
Į d	rum. The laundry at	ton the eria behoger eb			1
lc	lean out line inside o	f the dryers drums, that	1		1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDEIVSUPPLIERICUA IDENTIFICATION NUMBER:	(X2) MUL A. DUTLO	TIPLE CONSTRUCTION	TAO (6X)	O. 0938-03 E SURVEY PLETED
		345101	B. WING		os	/28/2013
	lovider or supplier Daks nursing and r	EHABILITATION CENTER		SYREET ADDRESS, CITY, STATE, I 208 CARY ST ENFIELD, NO 27823		140,2010
(X4) 10 PREFIX TAG	(PACH DEFICIENT	tatement of deficiencies by Must de Preceded by Full Leg Ioentifying Information)	ID PRET TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE D TO THE APPROPRIATE KIENCY)	COMPLETE DATE
F 263			F25	The facility admini will review facility week x4 weeks, 2x weeks, then week ensure tables with or lift belts stored drinks not in carto clothing protector Environmental QI The facility admin audit results of the Tool and present improvement Commonthly. Subseque will be developed when required. Identical trends we determine the neef requency of continuity and the subsequency of continuity administration of the subsequency of continuity administration.	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	
An observation of the exit door from the dining from 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 hell outside the dining from 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.		F253	Dryer drums were care services facil 3/27/13 to remove matter. Exit door exit door to hall owere properly sea	e cleaned by health ity manager on re brown and tan to dining room and outside dining room aled to prevent gaps	4/25/13	
	3/27/13 at 1:10 PM. The Administrator stated she expected the Maintenence Director to have made the repairs at the time of the recommendations from the past control vendor.			by facility mainter 3/28/13.	nance director on	

STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (XI) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DA	IO. 0938-03 TE SURVEY VPLETED
		345101	D. WANG			••••••
		REHABILITATION CENTER		STREGT ADDRESS, CITY, STATE, ZIP C 208 CARY ST ENFIELD, NO 27823		3/28/2013
(X4) ID PREFIX TAG) (each deficien	Statement of Deficiencies Ry Must de Preceded by Full R LSC Identifying (Ifformation)	ID PREFI YAG		CTION SHOULD BE THE APPROPRIATE	COMPLET
\$\$=D	to develop, review a comprehensive plan for each reside objectives and timet medical, nursing, an needs that are ident assessment. The care plan must to be furnished to att highest practicable psychosocial well-be \$483.25; and any se be required under \$483.10, including thunder \$483.10(b)(4). This REQUIREMEN' by: Based on resident a record reviews, the fof care for communit discharge plan in pla Resident #19 was 10/22/12 with diagno disorder, expressive	he results of the assessment and revise the resident's a of care. velop a comprehensive care in that includes measurable ables to meet a resident's ad mental and psychosocial lifed in the comprehensive describe the services that are tain or maintain the resident's physical, mental, and sing as required under rolces that would otherwise as a regular of rights under the right to refuse treatment. It is not met as evidenced and staff interviews and acility falled to develop a plan y discharge and had no ce for 2 (Resident #19 and ampled residents who he community,	F25	Continued from page 100% audit of exit do completed on 4/12/: administrator to ens were properly sealed gaps. All identified an were corrected by the Director or home off services by 4/25/13. 100% In-service of la initiated on 4/08/13 housekeeping and la manager regarding do cleaning. All newly his staff will be inserviced dryer drum cleaning services district maniorientation. The Mail Director was inservice Administrator on 4/1 ensuring exit doors a properly. The facility administry will review facility 3x weeks, 2x per weeks weekly x4 weeks to endoors without gaps, clean, and work order for equipment needil utilizing the Environn	ors was 13 by facility are exit doors i and without reas of concern the Maintenance tice support undry staff was by undry district ryer drum red laundry d regarding by health care tager during thenance the by the 8/13 regarding re sealed ator and DON per week x4 44 weeks, then the system the sy	4/25/33

STATEMENT VND PLAN OF	OF DEFICIENCIES CORRECTION	(XI) PROVIDENSUPPLIERICUA IDENTIFICATION NUMBER:	A. AULON	MONTOURY AUGUSTINE AUGUSTI	(X3) DAYE:	0938-0391 SURVEY ETED	
	onder or supplier Daks Hursing and R	346101 EHABILITATION CENTER	D. WING_	STREET ADDRESS, CITY, SYATE, ZIP CODE 20B CARY ST ENFIELD, NO 27823		8/2013	
(X4) ED PREFIX TAG	(ÉACH DEFICIENC	ATEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	ADBE]	DATE CONNECTION (XI)	
F 279	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 overell 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-dey admission		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			
revealed in part: completed 5-day admission assessment with the resident. Stated he felt depressed nearly everyday to wanting to return inope, was encouraged to accept care that's provided and participate in therapy. Offered it resident to see psychiatriefs, resident has accepted. Referral will be made. Although resident would like to go home one day soon, has adjusted to facility very welt. Resident for to social with other residents. There is no discharge plan in place at this time. During an interview with Resident #19 on 3/26 at 3:15 PM, the resident stated he needed to leave the facility because it was so depressing him. He stated he lost a lot of function from the strokes when he was admitted to the facility, thas regained a lot of mental functioning and physical functioning since. The resident state he wanted to go home or somewhere of lesse care that he could be stimulated to help impro		id to accept care that's atte in therapy. Offered for latitists, resident has illi be made. Although go home one day soon, he y very welt. Resident loves sidents. There is no at this time. with Resident #19 on 3/26/13 and stated he needed to use it was so depressing to stall the interesting and interesting and ince. The resident stated to or somewhere of lesser	F279	overall compliance. Discharge planning was initiat documented in the Social Prognotes for resident #19 on 3/26 the Social Worker. Resident #1 care plan was updated by the Worker to reflect community discharge on 3/26/13. On 3/2 and 4/15/13 resident #61 was interviewed by the Social Worregarding discharge planning resident #61 does not have a to be discharged to the commithis time.	gress 6/13 by 19's Social 8/13 irker and desire	4/25/19	

		S MEDICAID SERVICES			<u> </u>	0, 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILOING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345101	B. WING		b:	1/28/2013
	ROYDER OR SUPPLIER OAKS HURSING AND	rehabilitation center	\$	STREET ADDRESS, CITY, SYATE, 24P CODE 208 CARY ST ENFIELD, NC 27823		
(X4) ID PROFIX TAG	i (Pach Deficie)	Statement of Deficiencies NOY Must be preceded by full R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	Providers Plan of Co (Each Corrective action Cross-Hifferenced to the Deficiency)	ESHOULD DE	COMPLETIC DAYS
F 279	his mind and have stated he couldn't s home crowd with throwing things. It and sometimes he stated no one was lesser care environ. An interview was considered at the facility memory loss. He was for decisions about 2013. The last threstdent about his paquarterly assess hasn't spoken to his The SW stated she yet because there we place, but should his lated she felt the massisted fiving facility was ready. Record review reversity for the property of 2/25/13, or Celexe and start Lemedication) for deputing an interview.	options of doing things. He tend to be out in the nursing te resident's yelling and made him more depressed felt like he wanted to cry. He helping him here to find a ment. Onducted with the SW on . The SW reported the status has improved since he but still had some short term ras his own Responsible Party his care since Pebruary 1, no the SW telked with the dans was in January 2013 for nent. The SW stated she in the status has improved since he but still had some short term ras his own Responsible Party his care since Pebruary 1, no the SW telked with the dans was in January 2013 for nent. The SW stated she in the sweet of the sweet of the sweet of a discharge was not a discharge plan in ave written one. The SW saident could go to an ity and should have looked for for the resident for when he aled a physician's order of the resident for adjustment lity and stabilization of Resident #81 was admitted on for Celexa (an antidepressant Review of a physician's ders were given to discontinue xapro (an antidepressant	F 27	Continued From page 10 100% interview with all c and oriented residents to resident # 19 and residen with the resident represe non-alert and oriented re regarding request for discommunity was initiated the Social Worker. Care pupdated and discharge pinitiated for all residents to return to the commun documented in the social motes by the Social Work 4/25/13. An inservice was initiated MDS nurse, Administrated Worker, and Admission Cregarding the process for planning on 4/8/13 by the Consultant. Upon admission to the foresident or resident represident or resident represident or resident represident worker or Admission Consultant.	Include It #61 and Intative for all Isidents Isi	4/25/13

\$74Yeteney	AR DESALEMAN	MEDIO/40 SEKVICES				<u>OMB</u> N	O. 0938-03	
AND PLAN OF	OF DEFICIENCIES F CORRECTION	(XI) PROVIDENSUPPLIERICUA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BURLDING			COMPLETED	
···		346101	B. WNG			١,,	******	
HAME OF PI	ROVIDER OR SUPPLIER			97056	T ADDRESS, CITY, STATE, ZIP CODE	JU3	/28/2013	
ENFIELD	oaks nursing and r	ehabilitation center		208	CARY ST FIELD, NO 27823			
(X4)10	SUMMARY SY	ATEMENT OF DEFICIENCIES						
PRÉPIX TAG	(EACH DEFICIENC	y must be preceived by full LSC Identifying diformation	ID PREFD TAG	<u> </u>	Provider's plan of correction (each corrective action should e cross-referenced to the appropri deficiency)	NYE	COMMETIO (XI)	
F 279	Continued From page	F 2	279	Continued From page 11		4/25/13		
	PTA stated the reside			all residents or resident		4/25/13		
	dress and wash his u			representative request to return	to			
	himself if he were mo	livated.		-	the community. All residents to		Ì	
- 1					include resident #19 and resident			
	An interview was con-	ļ	1	#61 or all resident representative				
-	Administrator on 3/28			will be re-interviewed regarding				
- 1	Modern would be a	he expected the Sociel			preferences to be discharged to t	ha		
- 1	for the resident.	leveloped a discharge plan	ł		community by the Social Worker			
	ioi dio losidaliti				MDS Nurse through the RAI proc			
1			1			622		
ļ	2) Resident #61 was	admitted to the facility on		- 1	quarterly and annually unless	1		
1	1/30/13 and readmitte	d 3/7/13. Diagnoses for the	1		requested not to be interviewed.			
1	resident included anxi	oly state, depressiva		- [The Administrator will review the	,		
- 1	disorder, Stage IV pre	ssure ulcer, and paraplegia.		1	social progress notes 2x per weel	۲× ا	:	
1	ANDOLOU		1		4 weeks, then weekly x 4 weeks,	ļ		
1	A MUS BURNSSION ASS	essment of 2/12/13 Section			then monthly x 2 months to ensu			
1	Q revealed the reside	nt participated in the cled to discharge to the	-		residents have been interviewed			
1	COMMunity The seed	ssment documented there		-	and care plans have been update	d		
	was no active dischar	de niannino in niaco		1	utilizing a Discharge Planning Qi	I		
1	***************************************	go paratang at place.			Tool. The Administrator will follo	w		
	Review of a SW note	of 2/1/13 revealed			up immediately for identified are	as		
] -	documentation that the	e resident was admitted		•	of concern.			
1	from home with pressi	ure ulcer stage IV, and				- 1		
11	parapiegia. Will monit	or for adjustment to the	1		The Administrator will compile as	ıdit		
	lacilly and make plans	with community resources			results of the Discharge Planning			
- 1	as nacessary.				Tool and present to the Quality	~		
- 1.	A CIALANIA ALOMANA		1	1	Improvement Committee Meeting			
!:	o o an note of St12/13	revealed documentation of in place at this time, as	1	-	monthly. Subsequent plans of ac	- 1		
	บาย เกลเน ขนูเอเพชาไกล์เกิลล์ เรื่องศ์ haunw ลไกล์เกิลล์	s, a discharge plan will be		- 1	• • •			
1.	out in place at that time	a. a disolisiya pisii wili 08		-	will be developed by the Commit			
- '		••	1	1	when required, identification of	anty		
- 1	Review of the resident	's medical record			potential trends will be used to	- 1		
ļr	evealed a Social Histo	ory of 2/1/13 that	1		determine the need for action	- 1		
	focumented "Discharg	ie Plans" as "Stav is	ł		and/or frequency of continued			
	projected to be short-to	•			monitoring.			

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

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391			
STATEMENT (WO PLAN OF	of Deficiencies Correction	(XI) PROVIDER/SUPPLIER/CUA IDENTIFICATION NAMBER:	V BRUITON		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		346101	D. WING			03	/28/2013		
	ame of provider or supplier Enfield Oaks nursing and rehabilitation center			1	rreet address, City, State, ZIP code 288 Cary St Enfield, NO 27823				
(X4) 10 Phefix Yag	(EACH DEFICIENC	IENCY MUST BE PRECEDED BY FULL		Summay statement of deficiencies (each deficiency must du preceoed by ful regulatory or leg identifying information)		px S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DBE (COMPLÉI	
F 279	Continued From page 12			9	Continued From page 12		4/25/13		
F 309	2:10 PM, the SW rep discharge because if plan in place, but she An interview was col Administrator on 3/2. Administrator stated Worker would have for the resident. 483.25 PROVIDE C/ HIGHEST WELL BE	8/13 at 3:40 PM. The she expected the Social devoloped a discharge plan ARE/SERVICES FOR	F30:	19	The Administrator is responsible overall compliance. Resident #61 was assessed for si and symptoms of DVT by hall nu on 2/21/2013. Resident # 61 ha Ultrasound completed in-house radiology group on 2/25/2013. Physician was made aware of the findings of the ultrasound by the nurse on 2/25/2013. Order to so resident to ER for DVT was received by hall nurse on 2/25/2013 and	gns rse d an by The e e half end ved	4/25/13		
	mental, and psychos	ost practicable physical, locial well-being, in comprehensive assessment			resident # 61 was sent to hosp on 2/25/2013. A 100% audit of all residents to include resident #61 was completo assess for acute changes to in	eted			
	by: Based on staff inter facility falled to obtai out a deep vein three ordered causing a d of a blood clot for 1 sampted resident wi and the facility falled symptoms of a deep for 1 (Resident #61)	sasd on staff interviews and record reviews, the citily fatted to obtain an ultrasound test to rule ut a deep vein thrombosis (blood clot) as refered causing a delay in notification of results if a blood clot for 1 (Resident #61) of one ampled resident with a deep vein thrombosis; not the facility falled to monitor for signs and ymploms of a deep vein thrombosis (blood clot) or 1 (Resident #61) of one sampled resident with welling and warmth of the right arm			signs and symptoms of DVT to la edema, warmth and pain by Fac Wound Care Consultant and the treatment nurse initiated on 4/1/2013. The MD was notified identified areas of concerns immediately by the treatment of	nclude illty i	and the state of t		
	1) Resident#61 wa	s admitted to the facility on							
	1								

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE	MEDICAID SERVICES			OMBNO	D. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:	V BRICHING SHIOTHR	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		345101	B.VWRB		03	128/2013	
	ona duishig and	REHABILITATION CENTER	STREAT ADDRESS, CITY, STATE, ZIP CODA 208 CARY ST ENFIELD, NC 27823				
(X4)1D PREFIX TAG	(EACH DEFICIE)	Syatement of deficiencies ICY Must be preceded by Full R LSC IDENTIFYING INFORMATION	PREFIX TAG	Provider's Plan of Ca (Each Confective Actio Cross-Referenced to The Deficiency)	n should be Eappropriate	COMPLETION DATE	
F 30B	hospital return of 3/thromboembolism vi (blood clot) on the rice of a physicial service of a control of the service of a nurse of the service of the	itled 3/7/13. Diagnoses on 7/13 included a venous with deep vein thrombosis light subclavian vein. an 's verbal order, dated in order written as "Send rasound to right arm in the o (rule out) blood clot. RE: end hand. Continue	F309	An inservice was initiate 04/03/2013 for all licent include nurse #1 by the regarding monitoring act to include signs and symand notification to the presponsible party with documentation in the morecords. All newly hirecontres will be inserviced regarding acute change signs and symptoms of notification of the physical documentation in the morecords during orientation. The DON, MDS nurse, a nurse will review all nurnotes weekly X 4, then and then monthly X 2 midentified acute change to include signs and symptoms of the physical control of the physical c	ed on sed nurses to DON cute changes aptoms of DVT obysician and medical discensed diby the DON s to include DVT and ician with medical ion. Individual ion.	4/25/13	
	Resident stated shi discomfort to her ri- or symptoms of res Resident continues a pillow. Will continue Review of a nurse revealed: (Name of ultrasound to right	e's experiencing loss ght arm than earlier. No signs piratory distress noted. I to keep right arm elevated on		to ensure that the resid been assessed, MD not acute changes in condit documented in the pro	ified, and that ion are		

TATEMENT IND PLAN OF	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XS) MULTIPLE (XS) MULTIPLE	CONSTRUCTION	(X3) DAY	O, 0938-03 e survey kaleted
		345101	B.WING		0:	1/28/2013
ENFIGLD (X4) (O	SUMMARY ST	EHABILITATION CENTER	2 E	eet address, chiy, state, zip code de cary sy infield, no 27823 providers plan of corre	CTION	CONVICTIO
PREFIX TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LEG IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		DATE
F 309			F309 ,	Continued From page 14		4/25/13
	technique. Denies a	ed with aseptic (sterile) ny pain or discomfort to right		each shift until resolved utili	zing an	
		shift. Resident made aware trasound to Mondey 2/25/13.		Acute Change Assessment M	_	
	A leisohone Interview	www.conducted with the		QI Tool. All identified areas of will be corrected by the DON		
	Nuise # 1 on 3/28/13	3 at 2:46 PM. The nurse the rescheduled appointment		nurse and treatment nurse.	•	
	and remembered sh missed appointment member when she c	e told the resident about the and also told a family ame in later that evening, but he called the resident's		The Director of Nursing will a audit results of the Acute Change/Assessment Monito Tool and present to the Qua	rlng Qi	
	documented: reside therapy. PICC line to flushes well. No frit Pallent continues to right arm is elevated time. Right arm ultra as previously docum	on 2/23/13 at 12:32 PM ent remains on antibiotic oright arm remains intact, ation or redness at elle. have swelling in right arm, i, propped on pillow at this asound has been scheduled tented. No acute distress thed afebrile (no elevated shift.		Improvement Committee M monthly. Subsequent plans of will be developed by the Con when required. Identification potential trends will be used determine the need for action frequency of continued mon The Director of Nursing is re	eeting of action mmittee on of any to on and/or litoring.	
	Resident was sent of emergency room) at positive reading of the blood clot) to right at (name of radiotogist right erm at 5 PM. In (name of nurse from office). Nurse also Inurse) that resident (Name of resident to send resident out	nurse note of 2/26/13 at 10:04 PM revealed; sident was sent out to (name of hospital lergency room) at 6 PM per MD orders for sitive reading of DVT (deep vein thrombosis, od clot) to right arm. Nurse received call from time of radiologist), that resident have DVT to not arm at 5 PM. Nurse also received call from time of nurse from resident 's physician 's ce). Nurse also informed (Physician 's office res) that resident had a DVT to right arm. arms of resident 's physician's gave new orders sand resident out to ER. Resident was insported to (name of hospitat's emergency		for overall compliance.		

CENTE	iment of health a RS FOR Medicare &	IND HUMAN SERVICES MEDICAID SERVICES				RINTED: 04/12/201: FORM APPROVED
STATEMENT	of Deficiencies A Correction	(X1) PROVIDER/SUPPLIER/CLIA EDENTIFICATION NUMBER:	(X2) 1,000 A, GUILO	LTIPLE CONSTRUCTION DING		MB NO. 0938-038: 3) PATE SURVEY COMPLUTED
		345101	8. W/KG		!	
	novider or supplier Oaks Nursing and R	EHABILITATION CENTER		STREET ADDRESS, CRY, STATE, 20 208 CARY ST ENFIELD, NC 27823	IP CODE	03/28/2013
(X4) ID PREPIX YAG	EPIX (GACIL DEFICIENCY MUST BE PRECEDED BY FIRE		ID PREF TAG	IX (EACH CORRECTIVA CROSS-REFERENCES	W OF CORRECTION E ACTION SHOULD 69 O TO THE APPROPRIATE CIERCY)	COMPLETION DATE
	room) by EMS via str of the facility for an a back to facility for an a back to facility at abo service) came to the the ultrasound was darm. About 2 PM, the the nurse that the right was clotted, An interview was comphysician on 3/28/13 stated he didn't remeithe ultresound couldnesscheduled. The physholified, he would have hospital for the test at Monday. An interview was computed in the ultresound couldnesscheduled. The physholified, he would have hospital for the test at Monday. An interview was computed the physician was able to be done as soil 2). Resident #61 was 1/30/13 and readmitte hospital return of 3/7/1 thromboemboilsm will (blood clot) on the right Review of a physician (2/22/13) to (edema to right arm an (antibiotic) therapy as (antibiotic) therapy	retcher. Resident was out ppointment and returned ut 1 PM. (Name of rediclogy facility about 1:30 PM and one on the resident 's right a X-ray technician came to minery report and stated to the arm axilita (arm pit) area ducted with the resident 's at 4:05 PM. The physician miber receiving any call that i't be done on the day it was iclan stated that if he was are sent the resident to the not have waited until ducted with the Director of 18/13 at 4:25 PM. The DON d the nurses would have then the ultrasound wasn't heduled. admitted to the facility on d 3/7/13. Diagnoses on 13 included a venoue a deep vein thrombosis and subclavian vein. 's verbal order, dated order written as "Send ound to right arm in the rules out) blood clot. RE: d hand. Confinue				

CENTER	IS FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES	·····		PRINTED: 04/12/0 FORM APPRO OMB NO. 0938-0
NO PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:	(X2) MULTIP A BURDING	COMPLETED	
		346101	8. WANG	The animals deining state, which a substance or property or property or the state of the state o	D3/28/2013
	rovider or supplier Oaks hursing and r	ehabilitation center	1	REST ADDRESS, CITY, STATE, ZIP CODE 208 CARY ST ENFIELD, NC 27823	03/20/2013
(X4) IO PREFIX TAG	(EACH DEFICIENC	Ateuent of Deficiencies Ly Must be preceded by Full LSC Identifying Information	ID PREFIX YAG	Provider's Play of Correc (Each Corrective action sko Cross-referenced to the Appr Deficiency)	ULO BE coupler
F 309	Continued From pag- patent."	e 16			
1	revealed the resident (ewollen) and slightly assessed the resident and patent, the resident and patent, the resident's arm was el on-call physician was new orders were reck (intravenous) antibot patent and send resident tolerated the difficulty. PICC patent Resident stated she's discomfort to her righ or symptoms of respit.	ic while the PICC line was dent out for an ultrasound in at a blood clot. At 10 PM, IV antiblotic without at and flushing wall, experiencing less term than earlier. No signs ratory distress noted, a keep right arm elevated on			
	revealed in part: (Nai reacheduled ultrasour patent and intact, no s infection to insertion s	ite, cleansed with aseptic enles any pain or discomfort			
	documented: residentherapy, PICC line to flushes well. No irrita Patient continues to hight arm is elevated, time. Right arm ultres	on 2/23/13 at 12:32 PM It remains on antibiotic right erm remains intact, ition or redness at site, ave swelling in right erm, propped on pillow at this round has been scheduled inted. No actite distress			

PRINTED: 04/12/2013 FORM APPROVED

STATEMENT	of deficiencies Correction	MEDICAID SERVICES (X1) PROVIDER/SUPPLIET/CUA (DENTIFICATION NUMBER:	(XŽ) MUL A. BUILD:	TIPLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		345101				
	Ovider or Supplier DAKS Nursing and R	EHABILITATION CENTER		SYREGY ADDRESS, CITY, STATE, ZIP CO 208 CARY ST ENFIELD, NG 27823		128/2013
(X4) ID PREFIX YAG	(EACH DEFICIENC	ratement of deficiencies by must be preceded by full lac (dentifying information)	ID PREFI TAG		ION SHOULD BE INE APPROPRIATE	COMPLETE DATE
F 312 88-D	noted. Patient remail temperature) during: A nurse note of 2/25; part: About 2 PM, it the nurse with a prelit ultrasound) and state erm.exitla (arm pit) a was sont out to (nam room) at 8 PM per M of DVT (deep vein the arm. Review of the resider revealed no document regarding the condition of 2/22/13 for the 11 AM to 3 PM shift; on shift; no documentation on 2/26/13. An interview was con Nursing (DON) on 3/2 reported she expected the condition of the reshift. 483.25(a)(3) ADL CADEPENDENT RESID	ined alebrile (no elevated shift. 113 at 10:04 PM revealed in the X-ray technician came to minary report (from an ed to the nurse that the right rea was clotted. Resident e of hospital emergency Dorders for positive reading rombosis, blood clot) to right that 's medical record that one of the resident's right PM to 7 AM shift and the 7 2/23/13 for the 7 AM to 3 PM on for any shift on 2/24/13; on for the 7 AM to 3 PM shift that the ducted with the Director of 28/13 at 4:25 PM. The DON of nurses to document on eskient's right arm every	F312		to be followed 2 was seen by	4/25/18
	This REQUIREMENT	REMENT is not met as evidenced		for oral care. No areas with mouth care were		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/12/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) AUCTRILE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING _ and delivered the Popular Contract Agent Services and advanced 345101 B. WHO 03/28/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, SYATE, ZIP CODE 208 CARY ST ENFIELD OAKS NURSING AND REHABILITATION CENTER ENFIELD, NC 27823 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED YO THE APPROPRIATE (X5) COUPLETION DATE DEFICIENCY Continued From page 18 4/25/13 F 312 F312 Continued From page 18 Resident #2 was referred for a dental bv: Based on observation, record review and staff consultation by the DON on interviews, the facility falled to provide complete 4/3/2013. oral care for 1 (Resident #2) of 1 sampled residents requiring extensive assistance for 100% audit of all residents to include Activities of Dally Living (ADLs). resident #2 was completed to assess Findings Include: for oral care to include need of Resident #2 was admitted to the facility on dental consultation on 4/3/2013 by 12/05/12. Cumulative diagnoses included the DON and MDS nurse to ensure cerebral vescular accident (CVA/stroke). oral care was provided. All identified dementia, and depression, areas of concern were immediately addressed and corrected by the DON. Review of Resident #2 's annual Minimum Data Set (MDS) assessment, dated 01/07/13, Indicated An inservice was initiated on the resident was cognitively impaired, unable to make dally decisions, required extensive 3/28/2013 for all CNAs and licensed assistence with bathing and personal hygiene. nurses to include NA #3 by the DON and was impaired on both the right and left upper regarding providing oral care and and lower extremities notification to the nurse if there are areas of concern. All newly hired Review of the Resident #2 * s care plan, updated CNAs and licensed nurses will be 01/07/13, revealed an area of need as a care deficit for teeth or oral cavity that could be seen inserviced by the DON regarding oral by potential problems with the teeth and gums care during orientation. due to the resident's health condition. One of the interventions listed was to provide oral The staff facilitator, MDS nurse, and hygiene. DON will review resident's oral care to include resident #2, 5 times a 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

approximately the size of a quarter noted on the

An observation, on 03/27/13 at 9:55 AM, revealed

Resident #2 to have a white paste like substance

noted to have white paste like substance

lower right teeth and gum area,

Nursing.

week x 4 weeks, and then weekly x 4

residents receive oral care utilizing an

and then monthly x 2 to ensure all

Oral Care Resident Care Audit Qi

Tool. All identified areas of concern will be correct by the Director of

		(X1) PROVIDER/SUPPLIER/SUA IOGNIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		e survey Pleted
• • • •	• • • • • • •	345101 0.WAY9		03	1/28/2013	
	ovider or supplier Oaks nursing and	REHABILITATION CENTER	20	eet adoress, chy, staye, zip cc 18 cary 8 t NFIELD, NC 27823	ODE	
(X4)1D PREFIX TAG	Summary Statement of Deficiencies (Each deficiency nuet be preceded by full regulatory or LSC identifying information		ID PREFIX YAU	Proyders Play of Leach Corrective ac Cross-Referenced to Deficien	tion should be The appropilate	COMPLETAN DATE
f 312	approximately the lower right teeth at stated he had had An observation, or the Resident #2 to substance approximated on the lower of the Resident #2 to substance approximated on the lower resident stated he An observation, or made of Resident wheelchair. The twitte paste like stof a quarter noted gum area. An observation, or made of Resident NA #3 confirmed and indicated it is morning. NA #3 Resident #2 to be reported during the had bleed a little. An observation, or made of Resident confirmed the rescare given.	size of a quarter noted on the nd gum area. The resident had breakfast a little earlier. n 03/27/13 at 4:00 PM, revealed thave a white paste like imately the size of a quarter right teeth and gum area. n 03/28/13 at 7:55 AM, revealed have a white paste like imately the size of a quarter right teeth and gum area. The was welting for breakfast. n 03/28/13 at 11:40 AM, was #2 dressed and up in his resident was noted to have a ubstance approximately the size I on the lower right teeth and n 03/28/13 at 11:45 AM, was the resident needed mouth care hould have been done this stated that she had assisted ush his teeth last eventing and he brushing Resident #2 *s gums	F 312	The Director of Nursing audit results of the Oracare Audit QI Tool and Quality Improvement of Meeting monthly. Substantial action will be developed to the committee when requisite the committee when requisite the committee when the committee when the committee when results and/or frequent monitoring. The Direct responsible for overall substantial action and/or frequent monitoring.	al Care Resident I present to the Committee sequent plans of ed by the lired. otential trends line the need for cy of continued tor of Nursing is	

CENTERS FOR MEDICARE & MEDICAID SERVICES TAYBURNT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA		T			OMB NO. 0938-03		
NO PLAN O	F CORRECTION	(X1) PROVIDENSUPPLIENCUA IDENTIFICATION NUMBER:	A. BUILD:		CONSTRUCTION	COMPLETED	
		345101	B. WING		Marked Street, and the street,	03/28/2013	
NAME OF PE	ROYDER OR SUPPLIER			STRE	et address, city, state, zip code		TRUIZUIU
enfield	oaks nursing and F	EHABILITATION CENTER		20	8 CARY ST VPIELD, NG 27823		
(X4) ID PREFIX TAG	(EACH DEFICIENC	tatement of deficiencies Dy must be preceded by full Leg identifying hiforiaation)	IO PRESID TAG		Provider's Plan of Correction (each competive action should be cross-referenced to the approprial deficiency)		COMPLETIO OAYE
	expected the staff to unable to do oral car his self. She continu staff to notice a visua mouth and provided	ficated she would have assist a resident who is e or to complete the care by led she would have expected at build up in the resident's care.	F3				
F 314 SS=G	resident, the facility r who enters the facility does not develop pre- individual's clinical co they were unavoidab pressure sores recei	ESSURE SORES elicusive assessment of a must ensure that a resident y without pressure sores essure sores unless the public demonstrates that item is and a resident having was necessary treatment and tealing, prevent infection and	F3	314	Resident #61 was provided foot can by the assigned CNA on 3/28/13 are will continue to receive foot care p facility policy. Resident #61 bilaters feet were assessed by the DON and Facility Consultant on 3/28/13 and the Wound Care Consultants on 4/1/13, 4/2/13, and 4/3/13. The M was notified of resident #61 bilater feet unstageable pressure ulcers by the treatment nurse on 3/28/13.	nd er al 1 by D al	4/25/13
b; E re a: o:	by: Based on observation record reviews, the fassess, and treat 3 u	I is not met as evidenced ons, staff interviews, and callify failed to Identify, astageable pressure ulcers of 2 sampled residents with			Resident # 61 was sent to the wour 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.		
1	1/30/13 and readmitted. Review of the hospite 2/26/13 revealed the being followed by the hospital for a stage IV right isohial pressure.	Imitted to the facility on ed to the facility on 3/7/13. If History and Physical of resident the resident was wound care center at the / sacrel pressure ulcer and ulcer. Additional diagnoses tom the waist down to the			A 100% body assessment of all residents to include resident # 61 w completed by the treatment nurse, Wound Care Consultant, and RN Charge Nurse on 4/2/13. The MD w immediately notified of all identifie areas of concern by the treatment nurse.	vas	

PRINTEO: 04/12/2013 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES Statement of deficiencies and plan of correction (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED (X3) MULTIPLE CONSTRUCTION V ONEDMO " 345101 03/28/2013 HAVE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 208 CARY ST ENFIELD OAKS NURSING AND REHABILITATION CENTER ENFIELD, NC 27823 PROVIDER'S PLAY OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BU CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES io Prefix Tag CONSTRUCTION DATE (EACH DEFICIENCY MUST DE PRECEDED BY FULL REGULATORY OR LSO IOENTIFYING INFORMATION) DEFICIENCY 4/25/13 Continued From page 21 F 314 Continued From page 21 F 314 On 3/28/13 an inservice was initiated lower extremities. by the Director of Nursing with all **CNAs and License Nurses regarding** Review of a Nurse Admission Assessment of 1/30/13 revealed a stage IV pressure ofcer of the prevention intervention, routine skin right rear thigh that measured 2,7 cm (cubic check observation, reporting changes centimeters) by 2.0 cm x 3.0 cm deep. The and abnormalities in residents to resident was also assessed as having had a state include skin abnormalities, foot care, IV pressure ulcer of the sacrum that measured notification of acute changes in 11.5 cm x 12.6 cm x 3.0 cm deep. condition to include skin condition, and skin alerts. An inservice with all An observation was made of the wound treatment for the resident's sacrum on 3/28/13 at 11:30 licensed nurses was initiated on AM with the treatment nurse. When the resident 4/18/13 by the DON regarding was turned to her left side, her left outer ankle completing skin referral forms. All was exposed and a blackened area of 2.5 inches newly hired CNAs and License Nurses was noted over the bone. The treatment nurse will be inserviced regarding stated she was unaware of the area. During prevention intervention, routine skin additional observation of the resident's feet revealed the resident's left inner heel had a checks, observation and reporting darkened, purple colored circular area. The changes and abnormalities in trealment nurse reported the skin under the area residents to include skin was soft. Observation of the resident's right abnormalities, foot care, notification heel revealed a darkened, purple colored circular of acute changes in condition to area. On the center to outer right heel was a dark Include skin condition, skin alters, and purple colored area covered by dry peeling skin and also surrounded the area. The resident's skin referral forms by the DON during feet were covered by multiple dry hardened orientation. paeling skin on her toes, tops of her feet, and bolloms of each looi. The treatment nurse Skin checks on all residents to include reported she was unaware of the areas of the resident # 61 will be completed by the resident's heals. CNAs daily during routine care. If any During an observation of the resident's right abnormalities are noted the CNA will ankle and heels with the Director of Nursing

(DON) on 3/28/13 at 11:45 AM, the DON reported the creas on the resident 's heels were unstageable pressure ulcers and requested the resident 's feet were thoroughly washed and complete a skin alert. Licensed nurses

		MEDICAID SERVICES		· · · · · · · · · · · · · · · · · · ·	- OWID IN	Q, 0938-03	
Statement And Plan Oi	TATEMENT OF DEFICIENCIES (XI) PROVIDENSUPPLIENCUA NO PLAN OF CORRECTION (CENTURY CATION NUMBER:		A BUILDING	CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		345101	B. WANG		0:	/28/2013	
	rowder or supplier OAKS NURSING AND R	EHABILITATION GENYER	2	eet address, city, state, 21P code 88 cary st Infield, NC 27823			
(XO ID PREFIX YAG	(EACH DEFICIENC	Atement of deficiencies Y must be preceded by full LSC identifying information	ID Prefox Yag	Providents Plan of Co (Each Corrective action Cross-referenced to the Deficiency)	SKOULD BE	CONSTELX CATE	
F 314	fotion applied During an observatio ankie and heels with Consultant at 2:30 Pri area of the right ankik area with the top layer discoloration of the hend Nurse Consultan probably Stage IV promited and document areas on the resident the observation on 3/20/16 pm, the NA regwash resident's feet of the resident of the res	n of the resident's right the DON and Nurse M on 3/28/13, the blackened is was opened in a circular or of skin removed. The eals remelhed. The DON to stated the heels were essure ulcers and the right pressure ulcer. It's medical record attetion was recorded for the table of the east and ankle prior to 28/13. Ith NA #1 on 3/28/13 at eached NAs were expected to every day with their bath and it not look like they have not the east of t	F 314	Continued From page 22 will assess all residents w alerts, complete a skin re and treat according to the or facility protocol for all abnormalities noted. The nurse will review the skin form and ensure the skin abnormality has been ass treated according to the facility protocol. The Trea Nurse and RN Charge nur assess all residents to inc resident #61 weekly x 4 v weekly x 4 weeks, and th x 2 months to ensure all abnormalities have been and treated per physiciar facility protocol utilizing: Qi Tool. Any identified ar concern will be addresse immediately by the Treat or RN Charge nurse. The review the Skin Check Qi weekly x 4 weeks, Bi wee weeks, and Monthly x 4 t completion. The Director of Nursing v audit results of the Skin of Monitoring Qi Tool and p the Quality Improvemen Meeting monthly, Subse of action will be develop Committee when require	ferral form, e MD order skin treatment referral sessed and MD order or atment sessed will dude weeks, Bl en Monthly skin assessed n's order or a Skin Check reas of d tment Nurse DON will Tools ekly x 4 for will compile Check present to t Committee quent plans ed by the	4/25/13	

Syatement of Depiciencies And Plan of Correction		(X1) PROVIDENSUPPLIERICUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUALDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345101	8.WN0			03/	28/2013
	lowder or supplier Oaks Nursing and R	ehabilitation center		2	ieey address, city, state. 2ip code 88 Cary 6t Infield, HC 27823		
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F 329	Each resident's drug unnecessary drugs. drug when used in e duplicate therapy); o without adequate mo indications for its use adverse consequences and the reduced o combinations of the sead on a comprei resident, the facility in who have not used a given these drugs or therapy is necessary as diagnosed and direcord; and resident drugs receive graduly behavioral interventicontraindicated, in a drugs. This REQUIREMENT by: Based on observationally fail the physician the resident of the facility fail the physician the resident on the facility fail the physician the resident of the sead of the callity fail the physician the resident of the sead of t	regimen must be free from An unnecessary drug is any scessive dose (including for excessive duration; or mitoring; or without adequate s; or in the presence of ses which indicate the dose or discontinued; or any	F329		Continued From page 23 Identification of any potential tree will be used to determine the nee action and/or frequency of contin monitoring. The Director of Nursis responsible for overall compliance Resident #36 PT/INR was obtaine 4/11/13 and results were reporte the physician upon receipt on 4/1 by the Charge Nurse. Resident #3 PT/INR will continue to be monitor related to Coumadin use per physician's order and results will reported to the physician immedi by the charge nurse. A 100% audit of all resident's to include residents on Coumadin ai resident #36 lab orders for the 30 days to include PT/INRs was initiated by the Director of Nursi treatment nurse, and MOS nurse 4/4/13 to ensure tabs have been drawn per physician's order on si days and physician notified of re All identified areas of concern we immediately corrected by the Dir of Nursing. An inservice was initiated on 4/17/2013 for all licensed nurses the Director of Nursing regarding	d for ued ng is e, d on d to .2/13 6 ored be last on pecific sults. ere rector	4/25/13
	•	idmitted to the facility on			notifying the physician timely of		

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES				POR OMBNO	ED: 04/12/2013 MAPPROVES O. 0938-039
VIO L'VII O	of deficiencies correction	(XI) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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ENFIELD		ehabilitation center		:	reet adoress, city, state, zip code 208 cary st Enfield, no 27823		9/20/2013
(XA) ID PREFIX YAG	(EACH DEFICIENC	atement of deficiencies y must be preceded by full isc identation information	ID PREF TAG	ΙX	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE
	of cerebral vascular a bilateral (both lungs); clot in the lung). Record review of the j March 2013, revealed Coumadin. Lexicomp's Geriatric edition stated that the Warfarin was anticoar medication". "The in: Practices [ISMP] incluits list of drugs which it causing significant parerror." The Food and Drug A given its strongest was known as a "U.S Box "May cause mejor or fill was a mejor or fill was a medicated in Coumadin (Massociated with an included in Coumadin (Massociated with an included in Coumadin (Massociated with an included in Coumadin (Massociated with a line along with calculation normalized ration (INR every patient receiving Adjustments in the Coupon whether or not thrange. "The reference of on enticoagulation	tive diagnoses of s metilitus, previous history coldent and previous pulmonary embolism [blood physician 's orders for it the resident was on Dosage Handbook, 17th pharmacologic category of pulant and a "high elert stitute for Safe Medication des this medication among have a heightened risk of the stitute for Safe Medication des this medication end was the medication end of the harm when used in diministration (FDA) had rening on this medication end Warning which stead at bleeding." Por (prothrobin timo) and malized ratio). Lexicomps ratory Medicine 3rd edition /arfarin) thorapy is reased PT. In fact, the PT of the international to should be followed in the Coumadin therapy. Jamadin dose are based to range [INR] for patients is 0.8-1.2; the reference coumadin is 2.0-3.0 for the		329	Continued From page 24 results, obtaining labs to include PT/INRs for Coumadin monitoring physician order on specific days, a notifying the MD of refusals or an unsuccessful draws. All newly hir licensed nurses will be in serviced regarding notifying the physician timely of lab results, obtaining lab include PT/INRs for Coumadin monitoring per physician order or specific days, and notifying the M refusals or any unsuccessful draw during orientation by the Director Nursing. All new lab orders for all residents include resident #36 to include PT for Coumadin monitoring will be reviewed by the lab nurse and documented on the daily lab log of The Director of Nursing will review daily lab log to ensure labs have b drawn timely per physician notified immediately of results and Physic notified of refusals or unsuccessfu draws utilizing a Laboratory Log Monitoring Qi tool weekly x4 wee then bi-weekly x4 weeks then mo x 2 months. All identified areas of concern will be correct by the Dire of Nursing.	and y ed os to n D of s of s of laily. w the neen s on lian ul lab	4/25/13

PRINTED: 04/12/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DAYE BUKVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ B. WANG 03/28/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COUG 208 CARY ST ENFIELD OAKS NURSING AND REHABILITATION CENTER ENFIELD, NC 27823 PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION) (X4)10 PREFIX TAG (XS) HONTE FRANCO BIAD PREFIX 4/25/13 Continued From page 25 P 329 Continued From page 25 F 320 The Director of Nursing will compile Record review of the resident's chart revealed audit results of the Laboratory Log that Werferin 7.5 mg (milligrams) one tablet at Monitoring QI Tool and present to the bedtime was prescribed on 12/11/12. Laboratory **Quality Improvement Committee** results from 12/30/12 revealed an INR of 1.5 and a new order on 12/27/12 revealed the dose was Meeting monthly. Subsequent plans Increased to 8 mg daily; and recheck PT/INR on of action will be developed by the Monday (12/31/12). The INR drawn on 12/31/12 and reported on 01/01/13 was 4.2 [High]. The Committee when required. Identification of any potential trends physician assistant (PA) on call ordered that the will be used to determine the need for dose of Warferin be held (not given) for 2 days, action and/or frequency of continued and recheck PT/INR the next day, 01/03/12. monitoring. The Director of Nursing is Record review of the MAR (medication administration record revealed the dose was held responsible for overall compliance. 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 bedlime, Recheck PT/INR in one week

PRINTED: 04/12/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (EX) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERUSUPPLIERICUA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BILLIOING 345101 03/28/2013 NAME OF PROVIDER OR SUPPLIER Street aduress, City, State, Zip Code 208 CARY ST ENFIELD OAKS NURSING AND REHABILITATION CENTER ENFIELD, NO 27823 PROVIDER'S PLAY OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X4) ID PREFIX YAG SUMMARY STATEMENT OF DEFICIENCIES (x5) Completion Date (EACH DEFICIENCY MUST DE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG F 329 Continued From page 26 F 329 (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 talephone 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 The physician instructed to continue with the 8 mg of Warfarin and to recheck PT/INR in one week [02/08/13] The draw was done on 02/08/13 but the lab report said that the specimen volume was

Statement of Deficiencies And Plan of Correction		IX11 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPETED (x3) DATE SURVEY		
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	oaks nursing and re	EHABILITATION CENTER		208	it addréss, city, ôtate, zip code Cary ôt Field, NC 27823		1129,20	
(X4) ID PREFIX TAO	HX (EACH DEFICIENCY MUST DE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE		Providers plan of correction (Each Corrective action shourd Cross-referenced to the approp Deficiency)	N SHOULD DU COUNTERD APPROPRIATE DATE		
F 329	facility on 02/07/13 at was done until 02/10// discovered. In an interview with the 03/27/13 at 11 AM, at treatment nurse cann expectation was that should be notified so specimen. The "insu notification should not acted on as soon as if on the fax machine. A telephone order on assistant (PA) indicates should be held until the office of the condition of the condition of the condition of the assay of against atted as "insu redraw was not done, held" from 02/10/13(as 1.1; a telephone or stated to resume the 6 PT/INR in one week [if the poorted to have a PT.	ad. This was reported to the 5:35 A.M but no redraw 13 when the error was 19 when the first the ot get the draw, her she or one of the RNs they can try to get the fifcient specimen" to eignored but should be the was received by the facility 19 was error when the PT/INR of the Warferin dose we rosults from the PT/INR of the was driven to the hospital reported back as 6.68 wild the dose until Monday the PT/INR. It was driven to the hospital reported back as 6.68 will the dose until Monday the TrinkR. It was continued to be sunday) though 02/14/13 the another specimen was and the INR was reported der from the physician 3 mg dose and recheck 19/12/6/13, it was 1/INR value of 4.7 [High], wheed and ordered the dose	F	329				

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NCY MUST BE PRECEDED BY FULL	IO PREFIX YAG	(EACH CORRECTIVE ACTION SHOUL	DBG COUPLETION
101/13 [Saturday] revealed the is 2.3 [High], although the facility at 5:35 AM, it was anding physician until 03/04/13 is continue same dose (8 mg), at the resident did not receive /01/13 through 03/ 03/13 and on 03/04/13 reveals that the creased to 6 mg and recheck k. There was no the conflict in the orders. d' for the doses on 03/01/13 in 03/12/13 indicated the INR dephone order stated in 8 mg daily and recheck in is 8 mg daily and recheck in in 6 mg daily at 1.76 at	F364	steam table and stove top were immediately thrown away on 3, by the Dietary Manager. The st table temperature was adjusted the Dietary Manager on 3/27/1 Dietary staff was inserviced by the Dietary Manager regarding not exposing foods to prolong heat steam table and stove top and checking food temps on 4/16/1 newly hired dietary staff will be inserviced regarding not exposi foods to prolong heat on the st table and stove top and checking temps during orientation. Food temperatures will be recompained by the cook twice during meal to when the food is finished cooking prior to serving and the food temperature will be recorded of Food temperature Log. The Die Manager will review the Food temperature Log 3 x per week x 4 weeks then 2 x per week x 4 weeks then 2 x per week during	/27/13 eam I by 3. he on the 3. All ng eam ig food rded imes, ng and n the tary
	REHABILITATION CENTER STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL RESCIDENTIFYING INFORMATIONS INGO 28 (01/13 [Saturday] revealed the as 2.3 [High], silhough the as 2.3 [High], silhough the defallity at 5:35 AM, it was ending physician until 03/04/13 as continue same dose (8 mg), at the resident did not receive /01/13 through 03/03/13 and on 03/04/13 reveals that the preased to 6 mg and recheck k. There was no the conflict in the orders. d' for the doses on 03/01/13 In 03/12/13 indicated the INR tephone order stated in 6 mg daity and recheck in as an daity and recheck in as an energy of the conflict in the orders. In 6 mg daity and recheck in as an energy of the conflict in the orders and on 03/20/13 at 5:35 AM, are was elevated at 5.0 [High], orders to hold the dose for 2 one Friday (03/22/13). The period revealed that doses 20/13 through 03/24/13 with anys rather than 2days. The period revealed that doses 20/13 through 03/24/13 with anys rather than 2days. The period revealed that doses 20/13 through 03/24/13 with anys rather than 2days. The period revealed that doses 20/13 through 03/24/13 with anys rather than 2days. The period revealed that doses 20/13 through 03/24/13 with anys rather than 2days. The period revealed that doses 20/13 through 03/24/13 with anys rather than 2days. The period revealed that doses 20/13 through 03/24/13 with anys rather than 2days. The period revealed that doses 20/13 through 03/24/13 with anys rather than 2days. The period revealed that doses 20/13 through 03/24/13 with anys rather than 2days. The period revealed that doses 20/13 through 03/24/13 with anys rather than 2days. The period revealed that doses 20/13 through 03/24/13 with anys rather than 2days. The period revealed that doses 20/13 through 03/24/13 with anys rather than 2days. The period revealed that doses 20/13 through 03/24/13 with anys rather than 2days.	REHABILITATION CENTER STATEMENT OF DEFICIENCIES SYNTEMENT OF DEFICE OF DEF	MEDICAID SERVICES (X1) PROVIDERS PRINCIPLE CONSTRUCTION A BULDING STREET ADDRESS, CITY, STATE, 2IP CODE 288 CARY ST EMPIRED, NO 27823 STATEMENT OF DEFICIENCIES STATEMENT OF CORRECT (EACH CORRECTIVE ACTION OF SHAPE (EACH CORRECTIVE ACTION OF SHAPE (EACH CORRECTIVE ACTION OF THE APPROXI CROSS-REFERENCE OF TO THE APPROXI CROSS-REFERENCE OF THE OF THE APPROXI CROCK TO THE APPROXI CROCK TORS THE BIELD, NO 27823 The beans and peas that were exposed to prolonged heat on the steam table and stove top many by the Dietary Manager on 3/27/1 DIETARY Manager regarding not exposing foods to prolong heat steam table and stove top and checking food temps on 4/16/1 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 on 4/16/1 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 on 4/16/1 newly hired dietary staff will be inserviced regarding not exposing foods to prolong heat on the steam table

PRINTED; 04/12/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0301 (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION A BUILDING 346101 D. WNG 03/28/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 208 CARY 8T ENFIELD OAKS NURSING AND REHABILITATION CENTER ENFIELD, NO 27823 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) ID Prefix DAYE CONSCEANH (XI) (X4) IO PRGFAX 4/25/13 Continued From page 29 F364 F 329 Continued From page 29 food is not exposed to prolong heat draw was unsuccessful the Director of Nursing on the steam table and stove top should be notified immediately. utilizing a Food Temp Monitoring QI 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, F 364 Tool. All Identified areas of concerns PALATABLE/PREFER TEMP will be immediately corrected by the Each resident receives and the facility provides Dietary Manager. food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is The Administrator will compile audit palalable, altractive, and at the proper results of the Food Temp Monitoring lemperature. QI Tool and present to the Quality Improvement Committee Meeting This REQUIREMENT is not met as evidenced monthly. Subsequent plans of action will be developed by the Committee Based on observations and staff interviews, the when required, identification of any facility failed to preserve the vitamin and mineral potential trends will be used to content of time beens and peus by exposing it to determine the need for action and/or prolonged heat on the steam table and stove top. frequency of continued monitoring. Findings included: The administrator is responsible for Food temperatures wore taken at the steam table overall compliance. on 3/27/13 at 11:30 AM with the Dietary Manager, A calibrated thermometer inserted into a pan of Kitchen can opener was cleaned by 4/25/13 F371 lima beans registered at 202 degrees Fahrenheit the dietary manager on 3/25/13. on the A calibrated thermometer inserted into a Butter pats stored on the top shelf of pot of green peas on the stove top registered at 211 degrees Fehrenhelt. The inside of the pot of freezer were discarded by dietary pess had a darkened brown ring of 1/4 inch manager on 3/25/13. above the level of the peas. The liquid around the edge of the peas was bubbling. During an 100% audit of the kitchen was interview with the cook, the cook reported she completed by the Dietary Manager had started heating the vegetables at 10:30 AM. on 3/25/13 to ensure all equipment was clean and items were stored An Interview with the Dietary Manager on 3/27/13 properly. There were no identified at 11:45 AM, the Manager reported both vegetables were leftovers from the day before. areas of concern.

FORUA CISS-2557(02-07) Provious Versions Obsettes

The Manager stated the vegetables at those temperatures would no longer have had any

Event ID: 74WG11

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If continuation sheet Page 30 of 33

DEPART	iment of health ai	ND HUMAN SERVICES			PRINT FO	'ED: 04/12/2010 RM APPROVED
		MEDICAID SERVICES			OMB :	NO. 0938-0391
Statement of Deficiencies and Plan of Correction		(XI) PROVIDERSUPPLIERCLIA IDENTIFICATION HUMBER:		ltiple construction Ding	(X3) D/	NTE SURVEY MPLETED
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ENFIELD	OAKS NURSING AND RE	ehabilitation center		203 CARY ST ENFIELD, NO 27823		
(X4) 10 PREFIX TAG	(EACH DEFICIENC)	atement of depiciencies y must be preceded by full scidentifying information	ID PREF TAG	IX (EACH CORRECTIVE ACT)	ON SHOULD BE SE APPROPRIATE	COTATE ION OVE
F 364 F 371 SS=E	nutritive velue and ne 483.35(i) FOOD PRO STORE/PREPARE/S The facility must - (1) Procure food from considered sallsfactor authorities; and	eded discarded. CURE, ERVE - SANITARY sources approved or ry by Federal, State or local	F371	Continued From page 3 100% In-servicing with the staff was initiated on 4/dietary manager regard storage and equipment include can opener cleaning for and equipment cleanling can opener cleanling can opener cleanling.	he dietary (18/13 by the ing food cleanliness to nilness. All f will be ad storage ess to include	4/25/13
	by: Based on observation facility falled to mainte clean condition, and it butter pats free of spite Findings included: An observation was m on 3/25/13 at 9:43 AM ontice on the cardboard-type containmatter inside the confided gray/black the blade. The face of the cardboard-type containmatter inside the confided gray/black the blade. The face of the cardboard-type containmatter inside the confided gray/black the blade. The face of the cardboard-type containmatter inside the confidence of the cardboard-type containmatter inside the cardboard-type	ade of the klichen freezer and revealed two rows of he lop shelf. One of the ners had splatters of brown		The dietary manager an administrator will review 3x per week x4 weeks, 4 weeks, 4 weeks, then weekly x4 cleanliness of equipmer can opener cleanliness storage utilizing dietary tool. The facility administrate compile audit results of sanitation QI Tool and p Quality improvement Competing monthly. Substof action will be develop Committee when required the for action and/or frequents.	w the kitchen ex per week x is weeks for at to include and food sanitation Qi or will the dietary present to the committee equent plans and by the red. It is the need ency of	
	3/26/13 at 12:45 PM 1	ih the Distary Manager on he Manager staled staff n the can opener after each	***************************************	continued monitoring. I administrator is respon- overall compliance.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TAXGULARY OF DISCUSSION FOR MAIN PROPERTIES HER MAIN PROPERTIES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OWB MO). 0938-03	
Statement of Deficiencies and plan of Courection		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUS A. BUSEC		E CONSTRUCTION	(X3) OATE SURVEY COMPLETED		
346101			S. WING	0. WING		03/	3/28/2013	
NAME OF PR	OWDER OR SUPPLIER			4	reef adoress, City, State, ZIP Code			
ENFIELD (DAKS NURSING AND RE	EHABILITATION CENTER			08 CARY SY			
				[INFIELD, NC 27823			
(X4) ID PREFIX TAG	STAMMENS (EACH DEFICIENC) REGULATORY OR I	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(35) COMPLETIC DATE		
F 371	Continued From page	×31	F450	5	A new lint filter was placed by		4/25/13	
		expect staff to store foods			maintenance director on 3/27/13	3.		
		ezer, and the tray of butter						
		d were expected to have	1		100% audit was completed on 4/	18/13		
	been discarded.	•			by Maintenance Manager and	,		
		tial equipment, safe			Administrator to ensure all launc	rv		
SS*E	OPERATING CONDI	TION			equipment to include all dryers a			
	The feether work and	afaba add a a a a afab			safe operating condition, All ider			
	The facility must melt mechanical, electrical				areas of concern were addressed			
	oquipment in sale op				immediately by Maintenance Dir			
	odoshmont at oard ob	oratory contribut.			initiediately by Maintellance Di	ECIOI.		
					100% in-service of laundry staff	was		
		is not met as evidenced	1		initiated 4/08/13 by housekeep			
	by:				and laundry district manager			
		ns and staff interviews, the ain 1 of 2 gas powered			regarding lint screen cleaning an	ri		
		operating condition,			work order protocol. Maintenan			
	Findings included:	Aboutum & considers			director was inserviced by	ve		
	· · · · · · · · · · · · · · · · · · ·				administrator on 4/18/13 regard	ina		
		laundry room on 3/27/13 at			completion of work orders and f	- 1		
		ciolhes dryers were used			•			
-	by the facility. The ta	undry aide reported she			broken equipment in a timely m			
	used both dryers. Th	e lint filter on the left dryer			All newly hired laundry staff will	be		
	was torn and hanging	to the base of the dryer, eported the need for a new			Inserviced regarding lint screen			
		eponed the need for a new 22/13) last week to the	- 1		cleaning and work order protoco			
		, but kept using the dryer.	- [during orientation by health care	2		
	memoriality billions.	t sor note band the arion.			services district manager.			
		n of the dryers with the						
		on 3/27/13 at 10 AM, the			100% in-servicing with CNAs, Nu	rses,		
		was aware of the lint filter			Dietary department, Therapy			
		Friday (3/22/13), but has not			Department, Administrator,			
	done enything about	แ ยร ชะ yet.			Maintenance Director, Admissio			
	At 3 PM on 3/27/13	furing an observation of the			Coordinator, Social Worker, Acti			
		with the Administrator, the			Director, Staff Coordinator, Acco	unts		
		d she expected the lint filter			Payable Bookkeeper, Accounts			
	should have been ord			Receivable Bookkeeper, and Tra	nsport			

	910111140101111	MEDIOWIN GELLAIOEO					
BTAYEMENT OF DEPICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENYIFICATION NUMBER:	V BOJFO		(X3) Date Survey Coupleted		
		946101	B. WING	B. WING			28/2013
	ovider or supplier Daks nursing and ri	EHABILITATION CENTER		20	eet adoress, city, state, zip code B cary st NFIELD, NC 27823		
(X4)10 Prefix TAG	WACH DEFICIENC	atement of deficiencies y wost dii preceded by firi. Leo identifyens information)	PREF	ID PROVIDER'S PLW OF CO PRIETX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		g NTE	(x4) Completich Date
F 458	Maintenance Director	r was made awere of the staff should not have used	¥.	456	Continued From page 32 Coordinator was initiated on 3/26 by the DON, MDS nurse, and administrator regarding work ordibe filled out immediately upon discovery of broken equipment. A newly hired CNAs, ficense nurses, dietary aids will be in serviced regarding work orders to be filled immediately upon discovery of broken equipment. The facility administrator and DON review facility environment 3x perweek x4 weeks, 2x per week x4 weeks, 2x per week x4 weeks to ensure, if filters on dryers in tact and work orders complete for equipment needing repair utilizing environmental Tool and present to the Quality improvement Committee Meeting monthly. Subsequent plans of activity developed by the Committe when required, identification of a potential trends will be used to determine the need for action and frequency of continued monitorin. The administrator is responsible for overall compliance.	ers to If and out oken I will recks, int ental gon ee ny I/or g.	4/25/13

PRINTED: 04/22/2013 FORM APPROVED OMB NO, 0938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) E	EDICAID SERVICES PROVIDER/SUPPLIER/CLIA DENYIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION 01 - MAIN BUILDING 0	1° '	DATE SURVEY COMPLETED	Y
		·	345101	B. WING			04/18/2013	3
	ROVIDER OR SUPPLIER OAKS NURSING AN	D RE	HABILITATION CENTER	2	REET ADDRESS, CITY, S 08 CARY ST NFIELD, NG 27823			۸
(X4) ID PREFIX TAG	(BACH DEFICIENCY	/ MUST	NT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATI EFICIENCY)	E DATE	TION
K 050	Continued From pa	ıge 1		. , K 050		ce Manger was inservice	b(2))	13
, ,					on 4/30/13 by Fact drill protocol.	lity administrator on fire	3 -	
	A. Based on obser interviewed did not 42 CFr 483.70 (a)	vatlo know	met as evidenced by: n on 04/18/2013 the staff the fire drill procedure.		Manager, MDS Nui Coordinator, Social	Worker, Accounts	e	ı
K 056 SS=D	If there is an autom	atic s	Y CODE STANDARD sprinkler system, it is with NEPA 13, Standard	K 056	Bookkeeper, Medic Coordinator, Licens	er, Accounts Receivable cal Records, Activities sed Nursing Staff, CNAs		
	for the Installation of provide completers building. The system	of Spr overz m ls	inkler Systems, to age for all portions of the properly maintained in			Staff was initiated on cordinator regarding fire		
	accordance with NI Inspection, Testing Water-Based Fire I	FPA 2 , and Protect	25, Standard for the		reports monthly x4 at unexpected time		. /	
	supply for the syste systems are equipp	m.;F ced.w	Required sprinkler if the water flow and tamper			quarterly on each shift. vill audit staff on fire dri	·	
	switches, which are building fire alarm a		trically connected to the n. 19.3.5			veek x4 weeks, weekly x ply x2 utilizing Fire Drill	4	
11000			.,		The Administrator	`. will compile audit result tocol QI Tool and presel		
	A Based on obser	vatlo	met as evidenced by, n on 04/18/2013 the om the domestic water		to the Quality Impi Meeting monthly.	ovement Committee Subsequent plans of		
	supply to the washi	ng m wasil	achines ,the valves are the alarm switch wired. Ito the NFPA 13 system		when required. Ide	loped by the Committee intification of any Il be used to determine	:	
k och	that covers the rem 42 CFr 483.70 (a)	ainde	er of the facility.	K 069	the need for action continued monitor	and/or frequency of Ing. The Administrator i		
K 069 SS=D		. !	Y CODE STANDARD otected in accordance	i i noa	responsible for ove	raii compilance.		٠,

	T OF DEFICIENCIES OF CORRECTION	(X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRU G 01 - MAIN I		(X3) DA CO	TE SURVEY MPLETED >
			345101	B. WNG_	* _ * _ * · · · · · · · · · · · · · · ·	1	04	//18/2013
	PROVIDER OR SUPPLIER DÖAKS NÜRSING AN	, R	EHABILITATION GENTER	s	TREET ADDRE 208 CARY S ENFIELD, I	t .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	'MÚ:	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	(EA	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD SREFERENCED TO THE APPROPRIES DEFICIENCY	BE	COMPLETION DATE
K 069	1) NFPA 96	K 06	Facility s	apport services contacted by		612/13
	This STANDARD is A. Based on observinge hood inspecti 42 CFr 483.70 (a)	/ati	t met as evidenced by: on on 04/18/2013 the was out of date.	·	administ 4/25/13 supervise	ator 4/18/13 to discuss findir aundry room valves were d and alarm switch wired into system by CTE, inc. electriciar	o	
The street of th	; ;				5/14/13.	ire Protection visited facility Suniand to take sprinkler hea If domestic line and run to m	ds in ain	
				, .	K069 Kitchen ra by BFPE II	nge hood was inspected 4/23 ternational.	3/13	6/2/13
	·				inítiated o	idit of equipment inspections n 4/23/13 by facility ator and current book of records updated accordingly		
							•	٠
-		**	2			· · · · · · · · · · · · · · · · · · ·		
The state of the s								
		: ;						