

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

F 156

This Plan of Correction is the center's credible allegation of compliance.

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

F.156 Notice of Rights

07/28/12

Corrective Action for Resident Affected

A print out of how to apply for Medicare and Medicaid benefits was posted on 06/27/12 by the administrator outside of the main dining room.

Corrective Action for Resident Potentially Affected

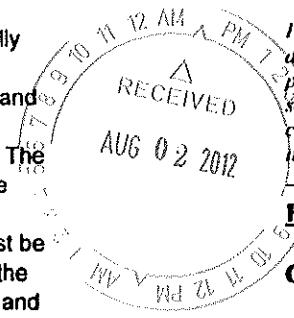
All residents have the potential to be affected by this practice. See corrective action below.

Systemic Changes

The "how to apply for Medicare and Medicaid" was posted in frames mounted to the wall by the maintenance director on 06/27/12 to prevent them from being removed.

Quality Assurance

The Administrator will monitor this issue using the "Survey QA tool".



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Peppy W. Bullard RN, LNSHA

TITLE

7/26/12

(X6) DATE

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

*4 updated
7/30/12
Peppy W. Bullard
Administrator*

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

PRINTED 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 345309	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012	
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 158 Continued From page 1

A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This

F 158

This Plan of Correction is the center's credible allegation of compliance

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law

The monitoring will include verification that the "How to apply for Medicare and Medicaid" posting is still hanging in the frame by the dining room. See attached monitoring tool. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. They have regularly scheduled meeting weekly which are attended by the Administrator, Director of Nursing, other nurse managers, and dietary manager.

It will also be reviewed in Quarterly QOL/QA committee attended by the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Environmental Director and Activities Director

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 156 Continued From page 2

F 156

includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on observations and staff interview, the facility failed to post information on how to apply for Medicare and Medicaid benefits for all residents.

Findings include:

Observation on 6/26/12 at 1:30 PM, and 6/27/12 at 4 PM revealed posted information was displayed in picture frames on a wall outside the main dining room for residents and family members to view. Review of the postings revealed no information on how to apply for Medicare/Medicaid benefits was posted.

During an interview with the Administrator on 6/27/12 at 5:28 PM, the Administrator stated the information was expected to be posted outside the main dining room with all of the other required

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 156 Continued From page 3
postings. The Administrator stated she was unaware the postings were not on the wall available to residents.

F 172 483.10(j)(1)&(2) RIGHT TO/FACILITY
SS=C PROVISION OF VISITOR ACCESS

The resident has the right and the facility must provide immediate access to any resident by the following:

Any representative of the Secretary;

Any representative of the State;

The resident's individual physician;

The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965);

The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);

The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);

Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and

Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of

F 156

This Plan of Correction is the center's only allegation of compliance.

F 172

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

F 172 Ombudsman

07/28/12

Corrective Action for Resident Affected

The administrator spoke to resident # 27, 20 and 36 on 07/19/12 to inform them of the ombudsman name and contact information.

Corrective Action for Resident Potentially Affected

All alert and oriented residents have the potential to be affected by this practice. On 07/19/12, 07/20/12, and 07/23/12 the social services director met with all alert and oriented residents to inform them of the ombudsman name and contact information. A print out of the information was also provided to them. They were also told that the name and contact information for the ombudsman is located outside of the main dining room and at each nurses' station.

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

PRINTED 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 172 Continued From page 4
the resident.

F 172

This Plan of Correction is the correct, credible allegation of compliance.

The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law

This REQUIREMENT is not met as evidenced by:

Based on observations, resident and staff interviews, the facility failed to ensure that 3 residents (Resident #27, #20, and #36) of 3 alert and oriented residents knew what the Ombudsman was, who the Ombudsman was, or how to contact the Ombudsman.

Findings include:

Resident # 27 was re-admitted to the facility on 6/25/11. Review of the resident ' s most recent MDS (Minimum Data Set), an annual assessment of 5/18/12, revealed the resident was cognitively intact.

During an interview on 6/27/12 at 2 PM, the resident reported he didn't know who the ombudsman was, what an ombudsman was, or how to get a hold of one.

Resident #36 was admitted to the facility on 1/9/10 . Review of the resident ' s most recent MDS, a quarterly assessment of 4/10/12, revealed the resident was cognitively intact.

During an interview with the Resident #36 on 6/28/12 at 8:02 AM, the resident stated she didn't

Systemic Changes

The social services coordinator was educated by the administrator on 07/19/12. This education included the need to meet with all new admissions within the first 72 hours of admission to notify them of the ombudsman's name and contact information and that it is posted outside of the main dining room if they need it in the future.

Quality Assurance

The Administrator will monitor this issue using the "Survey QA tool". The monitoring will include interviewing 5 alert and oriented residents to ensure that they know where the ombudsman's name and contact information is kept. This will include at least two new admits if available. See attached monitoring tool. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.

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

PRINTED 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 172 Continued From page 5

know who the Ombudsman was, what the Ombudsman was, or how to get in touch with the Ombudsman. The resident stated she didn't go to Resident Council Meetings and did not remember anyone discussing an "Ombudsman".

Resident #20 was admitted to the facility on 6/9/12. Review of an admission assessment, dated 6/15/12, indicated the resident was cognitively intact.

During an interview with Resident #20 on 6/28/12 at 7:54 AM, the resident reported she did not know what an Ombudsman was, who it was, or how to get in touch with the Ombudsman. The resident reported she did not remember anyone discussing the Ombudsman with her on admission to the facility. The resident reported she went to a Resident Council Meeting, but did not remember hearing any conversations about an Ombudsman.

During an interview with the Activities Director on 6/28/12 at 3:33 PM, the Director reported she helped the residents set up and conduct the Resident Council meetings. The Director reported they discussed what the Ombudsman did, and where to find the phone number. The Activity Director stated the information was discussed last year after the annual survey. The Director reported the Ombudsman was discussed at Resident Council meetings every couple of months but was not able to report when the discussions occurred.

Review of the minutes from Resident Council Meetings since August 2011 revealed no documentation of discussion about the

F 172

This Plan of Correction is the result of staff allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law

The QOL/QA committee is the main quality assurance committee. They have regularly scheduled meeting weekly which are attended by the Administrator, Director of Nursing, other nurse managers, and dietary manager. It will also be reviewed in Quarterly QOL/QA committee attended by the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Environmental Director and Activities Director

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 172 Continued From page 6
Ombudsman.

During an interview with the Administrator on 6/30/12 at 3:51 PM, the Administrator stated she expected the Activity Director discussed the Ombudsman at Resident Council meetings and the residents could obtain Ombudsman information from part of the admission packet that was given to newly admitted residents.

F 248 483.15(f)(1) ACTIVITIES MEET
SS=D INTERESTS/NEEDS OF EACH RES

The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on observations, record reviews and staff interviews the facility failed to provide an ongoing program of evening activities for 3 (Resident #11, #28 and #83) of 20 residents reviewed for activities.

Findings Include:

An observation on 6/26/12 at 3:56 pm in Resident #11 room revealed there were no activities listed after 4:00 PM on the June 2012 activities calendar.

An interview with the Activities Director on 6/27/12 at 4:19 PM revealed she was planning to start a summer movie night like she did last summer. There were some singing groups that

F 172

This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

F248 Activities

07/28/12

F 248

Corrective Action for Resident Affected

Evening activities are scheduled for July 26 and 31st, 2012. Evening activities are scheduled for 8 out of 30 days on the calendar for August. These activities include movie night, Wii activities, such as bowling and boxing.

Corrective Action for Resident Potentially Affected

All residents who participate in activities have the potential to be affected by this practice. See corrective actions for actions that also impacted those potentially affected.

Systemic Changes

An in-service was conducted for the activity coordinator on 06/29/12 and 07/19/12 by the administrator to explain the importance of weekend and evening activities.

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 248 Continued From page 7
come in the evening, which was usually at 7:00 PM. ---

An observation on 6/27/12 at 5:05 PM revealed the June 2012 activities calendar was posted in the restorative dining room. The latest activity indicated was at 4:00 PM for this month

An observation on 6/27/12 at 4:05 pm revealed the June 2012 activity calendar posted in the hallway outside of the main dining room. There was one day written in on 6/15/12 that a visiting group was scheduled at 7:00 PM.

A record review of the activity calendars from January 2012 to June 2012 was conducted. The latest activity listed was at 4:00 PM.

An interview with the Activity Volunteer #1 on 6/28/12 at 11:31 AM revealed he only assists with activities during the day, due to he goes to school in the evenings.

An interview with Activity Volunteer #2 on 6/29/12 at 10:15 AM revealed she volunteered on Tuesday and Friday 's from 8 AM-3 PM. There was a movie night activity done at 6:30 PM. She has gone with the Activity Director in the past to the movie night. The last time the Activity Director had conducted the movie night was over six months ago. She was not sure of why the movie night had stopped. There was a singing group that would visit in the evening. It has been over six months since this group has come.

An interview with the Activity Director on 6/29/12 at 3:35 PM revealed she had completed a three month activity training course at a local

F 248 *This Plan of Correction is the center's credible allegation of compliance.*

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

Strategies to increase the number of evening activities were identified to include calling on churches, speaking to community college to see if they have any fraternities that need community services hours and could volunteer in the evenings. The activity director was instructed to verify every morning that evening activities were completed by talking to residents and staff. Monday through Friday at the Department Head Morning Meeting, the Activities Coordinator will report on the evening activities scheduled for the following days along with any issues identified during any program.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

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

PRINTED 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 248 Continued From page 8
community college last year. The course reviewed the importance of having other staff involvement with activities and conducting evening activities. There was a couple of visiting groups that had come three evening last October. She revealed it was hard to get these visiting groups to come in the evenings. They want to come during the day. She did not have anyone come last month for evening. A visiting group had come once this month on 6/15/12 based upon they had called the facility and indicated they were coming. She attempts to call visiting groups about 2 weeks or a month before the next schedule comes out. She was not aware that there were no activities later than 4:00 pm on the calendars for the last six months and the ones posted in the resident rooms. She wanted puzzles and games to be done for one-on-one evening visits. There were staff members that indicated they were very busy and unable to assist with these activities. She had expressed her concerns to the prior Director of Nurses. She did have a movie night last summer. She planned to restart the movie night next Monday. She also planned to start an evening men's group. She recognized the evening activities were an issue. There were a lot of rehabilitation residents that would come to evening activities.

An interview with the DON and Administrator on 6/30/12 at 12:12 PM revealed the residents were interested in activities and asked about when certain activities would begin and would benefit from evening activities.

F 253 483.15(h)(2) HOUSEKEEPING & SS=E MAINTENANCE SERVICES

The facility must provide housekeeping and

F 248 This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law

Quality Assurance

The Administrator will monitor this issue using the "Survey QA Tool". The monitoring will include verifying that the evening activities are scheduled and completed as scheduled. See attached monitoring tool. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. They have regularly scheduled meeting weekly which are attended by the Administrator, Director of Nursing, other nurse managers, and dietary manager.

It will also be reviewed in Quarterly QOL/QA committee attended by the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Environmental Director and Activities Director

F 253

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 253 Continued From page 9
maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews, and record reviews, the facility failed to maintain 2 of 2 common shower room floor in clean condition; the facility failed to maintain resident bathroom walls in good condition in 3 resident bathrooms (rooms 101, 106, and 119) of 14 bathrooms; the facility failed to maintain doors in 6 resident rooms (rooms #101, 102, 104, 106, 107, and 121) of 25 resident rooms in good condition, bathroom walls in 3 rooms (rooms 101, 106, and 119) and 1 resident room wall (room 111) of 25 resident rooms in good condition.

Findings include:

During an observation on 6/28/12 at 8:22 AM of Shower Room #1, a line of rust-colored staining was observed on the shower 's tile wall for 1 tile and 2 inches of the next tile. Another line of rust colored staining was observed under the safety rail nearest to the shower control. Blackened build up in the grout for 22 tiles was noted on the shower head wall. The corners of the shower stall were observed having had a blackened build up in the grout between tiles. Large areas of floor tiles in the shower floor were observed with blackened matter in the grout lines. Marked areas on the wall under the soap dispenser had a light tan color streaking down the wall on 6 tiles and 1/3 of another. Build up of blackened matter was noted in the corner of the knee wall and adjoining wall of the shower. Both of the wall

F 253 *This Plan of Correction is the center's credible allegation of compliance.*

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

F253 Housekeeping and maintenance

07/28/12

Corrective Action for Resident Affected

Effective 07/25/12 the administrator and maintenance director verified that the following task have been completed. In the shower room # 1 these areas were cleaned (including grout and rust stains): shower wall, under the safety rail, shower head wall, floor tiles, areas under soap dispenser, corner of the knee wall and adjoining wall of the shower, both heater front covers. Shower room # 2 had the grout cleaned between the drain and the shower head wall, the base of the wall beside the commode, and floor tiles. In both shower rooms facility contracted with Carolina Care to clean tile and grout. This was completed on 07/18/12. Also the tile at the base of the entrance wall was replaced. Room 101 had repairs to the bathroom door and closet doors.

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 253 Continued From page 10
heater front covers were brown over the fluted areas.

An observation was conducted on 6/28/12 at 8:47 AM of the Common Shower/bathing area #2 on the 111 to 120 hall. Several tiles between the drain and the shower head wall had a build up of blackened matter between the the grout lines between tiles. The base of the wall beside the commode had a buildup of brownish/black matter in the grout between tiles from the floor upward of 1 to 2 inches. Large areas of grout were observed as having had blackened build up between floor tiles. A tile at the end of the base on the entrance wall was missing.

An observation of Room 101B on 6/26/12 at 9:33 AM revealed a gouge in the bathroom door that faced the resident's room. The closet doors had scrapes through the middle of both doors.

An observation of the bathroom for Room 101 on 6/26/12 at 9:36 AM revealed the bathroom cove base had separated from the wall opposite the commode. The cove base under the sink had brown stained build up. The inside of the bathroom door had white streaks and was scraped in two areas across the bottom of the door. The emergency pull cord was discolored a dark brownish color in multiple areas of the cord. Below the paper towel dispenser were two holes in the wall from previous equipment that have not been filled in or patched and painted. Bathroom equipment had been removed under the light switch and the holes remained un-repaired.

An observation of Room 103 on 6/26/12 at 3:09 PM revealed the closet doors were scratched

F 253 *This Plan of Correction is the center's credible allegation of compliance.*

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

Room 101 bathroom had the cove base fixed, the bathroom door repaired, the emergency pull replaced and the holes in the walls repaired and painted. Room 103 the closet doors were repaired and the bathroom wall was repaired and painted. The unrepaired holes in room 104 and closet doors were repaired. In room 106 the closet door and bathroom door was repaired. The bathroom was cleaned and the unrepaired holes were repaired. The emergency cord was replaced. In room 107 the closet doors were repaired. In room 110 the wall behind the soap dispenser was repaired. In room 111 the wall beside the soap dispenser was repaired and the wall above the first bed was repaired. In room 115 the area next to the soap dispenser and cove base in the bathroom was repaired. Room 118 the wall beside the soap dispenser was repaired. In room 121 the room door and bathroom door was repaired.

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 253	Continued From page 11 across the middle under the door handles. The bathroom wall above the sink had equipment removed and the remaining holes were unrepaired. An observation of the bathroom in Room 104 on 6/26/12 at 8:04 AM revealed unrepaired holes in the wall above the sink. Both closet doors had scrape marks across the bottom half An observation of Room 106 B on 6/26/12 at 2:41 PM revealed both closet doors had multiple scrapes across the door under the handles. The bathroom door has a gouge that was 5 inches wide. The bathroom wall had dried brown matter that dripped down the wall under the soap dispenser. Under the towel dispenser were two wall gouges that were unrepaired. The emergency pull cord in the bathroom was stained brown in areas and yellow in other areas. An observation of Room 107 on 6/26/12 at 2:58 PM revealed the closet doors in the room were scratched across the doors in the middle under the handle. An observation of Room 110B on 6/26/12 at 2:30 PM revealed the wall behind the soap dispenser was scraped down to the brown paper and had not been repaired. An observation of Room 111 on 6/26/12 at 10:21 AM revealed the wall beside the soap dispenser was scraped down to the brown paper and was unrepaired. The wall above the first bed in the residents' room had 2 one-inch holes with several surrounding holes.	F 253	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.</i> Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this practice. On 07/09/12 the administrator met with all department heads and reviewed an inventory list for all residents room. From 07/12/12 to 07/18/12 the department heads inventoried the residents rooms for repairs. On 07/25/12 the administrator and the maintenance director conducted a room review. The room review looked at repairs mentioned in inventory review. The doors (including closets, bathroom and entrance doors) to identify scrapes, soiled emergency pull cords, soiled walls around soap dispensers, cove bases in need of repair or cleaning, repairs to the bathroom/room walls where unrepaired holes might exist. Systemic Changes On 07/19/12 and 07/20/12 the administrator met with full time, part time and prn housekeeping and maintenance staff. Topics included: filling out maintenance request for

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 253 Continued From page 12

An observation of the bathroom for Room 115 on 6/26/12 at 10:01 AM revealed an area next to the soap dispenser that was scraped down to the brown paper and unrepaired. The cove base was separating from the wall on one side of wall of bathroom.

An observation of the bathroom for Room 118 on 6/26/12 at 4:18 PM revealed the wall beside the soap dispenser was scraped down to the brown paper and had not been repaired.

An observation of Room 119 on 6/26/12 at 3:40 PM revealed the bathroom wall next to the soap dispenser that was scraped down to the brown paper and unrepaired.

An observation of Room 121 on 6/26/12 at 11:04 AM revealed the room door and bathroom door were scraped across the doors below the door handles.

During a tour of the facility with the Administrator and Maintenance supervisor on 6/30/12 at 1:15 PM, the areas of scraped and gouged doors, the cove base of the named above mentioned rooms still separated from the walls, the walls were scraped down to the brown paper in the bathrooms and the holes in the resident's room remained unrepaired. The blackened areas of grout remained on the common shower room floors.

During an interview with the Maintenance Director on 6/30/12 at 1:44 PM, the Director stated the bathroom walls that were scraped was a result of replacement of the soap dispensers. The Director reported some of the soap dispensers

F 253

This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

doors, for soiled emergency pull cords, needed repairs to walls in bathrooms and rooms, and broken tiles in the shower rooms. They also discussed the importance of cleaning under and around the soap dispensers and the routine cleaning of the grout in the shower rooms. A weekly room rounds will be conducted by the Maintenance Director and reported on Thursday during the Morning Department Head meeting, identified concerns and a schedule for correction/repair submitted to the Administrator.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 253 Continued From page 13
were replaced causing the scrapes in the walls prior to his hire in September of 2011.

During an interview with the Maintenance Director on 6/30/12 at 2:30 PM, the Director reported the shower room floors were 30 years old and the blackened discolorations were in the grout. In the presence of the Administrator, the Maintenance Director demonstrated cleaning the floor tile in front of the sink with disinfectant cleaner and a long handled brush. The cleaning solution residue began turning gray in color. The brush bristles were a grayish color.

F 253

This Plan of Correction is the center's credible allegation of compliance

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law

Quality Assurance

The Administrator will monitor this issue using the "Survey QA Tool". The monitoring will include shower room checks to ensure cleanliness and that tiles are in good condition, 5 room and bathroom checks to ensure that bathroom, closet and room doors do not have scratches, walls are in good repair and clean, and that emergency pull cords are clean. See attached monitoring tool. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. They have regularly scheduled meeting weekly which are attended by the Administrator, Director of Nursing, other nurse managers, and dietary manager.

It will also be reviewed in Quarterly QOL/QA committee attended by the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Environmental Director and Activities Director

F 274 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE
SS=D

F 274

A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345 309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
			(X5) COMPLETION DATE

F 274 Continued From page 14
interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews and staff interviews the facility failed complete a significant change assessment for 1 (resident #8) of 1 sampled residents, who had unplanned weight loss of -15% in a 90 day period and -12.6% in a 180 day period and developed a Stage 2 pressure ulcer.

Findings include:

Resident #8 was originally admitted to the facility on 11/23/2004. Diagnoses for resident #8 include Cerebral Vascular Accident, Chronic Kidney Disease, Diabetes Mellitus, and Alzheimer's disease.

A review of resident #8's weight history documented by the Dietary Consultant revealed resident #8 had weighed 160.2 pounds on 12/21/11.

A quarterly Minimum Data Set (MDS) assessment dated 2/5/12 indicated the resident had lost weight and was not on a physician prescribed weight loss program. The weight listed on the MDS was 140 pounds. The skin assessment portion of the MDS indicated resident #8 did not have any pressure ulcers at the time of the assessment nor during the previous assessment period.

F 274

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F-274 - Comprehensive assessments: significant changes

07/28/12

Corrective Action for Resident Affected
A significant change for resident # 8 was completed on 07/22/12 by the MDS nurse.

Corrective Action for Resident Potentially Affected

All residents who have had a significant unplanned weight loss or a pressure ulcer have the potential to be affected by this practice. On 07/20/12 the MDS nurse reviewed all resident's who have had a significant weight loss (5 % in 30 days, 7.5% in 90 days and 10 % in 180) and all residents with pressure ulcers to identify any resident who should have had a significant change and did not. Any identified missing assessment was completed by 07/28/12 by the MDS nurse.

Systemic Changes

An in-service was conducted on 07/13/12 and 07/20/12 by Corporate MDS Nurse for the MDS nurse,

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 274 Continued From page 15

A review of the Quality of Life minutes dated 2/21/12 indicated resident #8 had developed a Stage 2 pressure ulcer on his left buttock on 2/7/12. The minutes also indicated the wound was acquired in the facility. Measurements were recorded as length 1.2 centimeters (cm.), width 2.0 cm. and 0 cm. depth. The wound tissue was described as granulated tissue.

On 2/22/12 the dietary consultant indicated resident #8 weighed 140 pounds and also revealed resident #8 had lost -15% in a 90 day period and -12.6% of body weight in a 180 day period. The note also indicated resident #8 had a decubitus on his left buttock and was already on Vitamin C and Zinc to aid in wound healing. In addition, the note revealed resident #8 had a food intake of 25-75% and no interventions would be added for weight loss because resident #8 had gained one pound in the past 2 weeks.

A review of the Quality of Life minutes dated 2/29/12 indicated resident #8 's stage 2 left buttock decubitus measured a length of 1.3 cm, width 2.0 cm, and there was no depth to the granulated tissue.

A review of the Quality of Life minutes dated 3/15/12 indicated resident #8 's weight loss had been discussed. The minutes included a weight history from 9/7/11 until 3/1/12. The recorded body weight for 12/22/12 for resident #8 was 161 pounds. The next weight for resident #8 was on 1/24/12 and the weight recorded in the minutes was 139.2. The minutes also revealed resident #8 's stage 2 pressure ulcer on his left buttock measured a length of 1.0 cm and a width of 2.2

F 274

This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law

dietary services manager, social services and activity director (the interdisciplinary care planning team)

The in-service topics included the following the requirements for completing a significant change assessment which included significant weight loss (5 % in 30 days, 7.5% in 90 days and 10 % in 180) and pressure ulcers. The team should review residents during the weekly quality of life meeting to identify residents who may require a significant change.

The weekly Quality of Life Meeting will review all resident with a weight loss or gain (5 % in 30 days, 7.5% in 90 days and 10 % in 180). This review will include but not limited to percentage of meal intake, supplements, snacks offered, labs, notification of MD and Family, referral to Dietician, review of care plan and consideration for the completion of a significant change MDS.

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
			(X5) COMPLETION DATE

F 274 Continued From page 16

cm. There was no depth to the wound and the tissue type was not documented.

A review of the Quality of Life minutes dated 4/5/12 indicated nutritional recommendations for weight loss and wound status were discussed for resident #8. The nutritional recommendations revealed supplements were to be initiated for resident #8. The wound documentation included the weekly measurements of the stage 2 pressure ulcer on the left buttock measured a length of 1.2 cm and a width of .6 cm. The wound bed had no depth and was epithelial tissue. The wound was showing progression towards healing.

A review of the Quality of Life minutes dated 4/27/12 revealed resident #8's weight was 142 pounds and his stage 2 left buttock pressure ulcer measured 1 cm in length and 1.8 cm in width, a depth was recorded of 0.01 cm. The tissue type is described as epithelial.

According to the most recent Minimum Data Set (MDS) completed on 5/2/2012 resident #8 had a moderately impaired cognition and was able to make his needs known and can respond adequately to simple and direct communication. The Nutritional portion of the MDS revealed resident #8 had lost weight and was not on a physician prescribed weight loss program. The MDS also indicated resident #8 did not have a pressure ulcer during the assessment period.

A review of the Quality of Life minutes dated 5/4/12 revealed resident #8 weighted 142 pounds and his stage 2 pressure ulcer on his left buttocks remained unhealed. The pressure ulcer was

F 274

This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law

A review of facility wounds including Pressure Ulcers will be presented by the Wound Care Nurse. This review will also include the care plan and consideration for the completion of a significant change MDS. Committee members will include at a minimum: Administrator, DON, SDC, Unit Director, MDS nurse, Wound Care Nurse Social Services, Dietary and other clinical team members as needed. This review will be documented on the DON daily checklist.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

Quality Assurance

The Director of Nursing will monitor this issue using the "Clinical QA Survey Tool".

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 274 Continued From page 17

described as epithelial tissue with a length of 0.4 cm and a width of 0.6cm and a depth of 0.01 cm.

A review of the care plan dated 5/11/12 indicated resident #8 was not identified for at risk or actual weight loss on his care plan. The care plan also revealed resident #8 had a new onset on 2/7/12 of a decubitus ulcer on his left buttock. An intervention for the pressure ulcer was a dietary consult for protein needs, supplements, and vitamins as needed.

On 6/28/12 at 3:00 PM during an interview with the DON it was revealed a Quality of Life meeting is held weekly and the information gathered at the meeting included pain, wounds, weight loss and nutrition. Members of the Quality of Life team included dietary, rehab, MDS, DON, and the Administrator. Dietary recommendations were discussed monthly. A review of the Quality of Life minutes for September 2011 until May 2012 revealed resident #8's wounds and weights were discussed by the interdisciplinary team. The DON indicated she was currently reviewing and signing the MDS's for all the residents. The DON indicated she had been at the facility for 4 weeks and was unsure why the significant change assessment had not been done for resident #8. Her expectations would be that if a problem was identified it would be discussed at the Quality of Life meeting and if a significant change was indicated it would be done. The DON also indicated a significant change assessment should have been done within 14 days of changes in resident #8's condition.

F 279 483.20(d), 483.20(k)(1) DEVELOP
SS=E COMPREHENSIVE CARE PLANS

F 274

This Plan of Correction is the center's credible allegation of compliance

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

The monitoring will include reviewing all residents who have experienced significant weight loss (5% in 30 days, 7.5% in 90 days and 10% in 180) and pressure ulcers to see if a significant change should have been completed. See attached monitoring tool.

This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. They have regularly scheduled meeting weekly which are attended by the Administrator, Director of Nursing, other nurse managers, and dietary manager.

It will also be reviewed in Quarterly QOL/QA committee attended by the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Environmental Director and Activities Director

F 279

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 279 Continued From page 18

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on observations, record reviews and staff and family interviews the facility failed to care plan interventions for pain and a significant weight loss for 1 of 36 residents sampled (Resident #8). Findings included:

- Resident #8 was originally admitted to the facility on 11/23/2004 and diagnoses for resident #8 included Chronic Kidney Disease, Diabetes Mellitus, and Alzheimer's disease.

Review of the care plan initiated in August 2011 revealed no problem or interventions related to pain for this resident.

F 279

This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

F279 Comprehensive Care Plans

Corrective Action for Resident Affected

Resident # 8 care plan was updated on 07/22/12 by the MDS nurse to include pain and significant weight loss.

Corrective Action for Resident Potentially Affected

All residents who have had significant weight loss (5 % in 30 days, 7.5% in 90 days and 10 % in 180) and use as needed pain medications or are in pain have the potential to be affected by this practice. On 06/30/12, the administrative nurses completed pain assessments on all residents currently in the facility. On 07/20/12 the administrative nurses reviewed all current resident's MAR to identify residents who receive PRN pain medications.

07/28/12

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 279 Continued From page 13

1a. A review of the Medication Administration Records (MAR) for resident #8 revealed in October 2011 resident #8 received PRN (as needed) pain medication 16 times for reasons that included general pain, leg pain, verbalizing hurting and moaning. In November 2011 resident #8 received PRN pain medication 8 times for reasons that included generalized pain

A review of nurses' notes for resident #8 revealed in the month of November 2011 signs and symptoms of pain which included drawing legs and arms upward, facial grimacing, and moaning.

In December 2011 resident #8 received pain medication 3 times no indications were documented regarding pain scale, symptoms or effectiveness. In January 2012 the MAR revealed resident #8 received PRN pain medication 3 times for reasons that included generalized pain.

During a record review of Physical Therapy notes indicated a start of care date of 1/3/2012. The Initial Assessment portion revealed the reason for the referral from nursing was resident #8 had increased tightness in his right elbow and both knees. Resident #8 had been complaining of pain. The assessment revealed resident #8 was able to follow simple commands and a treatment known as Diathermy (a treatment modality used to decrease pain through localized electrically induced heat) would be used to decrease resident #8's pain level. At the start of therapy resident #8's pain level was 6 of 10. A review of the Physical Therapy notes revealed on 2/3/12,

F 279

This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law

On 07/22/12 a computerized report was generated by the DON and MDS nurse consultant to identify residents who have had weight loss as defined above. Once these three list were completed the MDS nurse reviewed the care plans by 07/28/12 to ensure that pain and weight loss were appropriately care planned.

Systemic Changes

An in-service was conducted on 07/13/12 and 07/20/12 by Corporate MDS Nurse for the MDS nurse, dietary services manager, social services and activity director (the interdisciplinary care planning team). The in-service topics included ensuring that pain and significant weight loss were appropriately care planned.

The weekly Quality of Life Meeting will review all resident with a weight loss or gain (5 % in 30 days, 7.5% in 90 days and 10 % in 180). This review will include but not limited to percentage of meal intake, supplements, snacks offered, labs,

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY	STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 279 Continued From page 20
2/4/12, 2/5/12, 2/7/12, 2/8/12, and 2/9/12 resident #8 had discomfort and pain during the treatments. On the discharge date (2/9/12) resident #8 pain level was noted as 7 of 10 on the pain scale. The goal noted for pain was resident #8 would signify decreased pain by allowing bilateral stretching of hamstrings with no defensive aggressive behavior. A discharge summary for physical therapy dated 2/22/12 for resident #8 revealed the Diathermy treatments were discontinued because resident #8 was at his maximum potential and there was no significant progress made.

In February 2012 the MAR indicated resident #8 received pain medication 9 times for reasons which included verbalization of pain, yelling and hollering out, and generalized pain. In March 2012 the MAR revealed PRN pain medication was given to resident #8 13 times which included generalized pain. In April 2012 resident #8 received PRN pain medication (Lortab) 10 times for reasons that included " screaming out ", " crying out ", leg pain and generalized discomfort.

According to the quarterly Minimum Data Set (MDS) completed on 5/2/2012 resident #8 had moderately impaired cognition and was able to make his needs known and could respond adequately to simple and direct communication. The MDS also indicated resident #8 was not on a scheduled pain medication regime and was not offered or received any PRN (as needed) pain medication. The pain assessment interview on the MDS revealed that when asked, Resident indicated he did have pain.

Resident #8 was unable to respond to how much time he had spent in pain over the past 5 days, or

F 279

This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

notification of MD and Family, referral to Dietician, review of care plan and consideration for the completion of a significant change MDS.

A review of facility wounds including Pressure Ulcers will be presented by the Wound Care Nurse. This review will also include the care plan and consideration for the completion of a significant change MDS. Committee members will include at a minimum: Administrator, DON, SDC, Unit Director, MDS nurse, Wound Care Nurse Social Services, Dietary and other clinical team members as needed. This review will be documented on the DON daily checklist.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

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

PRINTED 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 279 Continued From page 21

if the pain interrupted his sleep, or limited his day to day activities. Resident #8 was not able to answer to the pain intensity and based on the gathered information a staff assessment for pain would be conducted. The staff assessment for pain on the MDS indicated there were no signs and symptoms of pain or possible pain observed. The MDS also indicated resident #8 was not on a scheduled pain medication regime and was not offered or received any PRN (as needed) pain medication. Resident #8 was unable to respond to how much time he had spent in pain over the past 5 days, or if the pain interrupted his sleep, or limited his day to day activities. Resident #8 was not able to answer to the pain intensity and based on the gathered information a staff assessment for pain would be conducted.

An observation of the care plan dated 5/11/12 revealed pain was not identified as a problem for resident #8. In May 2012 resident #8 received PRN pain medication 15 times for reasons that included moaning, verbalization of pain, and generalized discomfort.

On 6/26/12 during an observation at 2:30 PM resident #8 was in his bed and moaning, groaning and facial grimacing were evident. An interview with Nurse #2 revealed resident #8 had moaned of pain in the past and had physician orders for PRN medication. Nurse #2 asked resident #8 if he had pain and resident #8 was agitated and unable to verbally answer and pointed to his legs; Nurse #2 offered pain medication to the resident and he refused. Nurse #2 and Na #1 attempted to reposition the patient and resident #8 refused.

F 279

This Plan of Correction is the center's veritable allegation of compliance

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

Quality Assurance

The Director of Nursing will monitor this issue using the "Clinical Survey QA Tool". The monitoring will include reviewing 10 residents to ensure that weight loss and pain are care planned as appropriate. The 10 residents will be identified during the daily clinical meetings based on residents with weight loss concerns, pain or new telephone orders for as needed pain medications. See attached monitoring tool. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. They have regularly scheduled meeting weekly which are attended by the Administrator, Director of Nursing, other nurse managers, and dietary manager. It will also be reviewed in Quarterly QOL/QA committee attended by the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Environmental Director and Activities Director

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 279 Continued From page 22

F 279

On 6/27/12 during an observation at 12:10 PM resident #8 was lying in his bed and awake during an interview resident #8 verbalized he was in pain and pointed to his legs.

On 6/28/12 at 8:35 AM an interview was conducted with NA # 3 and she revealed she could usually tell when resident #8 was in pain because he moans. NA #3 also indicated Resident #8 would let you know he was in pain by moaning and sometimes he would be able to tell you. NA#3 also indicated resident #8 did not eat well this morning and was moaning and she was on her way to report it to the nurse.

On 6/28/12 at 10:00 AM an observation of resident #8 revealed he moaned when NA #2 attempted to remove a protective sheer sleeve used to protect fragile skin from his arm. NA #2 stopped care and asked resident #8 if he was in pain and he responded yes. NA #2 reported resident #8 's pain to Nurse #2. Nurse #2 assessed resident #8 and gave him pain medication.

On 6/28/12 at 11:30 AM resident #8 was observed to be lying in his bed quietly without moaning, groaning or facial grimacing.

On 6/28/12 at 11:45 AM during an interview with the Rehab Manager it was revealed therapy was initiated for resident #8 because of contractures and pain. Diathermy was used for resident #8 but was discontinued because it was not effective to relieve the pain for resident #8.

On 6/28/12 at 3:00 PM during an interview with the DON it was revealed a Quality of Life meeting

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 279 Continued From page 23

F 270

is held weekly and the information gathered at the meeting included pain and nutrition. Members of the Quality of Life team included dietary, rehab, MDS, DON, and the Administrator. A review of the Quality of Life minutes for September 2011 until May 2012 revealed resident #8 's pain was not discussed. Her expectations would be that if a problem was identified it would be discussed and care planned to assure the resident ' s needs are met. The DON indicated she assisted in MDS process and resident #8 had not triggered for pain and therefore a care plan had not been done for this identified problem. The DON was unsure why pain had not been care planned.

On 6/30/12 at 9:45 AM an interview with the family for resident #8 revealed that they had come to visit on multiple occasions and resident #8 was moaning and complaining of pain.

1b The most recent Care Area Assessment (CAA) dated 5/11/11 indicated resident #8 ' s nutritional status was identified as a concern.

A record review was conducted of the nutritional consultant notes for resident #8. The nutritional note dated 9/21/11 revealed a recommendation for med pass 2.0 60 ml (milliliters) to be given four times a day to resident #8 due to a concern that his food intake had decreased. There had been no weight loss and the supplement was to aid in the prevention of weight loss.

The dietary note dated 12/21/11 indicated resident #8 weighed 160.2 pounds with no significant change in 180 days. Interventions for wound healing and supplements remain in place.

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 279 Continued From page 24

F 279

A review of NA (Nurse Aide) documentation for December 2011, January, February, March, and April of 2012 revealed resident #8 had an average food intake of 75-100% for most of his meals.

A review of the dietary consultant's notes dated 2/22/12 revealed resident #8 weighed 140 pounds. The Dietary consultant indicated resident #8 had lost -15% of body weight in a 90 day period. The note also indicated resident #8 had an intake of 25-75% and no interventions would be added to the care plan at that time for weight loss because resident #8 had gained one pound in the past 2 weeks.

On 3/6/12 the dietary note revealed resident #8 had a stage 2 decubitus ulcer and significant weight loss. Interventions were recommended to prevent further weight loss; Promod 30 ml was to be given every day after lunch and a magic cup twice a day between meals. Resident #8's weight was listed as 136 pounds.

A review of the care plan dated 5/11/12 indicated resident #8 was not identified for at risk or actual weight loss on his care plan.

During an interview on 6/28/12 at 3:00 PM with the Don it was revealed Dietary recommendations were discussed monthly. Her expectations would be that if a problem was identified it would be discussed and care planned to assure the resident's needs are met. The DON was unsure why weight loss had not been care planned.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

F 280

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 280 Continued From page 25

F 280

This Plan of Correction is the center's credible allegation of compliance.

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

F280 care plans

07/28/12

Corrective Action for Resident Affected

Resident # 1, 7, 8 and 42 care plans were updated on 07/24/12 by the MDS nurse. # 42 was updated for significant wt loss

Corrective Action for Resident Potentially Affected

All residents have the potential to be affected by this practice. On 07/18/12 the Director of Nursing and MDS nurse reviewed the target dates for goals on all current residents. This was completed by reviewing both the electronic target dates and the target dates on the paper care plans. A list of residents whose care plan had not been updated in the last 3 months was identified. On 07/24/12 the interdisciplinary care plan team reviewed and updated care plans for those residents identified.

This REQUIREMENT is not met as evidenced by:

Based on staff interviews and record reviews, the facility failed to review and update 3 resident care plans (Resident #1, #7, #8, and #42) out of 20 resident care plans reviewed.

Findings include:

- 1) Review of Resident #1 's most recent care plan review date was documented as 6/2/12. The resident 's most recent MDS (Minimum Data Set) was a quarterly assessment dated 5/4/12.

During an interview with the MDS Coordinator on

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 280 Continued From page 26

6/30/12 at 2:12 PM, the nurse reported the Director of Nursing (DON) was responsible for updating the care plans in the facility.

During an interview with the DON on 6/30/12 at 9:59 AM, the DON stated she was responsible for updating the resident's care plan. The DON reported the care plan for Resident #1 should have been reviewed and updated on 6/2/12. The care plans were expected to be reviewed every 90 days.

2) Resident #7 was admitted to the facility on 9/22/12 and readmitted on 4/10/12. Review of the resident's most recent full MDS (Minimum Data Set) assessment revealed the assessment was completed on 4/24/12. The goal date of the resident's care plan was documented as 6/7/12.

During an interview with the MDS Coordinator on 6/30/12 at 2:12 PM, the nurse reported the DON was responsible for updating the care plans in the facility.

During an interview with the DON on 6/28/12 at 4:22 PM, the DON stated the care plans were reviewed every 90 days and re-evaluated with the MDS (Minimum Data Set) completion. The DON stated the care plan for Resident #7 should have been reviewed and updated on 6/7/12.

F 280

This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

All residents who have had significant weight loss (5 % in 30 days, 7.5% in 90 days and 10 % in 180) also have the potential to be affected by this practice. On 07/22/12 a computerized report was generated by the DON and MDS nurse consultant to identify residents who have had weight loss as defined above. The interdisciplinary team reviewed and updated those care plans on 07/24/12.

Systemic Changes

An in-service was conducted on 07/20/12 by Corporate MDS Nurse for the MDS nurse, dietary services manager, social services and activity director (the interdisciplinary care planning team). The in-service topics included ensuring that significant weight loss was appropriately care planned and that all care plans be reviewed quarterly. Documentation of the care plan update should be maintained by the MDS nurse.

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

PRINTED 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280 Continued From page 27

F 280

This Plan of Correction is the center's credible allegation of compliance

3) Resident #42 was admitted on 10/11/11 with diagnoses of dementia, stroke, urinary tract infections, chronic kidney disease and anemia. The care plan problem onset dated 8/3/11 indicated Resident #42 only ate preferred foods associated with the dislike of the therapeutic diet. The goal was continued on 6/27/12 to follow the therapeutic diet of no added salt for the next 90 days. The minimum data set dated 6/4/12 indicated Resident #42 required some assistance with meals.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

A record review of the facility weights was reviewed. The weight for Resident #42 was at 192lbs on 12/12/11. By 3/6/12, Resident #42 weight was at 163 lbs. There was significant weight loss during this time period.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

A record review of the facility nutrition notes was conducted. The note dated 5/25/12 indicated the diet order was for a 2 gram sodium diet. There was a recommendation to liberalize the diet to a regular diet to prevent further weight loss.

Quality Assurance

The Director of Nursing will monitor this issue using the "Clinical Survey QA Tool". The monitoring will include ensuring that care plans that have had quarterly MDSs completed in the last week have been updated. S will be reviewed if completed in since the last review. See attached monitoring tool. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. It will also be reviewed in Quarterly QOL/QA committee attended by the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Environmental Director and Activities Director

A record review of the facility physician order dated 6/4/12 indicated a diet change for a regular diet.

A record review of Resident #42 meal ticket dated 6/28/12 dinner meal revealed a no added salt diet to be served.

An interview with the Dietary Manager (DM) on 6/28/12 at 3:15 pm revealed Resident #42 had significant weight loss in the last nine months. She notified the Registered Dietitian (RD) in January 2012 of the significant weight loss. She

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

PRINTED 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 280 Continued From page 28
would usually call the RD when there was a weight loss. The RD visits the facility monthly. The DM indicated she would do nutrition intervention in between the RD visits. Resident #42 never indicated why she did not like her no added salt diet.

An interview with the Dietary Manager on 6/30/12 at 12:09 pm revealed she does the care plans for nutrition. She indicated she would also update care plans for the resident's nutrition status. She indicated she just got busy and did not update Resident #42 care plan for significant weight loss.

An interview with the Director of Nursing and Administrator on 6/30/12 at 12.12 pm revealed they had the new daily and weekly quality of life meetings now to address weight concerns more efficiently.

F 312 483.25(a)(3) ADL CARE PROVIDED FOR SS=D DEPENDENT RESIDENTS

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:

Based on observations, record review and staff interviews; the facility failed to provide appropriate perineal care for 1 (Resident #54) of 1 sampled residents observed for catheter care; and, failed to rinse soap from the resident's skin while providing perineal care and completing a bath for

F 280

This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

The QOL/QA committee is the main quality assurance committee. They have regularly scheduled meeting weekly which are attended by the Administrator, Director of Nursing, other nurse managers, and dietary manager.

It will also be reviewed in Quarterly QOL/QA committee attended by the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Environmental Director and Activities Director

F 312

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 312 Continued From page 29
1 (Resident #54) of 1 sampled residents observed for catheter care.
Findings include:

a. The facility policy, dated 10/01/12, titled "Catheter Care, Indwelling" indicated under Purpose was 1. To prevent infection. Under the section headed Procedure indicated: 4. Wash (the) perineum well with soap and warm water, (and) taking care to wash from front to back.

Resident #54 was admitted to the facility on 06/25/10 and readmitted on 03/05/12. Cumulative diagnoses included pyelonephritis, urinary retention and progressive supranuclear palsy (PSP). PSP is a rare brain disorder that causes problems with control of gait and balance, along with eye movement and thinking problems.

Review of the quarterly MDS (Minimum Data Set) assessment, dated 03/26/12, indicated Resident #54 had no cognitive impairment and was able to make decisions about her daily care. The assessment revealed the resident required extensive assistance with bed mobility, dressing, personal hygiene and bathing. The resident was assessed to have an indwelling catheter in place and be incontinent of bowel.

Review of the Resident #54's care plan, dated 03/26/12, indicated the resident had an indwelling catheter and one of the interventions was to provide catheter care every day.

On 06/28/12 at 10:50 AM, an observation was made of Resident #54 receiving catheter care. Nurse Aide #1 was observed to have a fresh basin of water, soap, clean towels and wash

F 312 *This Plan of Correction is the center's credible allegation of compliance.*

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

F 312 ADLS

Corrective Action for Resident Affected

Resident #54 had catheter care provided per policy by a NA as observed by a licensed nurse on 07/16/12. NA #1 was counseled and educated on 07/24/12 by Staff Development Coordinator.

Corrective Action for Resident Potentially Affected

All residents who have a foley catheter have the potential to be affected by this practice. See systemic changes for corrective action for residents potentially affected.

Systemic Changes

An in-service was conducted on 07/19/12 and 07/20/12 by Interim DON. All nurses attended: RNs and LPNs, NAs, FT, PT and PRN. Any in-house staff who did not receive in-service training by 07/27/12 will not be allowed to work until training has been completed.

7/28/12

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(Y1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 312 Continued From page 50

cloths ready. The NA unfastened the brief, folding the brief downward exposing the perineal area. The NA was observed to apply soap to the wash cloth and washed back and forth across the resident's abdomen times two times, then washed front to back and back to front down the left and right side of the perineum two times. The NA rinsed the cloth in the basin and applied additional soap. She was observed to wash the labia front to back and back to front two times, then she held the catheter at the insertion site and with a circular motion cleaned the insertion site and wiped the catheter downward two times. She was then observed to dry the perineal area. The NA turned the resident onto her left side and observed a moderate amount of brown matter at the rectal area. She was observed to use wipes to remove the brown matter, to place the wipes with the brown matter on the soiled brief, folded the brief inward and removed it from under the resident. The NA applied soap to the washcloth and washed the rectal area front to back three times, then dried the rectal area. The NA rinsed the washcloth, applied soap and washed both of the resident's legs and feet and then dried them.

An interview, on 06/28/12 at 11:20 AM, was conducted with NA #1. The observation was reviewed with NA #1 she indicated the correct way to wipe during perirenal care was from front to back and she thought she had done so.

An interview, on 06/29/12 at 3:12 PM PM was conducted with the Director of Nursing (DON). The DON stated the staff should follow the facility policies for perineal/catheter care. She indicated the policy provided step by step directions and those directions should have been used.

F 312

The Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

The in-service topics included the following the proper procedure for providing perineal care to residents with catheters and rinsing soap from the residents skin when providing perineal care or bathing. Additionally from 07/13/12 to 07/28/12 a registered nurse conducted perineal catheter care skills checklist on all active nursing assistants.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

Quality Assurance

The Director of Nursing or management nurse will monitor this issue using the "Clinical Survey QA Tool". The monitoring will include 5 observations of perineal and catheter care to ensure that staff use proper procedures and wash soap from resident's skin. See attached monitoring tool.

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 312 Continued From page 31

F 312

This Plan of Correction is the center's credible allegation of compliance.

b. Resident #54 was admitted to the facility on 06/25/10 and readmitted on 03/05/12. Cumulative diagnoses included pyelonephritis, urinary retention and progressive supranuclear palsy (PSP). PSP is a rare brain disorder that causes problems with control of gait and balance, along with eye movement and thinking problems.

Review of the quarterly MDS (Minimum Data Set) assessment, dated 03/26/12, indicated Resident #54 had no cognitive impairment and was able to make decisions about her daily care. The assessment revealed the resident required extensive assistance with bed mobility, dressing, personal hygiene and bathing. The resident was assessed to have an indwelling catheter in place and be incontinent of bowel.

On 06/28/12 at 10:50 AM, an observation was made of Resident #54 receiving perineal care and completion of a bed bath. The NA was observed to place soap on the washcloth, to wash the perineum, the labia, and catheter, and to dry the areas. The NA proceeded to rinse the wash cloth, apply soap and to wash and dry the rectal area; then the NA rinsed the wash cloth, applied soap, washed the resident's legs and feet, and dried them.

Review of the directions on the bottle of soap at the bedside revealed directions to wash with soap, rinse thoroughly and then dry the resident.

An interview, on 06/28/12 at 11:20 AM, was conducted with NA #1. The observation was reviewed with NA #1, and she confirmed she was

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. They have regularly scheduled meeting weekly which are attended by the Administrator, Director of Nursing, other nurse managers, and dietary manager.

It will also be reviewed in Quarterly QOL/QA committee attended by the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Environmental Director and Activities Director

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
		(X5) COMPLETION DATE	

F 312 Continued From page 32
aware the soap needed to be rinsed off before drying the resident and she had forgotten to do that.

An interview, on 06/29/12 at 3:12 PM was conducted with the Director of Nursing (DON). The DON stated the facility had always used soap that needed to be rinsed off and she expected the staff when giving a bath or providing care to rinse the soap off before drying a resident.

F 325 SS=G 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE

Based on a resident's comprehensive assessment, the facility must ensure that a resident:

- (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
- (2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:

Based on staff interviews and record reviews the facility failed to failed to prevent weight loss for 1 (Resident #42) of 2 residents with weight loss.

Resident#42 was admitted to the facility on 10/11/11 with diagnoses of dementia, stroke, urinary tract infections, chronic kidney disease and anemia. The Minimum Data Set (MDS) dated 6/4/12 indicated Resident#42 required some assistance with meals and was not on a

F 312 This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

F 325 F325 Avoiding nutritional status decline unless unavoidable

Corrective Action for Resident Affected

For Resident #42, Promod, medpass and mighty shakes were initiated and the care plan was updated on 06/30/12. Resident # 42 was reviewed on 07/22/12 by the corporate dietician

Corrective Action for Resident Potentially Affected

All residents have the potential to be affected by this practice. A computerized weight loss report was generated for all residents who have had a significant weight loss (5 % in 30 days, 7.5% in 90 days and 10 % in 180). Any resident who has had a significant weight loss and is still losing weight was reviewed by the dietician on 07/20/12 and 07/22/12 and interdisciplinary care planning team on 07/24/12 to ensure that appropriate interventions were implemented and care planned.

07/28/12

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 325 Continued From page 33

prescribed weight loss plan. She was also at a low cognitive level. The Care Area Assessment dated 12/22/11 indicated Resident #42 triggered for nutrition and pressure ulcer risk. These two risk areas were to be care planned. The care plan problem onset dated 8/3/11 for nutrition indicated Resident #42 only ate preferred foods associated with the dislike of the therapeutic diet. The goal was continued on 6/27/12 to follow the therapeutic diet of no added salt for the next 90 days.

A record review of the facility weights was reviewed. The weights for Resident #42 was the following: 192 lbs (10/19/11), 191 lbs (11/1/11), 192 lbs (12/12/11), 170 lbs (1/24/12), 168 lbs (2/16/12), 163 lbs (3/6/12), 156 lbs (4/10/12), 156 lbs (5/8/12) and 155 lbs (6/1/12). There was a greater than 10% weight loss in one month for January 2012.

A record review of the facility nurse notes was conducted. The note dated 1/26/12 indicated the physician had called the facility and asked about Resident #42 eating the last few days due to Resident #42 family member had called the physician about Resident #42 appetite. The note dated 1/27/12 indicated Resident #42 had eaten only 25% of her meal and was drowsy. The family member was concerned about Resident #42 changes and poor appetite. There was a fax sent to the physician about this concern.

A record review of the facility physician orders dated 1/31/12 revealed an order for a dietary consult.

F 325

This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

Systemic Changes

An in-service was conducted on 07/13/12 and 07/20/12 by Corporate MDS Nurse for the MDS nurse, dietary services manager, social services and activity director (the interdisciplinary care planning team) The in-service topics included appropriate weight loss interventions and to continue interventions until weight loss is stabilized or discontinued by MD.

The weekly Quality of Life Meeting will review all resident with a weight loss or gain (5 % in 30 days, 7.5% in 90 days and 10 % in 180). This review will include but not limited to percentage of meal intake, supplements, snacks offered, labs, notification of MD and Family, referral to Dietician, review of care plan and consideration for the completion of a significant change MDS. A review of facility wounds including Pressure Ulcers will be presented by the Wound Care Nurse. This review will also include the care plan and consideration for the completion of a significant change MDS.

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 325 Continued From page 34

A record review of the facility weekly wound review assessment was conducted. It indicated a new wound was acquired in the facility on 2/7/12. The wound was located on the left buttock. It was a stage II wound.

A record review of the facility nursing remarks document dated 2/16/12 revealed a report of a low appetite and constipation to the physician.

A record review of the facility nutrition notes was conducted. The nutrition note dated 10/19/11 revealed Resident #42 weight at 192 lbs. There was a recommendation of a protein liquid of 30 milliliters (ml) once daily due to a low albumin level of 2.8. The note dated 2/22/12 indicated a current body weight of 168 lbs. There was a decubitus to the buttocks area at stage II. The diet was a no added salt diet. There was a recommendation of a high calorie nutrition supplement at 60 ml twice daily. This was to aid in the prevention of significant weight loss. The nutrition assessments dated 3/20/12 and 6/6/12 indicated there was weight loss over the last six months. The Registered Dietitian and Physician were made aware and there were recommendations. The facility nutrition notes dated 5/25/12 revealed Resident #42 current body weight was 156 lbs. There was significant weight loss indicated for the three and six month periods. There was a recommendation to liberalize the diet to a regular diet.

A record review of the facility medical nutrition therapy recommendation document dated 2/22/12 revealed a recommendation of a high calorie nutrition supplement at 60 ml twice daily due to a decrease in food and beverage intake

F 325

This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

Committee members will include at a minimum: Administrator, DON, SDC, Unit Director, MDS nurse, Wound Care Nurse Social Services, Dietary and other clinical team members as needed. This review will be documented on the DON daily checklist.

When dietary recommendations are made, Dietician reviews with the Dietary Manager and Director of Nursing. The DON will give a copy of the dietary recommendation to Medical Records to forward to the physician. Once the dietary recommendation is received back to the facility, the DON will ensure that the staff nurses review the recommendation, write the recommendation on a telephone order, then forward to the dietary manager to make changes in the tray tracker. Orders will be reviewed in the next quality of life meeting to ensure all departments are aware of the changes.

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 325 Continued From page 35 and risk for weight decrease. The recommendation was approved by the physician on 2/29/12.

A record review of the physician orders revealed an order for a protein liquid of 30 ml daily and high calorie supplement 60ml twice daily on 3/26/12. Another reorder for the same nutritional supplements was ordered on 4/4/12.

A record review of the physician orders revealed a diet order change to a regular diet on 6/4/12.

A record review of Resident #42 meal ticket dated 6/28/12 dinner meal revealed a no added salt diet was served.

An interview with the Dietary Manager (DM) on 6/28/12 at 3:15 pm revealed Resident #42 had significant weight loss in the last nine months. She notified the Registered Dietitian (RD) in January 2012 of the significant weight loss. She would usually call the RD when there was a weight loss. The RD visits the facility monthly. The DM indicated she would do nutrition intervention in between the RD visits. There was a nutrition shake started three times daily but Resident #42 did not drink it. This nutrition shake was stopped. Resident #42 never indicated why she did not like her no added salt diet. She had started snacks three times daily but Resident #42 did not eat the snacks. She then had stopped the snacks. The DM did not have documentation of the snacks or nutrition shakes that were started.

An interview with the RD on 6/28/12 at 4:57 pm revealed Resident #42 had significant loss the last 180 days and she had recommended a high

F 325 *This Plan of Correction is the center's credible allegation of compliance.*

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

Quality Assurance
The Director of Nursing will monitor this issue using the "Clinical Survey QA Tool". The monitoring will include reviewing all residents who have had a significant weight loss (see definitions above for significant wt loss) to identify any resident whose weight is not stabilized or improved. For those residents a review will be conducted to ensure that additional interventions are identified.

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

PRINTED 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 325	<p>Continued From page 36</p> <p>calorie supplement back in February 2012. When she had visited in May 2012, she saw another decline in weight status and recommended to liberalize Resident #42 diet to a regular diet. When she visits monthly, the DM would provide her with a list of people with significant weight loss and dietary consults. The Quality of Life (QOL) team would meet weekly and discuss residents with weight loss between her monthly visits. The QOL team would do nutrition interventions between her visits.</p> <p>A record review of the facility weekly QOL committee minutes was reviewed. Resident #42 was discussed on 1/16/12, 2/29/12, 3/15/12, 3/23/12, 3/30/12, 4/5/12, 4/13/12, 4/19/12, 5/4/12, 5/10/12, 5/18/12 and 5/31/12. The meeting dated 2/29/12 indicated a weight of 161 lbs. There was indication of a multivitamin in place. The meeting dated 3/15/12 and 3/23/12 did not indicate interventions. The meeting dated 3/30/12 indicated a weight status of 159 lbs. There was a recommendation for a liquid protein and high calorie supplement. The meeting dated 4/5/12 indicated a facility medical recommendation on 3/6/12 for a liquid protein supplement at 30 ml and high calorie supplement 60 ml twice daily. It indicated this recommendation was faxed on 4/2/12 for the third attempt and for the physician to respond. The meeting dated 4/13/12 indicated the weight status was at 156 lbs. The protein liquid and high calorie supplement had started.</p> <p>An interview with the Administrator and QA Nurse Consultant on 6/29/12 at 11:38 pm revealed they started to conduct daily clinical meetings to review weights. There were trials of this meeting which started in March 2012 and officially started</p>	F 325	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law</i></p> <p>See attached monitoring tool. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. They have regularly scheduled meeting weekly which are attended by the Administrator, Director of Nursing, other nurse managers, and dietary manager.</p> <p>It will also be reviewed in Quarterly QOL/QA committee attended by the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Environmental Director and Activities Director</p>

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 325 Continued From page 37
6/11/12. There was weekly and monthly QOL meetings where weight loss and nutrition problems were discussed. Then there would be a Quarterly QOL performed for weights as well. The Social Worker, DM, Director of Nursing (DON), Administrator and other Administrative staff attended these meetings.

F 325 *This Plan of Correction is the center's credible allegation of compliance.*

An interview with the DON and Administrator on 6/30/12 at 12:12 pm revealed they have the new daily QOL meetings now to address weight concerns more quickly. They would expect to have nutrition intervention for significant weight loss immediately.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
SS=E

F 371 No specific resident was identified in the 2567. On 06/25/12 all unlabeled stored items were discarded. Sanitation cloths were properly stored on 06/28/12 by the dietary manager. The nourishment refrigerator was replaced on 07/02/12 by the maintenance director..

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

F-371 - Food, Prepare, Store, Serve 07/28/12

Corrective Action for Resident Affected

Corrective Action for Resident Potentially Affected

All residents have the potential to be affected by this practice. See systemic changes listed below for corrective action for residents potentially affected.

Systemic Changes

An in-service was conducted on 07/23/12 by the dietary consultant. All dietary staff attended: dietary aides and cooks, FT, PT and PRN.

This REQUIREMENT is not met as evidenced by:
3) An observation on 6/27/12 at 5:50 PM of the nourishment room revealed a refrigerator with multiple brown/tan spots of debris on the sides of the inner walls. The bottom shelf of the refrigerator had visible round brown stains and other brownish colored debris. Yellowish/tan splattered debris was noted on each of the shelves of the door. An observation of the

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 371 Continued From page 38
nourishment refrigerator on 6/28/12 at 9:30 AM revealed the debris remained in the refrigerator.

During an observation with the Administrator and Housekeeping Director on 6/30/12 at 1:30 PM, the Administrator and Housekeeping Director agreed the refrigerator was expected to be clean and free of debris. The Housekeeping Director reported the refrigerator was cleaned weekly and was last cleaned 6/25/12 and should not be dirty.

Based upon observations, record reviews and staff interviews the facility failed to contain stored food items, label and date opened food and store sanitation cloths in a sanitation bucket in the main kitchen, and the facility failed to maintain 1 of 1 nourishment refrigerators in clean condition.

Findings Include:

1. An initial main kitchen tour conducted on 6/25/12 at 6:20 pm with the Dietary Manager (DM) revealed there was vanilla extract and red food color dye unlabeled and undated in the dry storage room. At 6:23 pm there was prepared unsweetened tea and sweetened tea unlabeled and undated on the food preparation table next to the exit door. At 6:30 pm there was french dressing, pickle relish and a chocolate sheet cake unlabeled and undated in the reach-in refrigerator. The chocolate sheet cake was uncovered. At 6:32 pm there was a pitcher of unlabeled and undated prepared pitcher of tea and whipped cream in the walk-in refrigerator. At 6:33 pm there was a container of unlabeled and undated chocolate ice cream in the walk-in freezer.

F 371

This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

Any in-house staff who did not receive in-service training by 07/28/12 will not be allowed to work until training has been completed. The in-service topics included the following proper dating and labeling of opened food and proper storage of sanitation cloths.

On 07/19/12 the administrator also conducted in-service training for all current housekeeping and maintenance staff to validate the proper procedure for cleaning the nourishment refrigerator. Any in-house staff who did not receive in-service training by 07/28/12 will not be allowed to work until training has been completed.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 371 Continued-From page 39

F 371

This Plan of Correction is the center's credible allegation of compliance.

An observation in the main kitchen on 6/28/12 at 1:29 pm revealed a block of sliced cheese loosely wrapped with cellophane in the reach-in refrigerator. One side of the cheese was exposed to the air. A cup of orange juice was unlabeled and undated in the reach-in refrigerator.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

A record review of an undated food service staff in-service was conducted. There was an in-service entitled "Cross-Contamination and Food Storage Practices." It reviewed the proper storage of food items.

Quality Assurance

The Administrator will monitor this issue using the "Survey QA Tool". The monitoring will include checking to see if the nourishment refrigerator is clean, that all open foods stored are properly labeled and that sanitation cloths are properly stored. See attached monitoring tool. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. They have regularly scheduled meeting weekly which are attended by the Administrator, Director of Nursing, other nurse managers, and dietary manager.

An interview with the DM on 6/28/12 at 1:52 pm revealed the staff used zip lock bags to store opened food items. She was not sure of why the cheese and cake was not covered. The DM indicated dietary staff knew they would use the zip lock bags to cover food items. The DM indicated that opened foods should be labeled.

It will also be reviewed in Quarterly QOL/QA committee attended by the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Environmental Director and Activities Director

2. An initial main kitchen tour conducted on 6/25/12 at 6:23 pm with the Dietary Manager (DM) revealed a sanitation cloth with stains was stored on the food prep table next to the exit door.

An observation in the main kitchen on 6/28/12 at 1:34 pm revealed a sanitation cloth was stored on the food prep table next to the stove.

An interview with Diet Aide #1 on 6/28/12 at 1:35 pm revealed the sanitation rag should not have been left on the table.

A record review of an undated food service staff

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
		(X5) COMPLETION DATE	

F 371 Continued From page 40
in-service was conducted. There was an in-service entitled " Proper Cleaning, Sanitizing and Storage of Service Ware. " The in-service mentioned that sanitizing cloths were to be stored in the sanitizing solution.

An interview with the DM on 6/28/12 at 1:52 pm revealed dietary staff had been informed that they would need to store sanitation cloths in the sanitation buckets.

F 431 483.60(b), (d), (e)-DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS
SS=E

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the

F 371

This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

F 431 refrigerator temps

07/28/12

F 431

Corrective Action for Resident Affected

The medication refrigerator was replaced on 06/30/12 by maintenance director.

Corrective Action for Resident Potentially Affected

All residents have the potential to be affected by this practice. See systemic changes for corrective actions.

Systemic Changes:

All medication refrigerators will have thermometers and daily checks for refrigerator temperature will be recorded by the charge nurse. Any refrigerators with temp outside the range of 36 to 46 degrees will be reported to the Maintenance Director for appropriate follow up and repair.

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 431 Continued From page 41
Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, record reviews and staff interviews, the facility failed to maintain the proper temperature for medication storage for 1 of 1 medication storage rooms.

Findings include:

Review of an undated facility form titled "Refrigerator/Freezer Temperature Log" indicated the temperature range for the refrigerator should stay between > (over) 32 degrees and < (under) 40 degrees, and "notify Maintenance if thermostat does not keep temps (temperature) within range."

On 06/30/12 at 9:00 AM accompanied by the Director of Nursing (DON), an observation of the temperature of the refrigerator in the medication room registered 38° F. Review of the temperature log for the refrigerator in the medication room revealed for 11 of the 29 documented days of June the temperature was 32°F, and for 6 of the 29 days documented for the month of June the temperature was 34°F.

On 06/30/12 at 9:30 AM, accompanied by Nurse #5, the refrigerator temperature was observed

F 431 *This Plan of Correction is the center's credible allegation of compliance.*

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law

An in-service was conducted on 07/19/12 and 07/20/12 by Interim DON. All nurses attended: RNs and LPNs, FT, PT and PRN and the Maintenance Director.

Any in-house nurse who did not receive in-service training by 07/27/12 will not be allowed to work until training has been completed. The in-service topics included the following: ensuring that temperature logs are maintained for the medication refrigerator and that temperature should be maintained between 36 and 46 degrees. If a temperature is noted to be above or below this parameter then maintenance should be notified. Nurses on 11p - 7a should record the temperature on the temperature log.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

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

PRINTED 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 431 Continued From page 42
and confirmed by the nurse to be 34°F when the refrigerator was opened.

On 06/30/12 at 9:45 AM, accompanied by Nurse #5, the refrigerator temperature was observed and confirmed by the nurse to be 34° F when the refrigerator was opened.

The medications observed in the refrigerator were: 9 Levemir Insulin Pens; 9 Humalog Insulin Pens; 4 Humalog 70/30 Insulin Pens; 5 vials of Humulin 70/30 insulin; 8 Novolog Insulin Flex Pens; 2 vials of Novolog insulin; 1 vial of Novolog R insulin; 2 Lantus Insulin Pens; 4 vials of Pneumococcal vaccine; 7 vials of Hepatitis B vaccine; 1 single dose vial of Vitamin B12; and 1 box of Trelstar. Levimer, Humalog, Humulin, Novolog, and Lantus are insulin products used to treat diabetes, B12 is used to treat Vitamin B12 deficiency, and Trelstar is used to treat symptoms associated with advanced prostate cancer.

The manufacturer product information for Levemir insulin reads in part: "unopened Levemir Pens should be stored in a refrigerator at 36-46° F. Do not freeze. Do not use if has been frozen."

The manufacturer product information for Humalog 70/30 and Humalog insulin reads in part: "unopened vials and pens should be stored in a refrigerator at 36-46° F. Do not freeze. Do not use if has been frozen."

The manufacturer product information for Novolog insulin reads in part: " unopened vials and pens should be stored in a refrigerator at 36-46° F. Do not freeze. Do not use if has been

F 431

This Plan of Correction is the center's credible allegation of compliance

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

Quality Assurance

The Director of Nursing will monitor this issue using the "Clinical Survey QA Tool". The monitoring will include ensuring that temperatures are documented and that the range is between the appropriate level. See attached monitoring tool.

This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. They have regularly scheduled meeting weekly which are attended by the Administrator, Director of Nursing, other nurse managers, and dietary manager.

It will also be reviewed in Quarterly QOL/QA committee attended by the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Environmental Director and Activities Director

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 43</p> <p>frozen."</p> <p>The manufacturer product information for Lantus insulin reads in part: "unopened vials should be stored at in a refrigerator at 36-46° F. Lantus should not be allowed to freeze."</p> <p>The manufacturer product information for Pneumococcal vaccine reads in part: "unopened and opened vaccine should be stored at in a refrigerator at 36-46° F. Do not freeze."</p> <p>The manufacturer product information for Hepatitis B vaccine reads in part: "store in refrigerator between 36-46° F. Do not Freeze."</p> <p>The manufacturer product information for Vitamin B 12 injectable reads in part: "Store at room temperature between 59-86° F. Do not freeze."</p> <p>The manufacturer product information for Trelstar and the label on the box read in part: "store Trelstar at room temperature between 68 and 77 ° F. Do not freeze."</p> <p>Review of the temperature logs for the refrigerator in the medication room for the month of April 2012 revealed documentation for 7 of the 30 days of April the temperature of the refrigerator was 33°F, for 6 days of month of April the temperature for the refrigerator was 34°, and for 8 of the 30 days of April the temperature for the refrigerator was 35°F</p> <p>Review of the temperature logs for the refrigerator in the medication room for the month of May 2012 revealed documentation that for 14 of the 31 days of May the temperature of the refrigerator was 32°F, and for 6 days of month of May the temperature for the refrigerator was 34°F</p>	F 431		

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 431 Continued From page 44

F 431

An interview, on 06/30/12 at 9:15 AM, was conducted with the Director of Nursing (DON). The DON stated she was not aware that the refrigerator temperature log parameters were out of range to store the medications. She reviewed the June 2012 log and noted the nurses had stayed within the parameters on the temperature log. The DON indicated she was not aware where the temperature log form had originated.

A phone interview, on 07/10/12 at 4:15 PM, was conducted with the Administrator and she indicated she was unaware the temperatures of the medication refrigerator log were in error. When asked if the Consultant Pharmacist checked the refrigerator on the monthly visit, the Administrator indicated she was uncertain if the Consultant Pharmacist checked it. She reviewed the last monthly visit report and relayed that she did not see any information regarding the refrigerator temperatures.

A phone interview, on 07/11/12 at 8:55 AM, was conducted with the Consultant Pharmacist. The Consultant Pharmacist relayed the pharmacy had a nurse that visits the facility monthly and check the stock medication and the refrigerator. She indicated the nurses had not been available for the past few months, but there was a nurse now. The Consultant Pharmacist stated she did check the temperature of the refrigerator on her visit in April and per her report the temperature was 40° F. She indicated she does not usually look at the temperature log and was not aware the temperature log designated the range of the refrigerator temperature to be under 32° and over

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

PRINTED 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 45 40° F. She confirmed the temperature for the medication refrigerator needed to be kept between 36 - 46°F.	F 431	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	<i>Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.</i> F 441 Infection Control Incontinent care Corrective Action for Resident Affected Resident #54 had catheter care provided by an aide on 07/16/12. The fan in the laundry room was cleaned on 06/28/12 by laundry staff. Also, see systemic changes. Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this practice. See systemic changes for corrective action for residents potentially affected. Systemic Changes An in-service was conducted on 07/19/12 and 07/20/12 by Interim DON. All nurses attended: RNs and LPNs, NAs, FT, PT and PRN.	07/28/12

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 441 Continued From page 46
transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interviews, the facility failed to ensure staff changed gloves after removing fecal matter while providing perineal care and completing a bath for 1 (Resident #) of 1 residents observed for perineal care, and failed to ensure soiled linen was handled and stored in a manner to prevent the spread of infection during 1 of 1 observations of soiled linens being placed on the resident's bed linens; and the facility failed to maintain resident clothing and linen in the clean area of the laundry room away from 1 of 1 fans with built-up lint on the grill.

Findings included:

1) The facility policy, dated 10/01/01, titled "Perineal Care" indicated under the Purpose was: 2. to prevent infection and odor. And, under the General Infection Control Guidelines that employees were to: 1. Observe (standard) universal precautions or other infection control standards as approved; 2. Wash you hands before and after all procedures. Wear gloves when appropriate; 6. Dispose of disposable equipment appropriately; and, 9. Dispose of soiled linen appropriately.

a. On 06/28/12 at 10:50 AM, an observation was made of Resident #54 receiving perineal care.

F 441 This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

Any in-house staff who did not receive in-service training by 07/27/12 will not be allowed to work until training has been completed. The in-service topics included the following the proper procedure for providing perineal care to residents with catheters, proper handling and storage of linen to prevent the spread of infection. Additionally from 07/13/12 to 07/28/12 a registered nurse conducted perineal catheter care skills checklist on all active nursing assistants.

Annual CNA skills check list includes bed bath procedure, pericare and foley care each NA must demonstrate skill and understanding of the policy/procedure. Any task not completed by the NA to the satisfaction of the observing Nurse will be reeducated until demonstration of proper technique per policy/procedure is achieved. Any concerns will be reported the DON for appropriate follow up.

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 441 Continued From page 47

NA #1 was observed to be in the midst of bathing the resident. She had obtained a fresh basin of water, and washed the perineal area. When she turned the resident onto her left side, she observed a moderate amount of brown matter at the rectal area. The NA used wipes to remove the brown matter, placed the wipes with the brown matter onto the brief under the resident, and folded the brief inward. The NA proceeded to wash the rectal area with soap and water, dried the area, and turned the resident onto her back. With the same gloves on and using the same basin of water used to clean the rectal area, the NA washed and dried the resident's legs and feet. The NA continued with the same gloves on to put a new brief on the resident; to put on the resident's shorts; to adjust the resident's gastrostomy tube and shirt. With the same gloves on, she was observed to take the basin of water; to open the bathroom door, to turn on the faucet; and, to rinse and dry the basin. After exiting the bathroom, she removed her gloves, donned new gloves, placed the soiled brief containing the brown matter into a plastic bag, placed the soiled towel and wash cloth into a plastic bag, proceeded to open the resident's door, then opened the soiled utility door, disposed of the plastic bags, returned to the resident's room, removed her gloves, and washed her hands.

An interview, on 06/28/12 at 11:20 AM, the observation was reviewed and an interview was conducted with NA #1. The NA indicated she should have changed her gloves and gotten a fresh basin of water to wash the resident's legs and complete the resident's care. The NA relayed she really had not been feeling well.

F 441

This Plan of Correction is the center's credible allegation of compliance.

Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.

The maintenance director was in serviced on 07/20/12 by the administrator to ensure understanding of the need to maintain a clean laundry area including the fan.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

Quality Assurance

The Director of Nursing will monitor this issue using the "Clinical Survey QA Tool". The monitoring will include 5 observations of perineal and catheter care and proper handling of linen to prevent the spread of infection. The Administrator will also monitor this issue using the "Survey QA Tool. The monitoring will include a review of the laundry room to ensure that the fan and area is clean and free from lint. See attached monitoring tools.

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

PRINTED 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY			STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 48 An interview, on 06/29/12 at 3:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she would have expected the NA to have removed her gloves and washed her hands after providing perineal care and removing stool. She relayed NA#1 had received training regarding infection control, perineal care, and bathing. b. On 06/28/12 at 10:50 AM, an observation was made of Resident #54 receiving perineal care and completion of a bed bath. NA #1, with gloves on, was observed to use wipes to remove the brown matter from the resident's rectal area, placed the wipes with the brown matter onto the brief under the resident, and folded the brief inward. She completed the bed bath. The NA was then observed to remove the brief, wrapped up the brief containing the brown matter, and laid the brief on top the resident's bed linens. She then proceeded to ring out the wash cloth and placed the soiled towel and wash cloth on top of the resident's bed linens. The NA took the basin of water to the bathroom and emptied it. After exiting the bathroom, she removed her gloves, donned new gloves, took the soiled brief containing the brown matter on top of the resident's bed linens and placed it into a plastic bag. The NA then took the wet wash cloth and towel on top of the resident's bed linens and placed the soiled linen into another plastic bag. An interview, on 06/28/12 at 11:20 AM, the observation was reviewed and an interview was conducted with NA #1. She indicated she should have placed the soiled brief and soiled linens in plastic bags and not on the resident's bed	F 441	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i> This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. They have regularly scheduled meeting weekly which are attended by the Administrator, Director of Nursing, other nurse managers, and dietary manager. It will also be reviewed in Quarterly QOL/QA committee attended by the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Environmental Director and Activities Director	

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 441	<p>Continued From page 49</p> <p>linens. The NA relayed she had not been feeling well.</p> <p>An interview, on 06/29/12 at 3:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she would have expected the NA to follow the policy for infection control. She relayed NA#1 had received training regarding infection control, perineal care, and bathing.</p> <p>2) An observation of the clean area of the laundry room on 6/28/12 at 1:49 PM revealed a 24 " fan rested on a black plastic box blowing on high speed from one side of the room to the other side. The front grill of the fan was covered with lint. The back grill of the fan was also covered with lint. A rack of resident clothing and a table of unfolded linens, blankets, and clothes that were uncovered, were located on the opposite wall facing the blowing fan.</p> <p>During the observation, an interview was conducted with the Director of Housekeeping and Laundry. The Director stated it was hard to keep lint at a minimum because it was the laundry room. The Director stated the fan had just been wiped off " last week " and " needed done as often as it needed to be ". The Director stated he " guessed " the fan should not be blowing over linen.</p> <p>During an interview with the Administrator on 6/30/12 at 3:33 PM, the Administrator stated she expected the fan in the laundry room to be clean and free of lint</p>	F 441	

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

PRINTED: 08/20/2012
FORM APPROVED
OMB NO: 0938-0391

RECEIVED
SEP 12 2012
CONSTRUCTION

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

345309

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING
B. WING

(X3) DATE SURVEY
COMPLETED

08/17/2012

NAME OF PROVIDER OR SUPPLIER

LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY

STREET ADDRESS, CITY, STATE, ZIP CODE

101 CAROLINE AVENUE
WELDON, NC 27880

COPY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation and staff interview on 08/17/2012 the staff did not know about the master release switch at the nurses station. 42 CFR 483.70 (a)	K 038	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. K 038 SS=D Corrective Action All staff that was present on 8/24/12 were instructed on the use and location of the Master Release Switch for the Magnetic Door Lock System. The staff not present for the in-service have been shown where it is located and how it works.	8/24/12
K 072 S=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: A. Based on observation on 08/17/2012 there items stored in the egress corridors that were not in use. a. two (2) lifts near room 106 b. clean and soiled linen stored near room 114 42 CFR 483.70 (a)	K 072	Identification of related safety hazards potentially affecting Residents All Staff have been instructed in the location and use of the Magnetic Door Lock System (Nurses Station) Systemic Changes In-service was conducted on 08/24/12 by the Administrator. All Staff, FT, PT, and PRN employed by this facility have completed the in-service. The in-service topics included: 1) Location of the Master Release Switch for the Magnetic Door Lock System (Nurses Station) 2) How and when to utilize the Master Release Switch for the Magnetic Door Lock System 3) This information has been integrated into the standard orientation training for all staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained	8/24/12
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	K 038 (continued)	8/19/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Jessie Pet

TITLE

Administrator

(X6) DATE

9/10/12

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

CD

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

PRINTED: 08/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345309	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/17/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY	STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 08/17/2012 the med. refrigerator was not on the emergency power. 42 CFR 483.70 (a)	K 147	<p>K 147 SS=D</p> <p>Corrective Action The med refrigerator was moved on 8/19/12 in order for it to be plugged into the emergency power receptacle.</p> <p>Identification of related safety hazards potentially affecting Residents This will be monitored by the administrator during daily rounds.</p> <p>Systemic Changes The nurses have been in serviced not to rearrange the med room explaining the reason for having the refrigerator plugged into an emergency power receptacle.</p> <p>Quality Assurance The monitoring is to include all nurses (LPN/RN) because they are the only ones who have a key to this room. They all know not to move the refrigerator from its location in case of an emergency power outage.</p>	