STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425314	A. BUILDING _____ B. WING _____	**10/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHERN OAKS REHABILITATION AND HEALTHCARE CENTER	**109 BENTZ ROAD PIEDMONT, SC 29673**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review, the facility failed to arrange for services that met professional standards of practice for one (1) of three (3) sampled residents (Resident #1). Resident #1 was admitted to the facility on [DATE] from an acute care hospital with an order for [REDACTED].#1's appointment was not arranged prior to discharge from the facility on 9/8/2020. Findings include: Review of the facility's policy titled, Care Plan Process, dated December 2019, revealed an interdisciplinary team would provide an individualized and comprehensive resident assessment to maximize and maintain every resident's functional potential and quality of life. Based on the comprehensive interdisciplinary assessment, the care team would address individualized needs to include physical, psychosocial, functional, activities, emotional, spiritual, and communication needs. Care planning also addressed needs resulting from the resident's condition and considered the residents expectations, characteristics, and previous daily routines. A baseline care plan would be developed immediately after admission, based on information obtained during the admission process. The IDT care plan would be developed as soon as possible after admission, but no later than one week after completion of the comprehensive assessments. Individual care and treatment goals would be identified. These goals would be reasonable and measurable and would reflect, the resident's unique needs; and, when appropriate, include a time frame for achieving these goals. The Interdisciplinary Team would be responsible for ensuring that the care plan process was followed and that care and services were provided through this process. Review of Resident #1's clinical record revealed the facility admitted the resident on 8/20/2020 from an acute care hospital with multiple diagnoses, which included chronic [MEDICAL CONDITION] with [MEDICAL CONDITION], chronic lymphocytic [MEDICAL CONDITION] of b-cell type not having achieved remission, type II diabetes mellitus without complications, encounter for attention to [MEDICAL CONDITION] and chronic diastolic [MEDICAL CONDITION]. Resident #1 was discharged from the facility on 9/8/2020 to a sister facility. Review of Resident #1's acute care hospital discharge summary, dated 8/19/2020, revealed a physician's orders [REDACTED]. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 8/27/2020, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of 12 out of 15 and determined the resident was interviewable and cognitively intact. Review of Resident #1's Care Plan, dated 9/2/2020, revealed the resident had a [MEDICAL CONDITION] with a goal not to have respiratory complications and an intervention to provide [MEDICAL CONDITION] care as ordered. Review of Resident #1's physician's orders [REDACTED].#1's facility discharge summary, dated 9/8/2020, revealed a physician's orders [REDACTED]. Interview on 10/2/2020 at 1:00 p.m., with Licensed Practical Nurse (LPN) #1, revealed he/she took off the order for the ENT appointment off the chart on 8/21/2020 for Resident #1 and gave it to the Unit Manager (UM) to schedule the ENT appointment. Interview with the Unit Manager (UM) on 10/2/2020 at 12:30 p.m., revealed that he/she was responsible for supervising nursing staff, admitting and discharging residents, entering physician's orders [REDACTED]. The UM stated that after residents were admitted , he/she would enter the physician's orders [REDACTED]. Continued interview revealed, the UM didn't recall faxing Resident #1's referral to the ENT for an appointment on 8/21/2020; however, the UM scheduled a chest x-ray and a urinalysis (UA) for Resident #1 on same date the ENT appointment was ordered. The UM stated he/she forgot to follow-up on the ENT appointment because he/she was transferred to another unit the following week due to a COVID-19 outbreak. However, there was no documented evidence that the order was sent to the ENT's office. Interview with the Advanced Registered Nurse Practitioner (ARNP) on 10/2/2020 at 2:56 p.m., revealed that he/she ordered the ENT referral on 8/21/2020 for Resident #1. The ARNP stated he/she expected the nurses to follow the plan of care and inform him/her of the status of orders within a week. The ARNP stated that the UM informed him/her that the ENT referral was faxed but didn't recall the date. Continued interview revealed, that the laryngeal stroboscopy and [MEDICATION NAME] appointments were ordered to determine removal of Resident #1's trach. The ARNP stated the [MEDICATION NAME] was performed on 9/3/2020; however, the laryngeal stroboscopy wasn't scheduled while Resident #1 resided at this facility. Further interview revealed the ENT appointment was not arranged until 11/3/2020 after Resident #1 was discharged from the facility on 9/8/2020 and admitted to another nursing facility. Interview with the Director of Nursing (DON), on 10/2/2020 at 8:07 p.m., revealed he/she expected nursing staff to follow the care plan which served as a guideline on how to care for the residents. The DON stated that he/she had only worked a couple of weeks at the facility when Resident #1 was admitted . The DON stated he/she remembered discussing the order for the ENT referral in the morning meeting and expected the UM to arrange appointments for residents per the physician's orders [REDACTED].#1 removed Resident #1's order from the chart for the ENT follow-up appointment and gave it to the UM to process on 8/21/2020. Continued interview revealed there was no documented evidence that the UM faxed the ENT referral, but the UM made other appointments ([MEDICATION NAME] and urinalysis) on 8/21/2020.

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