

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

AUG 22 2013

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE 2316 HIGHWAY 242 NORTH BENSON, NC 27504
--	---

(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 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal</p>	F 156	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>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.</p> <p>F 156 Corrective Action for Resident Affected There were no residents identified as having been affected by the alleged deficient practice. 8</p> <p>Corrective Action for Resident Potentially Affected All residents have the potential to be affected by the alleged deficient practice. On 07/25/13, the Facility Administrator posted the State contact information (address for Division on Health Services Regulation and phone number designating the number for complaint intakes) on the front hall way in the information center that is easily accessible and at wheel chair height.</p> <p>Systemic Changes On 08/09/13 the Activities Director discussed during the monthly Resident Council meeting the posting of the State contact information (address for Division on Health Services Regulation and phone number designating the number for complaint intakes) on the front hall way in the information center. All residents in attendance went to the front hall and observed the Posting. This discussion will continue by the Activities Coordinator on a monthly basis during each Resident Council Meeting.</p>	7-25-13
---------------	--	-------	--	---------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Lynna Monahan* TITLE: *LW Htt* (X6) DATE: *8-13-13*

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.

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504		
(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 155	<p>Continued From page 1 funds, under paragraph (c) of this section;</p> <p>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.</p> <p>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.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>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.</p>	F 155	<p>Quality Assurance The Administrator will monitor this issue using the "Posting QA Tool for Monitoring the required posting and monthly resident council meetings discussion". See attached monitoring tool. This tool will be completed every month times three months or until resolved by Quality of Life committee. Reports will be given to the monthly Quality of Life Quality Assurance committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Unit Manager, Support Nurse, Business Office Manager, Dietary Manager, Social Worker, MDS Coordinator and others as assigned. See Exhibit A _____.</p>		

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2316 HIGHWAY 242 NORTH BENSON, NC 27604		
(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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the state contact information in a prominent area. The findings included; During the initial tour on 7/22/13 2:00 PM., it was observed that the state contact information (address for Division on Health Services Regulation and phone number designating that number was for the complaint intake unit) was not posted in the facility. On 7/25/13 at 10:15 AM., a tour of the facility was conducted with Administrative staff #1. The correct state contact information was not posted anywhere in the facility; only contact information was for the ombudsman with a small area at the bottom of the left side of the Resident Bill of Rights poster that stated Division of facility services 1-800-624-3004. On 7/25/13 at 11:00 AM., Administrative staff #1 stated she was aware that the state contact information with the address and phone number for the complaint intake unit should be posted for easy access for residents and families if they had a complaint to call in to the state agency. She stated that would be corrected today with a poster for the state contact information for the complaint intake unit with the correct address and phone number. The poster would be placed in the front hallway and easily accessible at wheelchair height.	F 156			
F 221	483.13(a) RIGHT TO BE FREE FROM	F 221			

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504		
(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 221 SS=D	<p>Continued From page 3 PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to ensure a resident's mobility was not restricted by locking the wheelchair (Resident #82) for 1 of 4 sampled residents observed.</p> <p>The findings included:</p> <p>Resident #84 was admitted on 13/3/10 with diagnosis including Alzheimer ' s disease, dementia, dysphasia, and depression.</p> <p>The 4/11/13 Significant Change Minimum Data Set (MDS) revealed Resident #84 had short and long term memory problems and was significantly impaired in decision making.</p> <p>Review of the Plan of Care for Resident #84 revealed a problem/need area for " I am at risk for elopement " interventions included: Wanderguard at all times, redirect exit seeking behaviors and provide diversional activities.</p> <p>On 7/24/13 at 2:15 PM Resident #84 was observed, from the open doorway to her room. She was sitting in her wheelchair alone in the room facing towards the open doorway and wearing a nightgown. The locks on the wheelchair wheels appeared to be locked and</p>	F 221	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>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.</p> <p>F221</p> <p>Corrective Action for Resident Affected For Resident #84, nurse #5 immediately unlocked the resident's wheel chair allowing the resident freedom of movement. In addition to this, the residents care plan was updated to reflect the interventions to aid the staff in providing care for her when signs of agitation are noted. See Exhibit B__.</p> <p>Corrective Action for Resident Potentially Affected All residents who self-propel in a wheel chair and exhibit signs of agitation have the potential to be affected by the alleged deficient practice. On 08/09/13 the Nurse Management Team (Director of Nursing, Unit Manager, Support Nurse) audited all residents and developed a roster of residents who self-propel in a wheel chair and exhibit signs of agitation such as wandering in the hall way, restlessness, fidgeting. See exhibit __C_. These identified residents had their care plans reviewed by the Care Plan Team for resident specific interventions to aid staff in providing care for them when exhibiting signs of agitation .All residents that were identified had their care plans updated on 8-9-13 by the MDS nurse.</p>		

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504
--	---

(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 221	<p>Continued From page 4</p> <p>Resident # 84 was making a rocking movement as if to try and move forward. She was not making any verbalizations and her facial expression was relaxed. Upon entering the room it was confirmed that the locks to both the right and left wheelchair legs were locked. Resident # 84 did not respond to questions and did not attempt to unlock the wheelchair wheel locks when asked.</p> <p>On 7/24/13 at 2:17 Nurse # 5 observed Resident #84 sitting in her wheelchair in her room with the wheelchair legs locked. She indicated that Resident #84 was capable of self propelling in her wheelchair with her feet. She also stated that the wheelchair wheels should never be locked as locking them would be a restraint. Nurse # 5 promptly unlocked the wheels of Resident #84's wheelchair. Nurse # 5 indicated that she had recently observed Hospice Nursing Assistant # 1 (HNA #1) enter Resident # 84 ' s room and then leave, and no staff or visitors had been observed entering or leaving the room since then. Resident #84 was observed at this time to shuffle her feet and start moving her wheelchair a little bit forward and then back towards the bed.</p> <p>On 7/24/13 at 2:20 PM Hospice Nursing Assistant #1 was interviewed in Resident #84's room and stated that she had entered Resident #84's room a short time prior but only went in to set down her bag and then left again to go and get something to eat as she had not had time for lunch and it was not yet 2:30 which was her scheduled time to start with Resident #84. HNA #1 stated that she had not touched the resident or wheelchair when she was in the room and had not noticed that the wheelchair wheels were locked. She stated that the wheel chair legs could not be locked because</p>	F 221	<p>Systemic Changes</p> <p>An in-service was conducted on 7-24-13 by the Staff Development Coordinator. Those who attended were all RNs, LPNs, Med Tech's and CNAs, FT, PT, and PRN. The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included:</p> <p>Dealing with agitated/restless behaviors In-service When a resident becomes agitated or restless, it is important to identify any physical causes such as pain or discomfort. Other causes may include the resident being bored, depression, change in care giver, fatigue, etc. In addition to this, acute changes such as a UTI could be the cause.</p> <p>Interventions:</p> <p>Assess the resident for signs of pain or discomfort such as grimacing when certain areas are palpated or extremities are moved. Could they be constipated? Are they in need of toileting or incontinence care? If appropriate take the resident to the bathroom and allow them to sit on the commode for a few minutes. If the behavior is new or increased, could they be developing a UTI? Administer pain medications/laxatives as needed, contact the MD for a u/a if indicated. Offer activity boards to the resident, assist them to activities if appropriate. Allow time for the resident to voice any frustrations, fears or just talk if they are able. It may be appropriate to lay the resident down for a nap or take the resident for a stroll. Follow the plan of care for individualized approaches</p>	8-22-13
-------	---	-------	---	---------

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504		
(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 221	<p>Continued From page 5</p> <p>that would be a restraint. She added that usually when she came to care for Resident #84 the resident was not in her room because she was out roaming in the facility in her wheelchair. Resident #84 was observed to make eye contact with HNA #1 at this time; Resident #84 smiled and started moving her feet to propel the wheelchair forward.</p> <p>On 7/24/13 at 2:22 PM Nursing Assistant #3 (NA #3) was interviewed. She indicated that she was one of the two NA 's assigned to Resident #84 's hall that day but that the other NA (NA #4) had that room assignment. NA #3 revealed that she had helped get Resident #84 up that morning and had gone in the room on several occasions to put a blanket back over Resident #84 's legs and to replace the call light the resident had pulled out of the wall. NA #3 stated that she did not lock the resident ' s wheelchair wheels because that would be a restraint and did not observe the wheelchair wheels locked. She added that Resident #84 was able to lock and unlock her right wheelchair leg but not the left.</p> <p>On 7/24/13 at 2:24 PM Nursing Assistant #4 (NA #4) was interviewed. She indicated that she was assigned to Resident #84 's room that day and that she had fed Resident #84 her lunch in her room, but did not lock the wheels of the resident' s wheelchair and leave her in the room as that would be a restraint. NA #4 indicated Resident #84 was in her nightgown, at that time, as HNA #1 was supposed to give Resident #84 a bath that afternoon. NA #4 acknowledged that Resident #84 could self propel her wheelchair with her feet and was likely to try and come out of her room with her nightgown on, since she had a habit of wandering within the facility in her</p>	F 221	<p>for the resident. Assignment consistency can also aide in a calming effect for residents that are easily agitated. This is optimal but at times may be difficult to provide. In this event, all residents should be treated in a kind, gentle manner and each staff sensitive to their needs. At times it may be appropriate to administer anti-anxiety medications as ordered by the MD. If the above efforts are not effective, notify the MD for additional interventions.</p> <p>At no time should the resident be restrained to their room either by locking their wheel chair or closing their door. If this is ever observed, immediately report this to the DON or Supervisor on duty.</p> <p>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.</p> <p>Quality Assurance The Director of Nursing will monitor this issue using the "Restraint QA Tool for monitoring sampled residents for locked wheel chairs by rounding and observing care". See attached monitoring tool. This tool will be completed every week times four weeks then monthly times three months or until resolved by Quality of Life committee. Reports will be given to the monthly Quality of Life Quality Assurance committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Unit Manager, Support Nurse, Business Office Manager, Dietary Manager, Social Worker, MDS Coordinator and others as assigned. See Exhibit <u> D </u>.</p>		

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504
--	---

(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 221	<p>Continued From page 6</p> <p>wheelchair. NA #4 said she was not concerned about Resident #84 coming out of her room in her wheelchair with her nightgown on because staff could just bring her back to her room if it happened.</p> <p>On 7/25/13 at 10:03 AM Administrative Staff #2 was interviewed. She stated that she had gotten statements from all the staff who worked with Resident #84 on the day shift on 7/24/13 and they were all aware that locking wheelchair wheels for resident' s, as a restraint, was not permitted. She indicated that they were also all aware that locking the wheels of Resident #84' s wheelchair restrained her from free movement in her wheelchair and restrained her from leaving the room. None of the staff or the HNA admitted being the one to lock the wheelchair wheels. Administrative Staff #2 stated that the incident was still under investigation and NA #4 had been suspended pending the outcome of the investigation.</p>	F 221		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to administer the suppository as ordered for 1 (Resident #69) of 10 sampled residents. Finding included: Resident #69 was originally admitted to the facility on 11/1/10 with multiple diagnoses including constipation.</p>	F 281	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>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.</p> <p>Corrective Action for Resident Affected For Resident #69, the MD was contacted by the lead Support nurse on 07-25-13 to clarify the administration time of the Dulcolax suppository. Once clarified, the suppository was administered on 7-25-13 per the MD order on by the hall nurse.</p>	

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2316 HIGHWAY 242 NORTH BENSON, NC 27504		
(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 281	Continued From page 7 Review of the current physician 's orders revealed that Resident #69 had an order dated 3/27/13 for Dulcolax (stimulant laxative drug) 10 mgs 1 suppository rectally twice a week for constipation. The July, 2013 Medication Administration Record (MAR) was reviewed. The original time of administration for Dulcolax was 9 AM, but it was crossed out and was changed. It was not clear if the time of administration was 9 AM or 9 PM. It looked like it was changed to 9 PM and somebody changed it back to 9 AM. The MAR indicated that Dulcolax was supposed to be given on July 1, 4, 8, 11, 15, 18, 22 and 25. There were no initials to indicate that Dulcolax was administered on those dates. On 7/25/13 at 10:30 AM, Nurse # 4 was interviewed. Nurse #4 was one of the administrative staff who was pulled to work on the floor. She stated that she had already administered Resident #69 's medications. When asked about the Dulcolax, she stated that she had not administered it yet as she was waiting for a staff to help her. The medication cart was observed and there was no Dulcolax available in the cart. On 7/25/13 at 10:35 AM, Lead Nurse #1 was interviewed. She stated that she tried to call the nurses who worked on the days the Dulcolax was scheduled to be administered but were not available. She acknowledged that the MAR had no initials to indicate that Dulcolax was administered to the resident.	F 281	Corrective Action for Resident Potentially Affected All residents have the potential to be affected by the alleged deficient practice. All residents current MAR's were audited for medications not signed for. The affected residents were also reviewed for needed order clarifications and had their MD called for clarification if needed. In addition to this, the medication carts were assessed for the needed medication (if any are identified) and supplied if not on the cart. This was completed by the Nurse Management Team (Director of Nursing, Unit Manager, and Support Nurse) on 08-09-13. See Exhibit <u> E </u> . Systemic Changes An in-service was conducted on 08-09-13 by the lead support Nurse. Those who attended were all RNs, LPNs, Med Tech's FT, PT, and PRN. The Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included: Medication Administration: When administering medications, the nurse should review the Medication Administration Record (MAR) for the needed medication and then obtain the medication from the cart, stock supply in the medication room, McNeill's Long Term Care Pharmacy or from the back-up pharmacy (Kerr Drug). If the medication cannot be obtained from either of these sources, the MD should be contacted for an alternate medication if indicated. At no time should blanks be left on the MAR. If a medication is not administered to the resident, then the block should be initialed by the nurse, circled and document the reason for the omission on the back of the MAR. In addition to this, it is not acceptable practice to initial a medication, circle it and write "medication not available". Every effort should be made to obtain the		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a				

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2316 HIGHWAY 242 NORTH BENSON, NC 27504		
(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 315	<p>Continued From page 8</p> <p>resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that indwelling catheter was not used unless there was a valid medical justification and failed to secure the catheter tubing to prevent excessive tension and/or accidental removal for 2 of 3 sampled residents (Residents #182 & #197) with an indwelling catheter. The findings included:</p> <p>1 a. Resident # 182 was admitted to the facility on 5/20/13 with multiple diagnoses including Congestive Heart Failure and Chronic Kidney Disease. The admission Minimum Data Set (MDS) assessment dated 5/27/13 indicated that Resident #182 had memory and decision making problems. The assessment revealed that Resident #182 had no indwelling catheter.</p> <p>The care plan dated 5/24/13 was reviewed. One of the problems was " I use indwelling catheter daily. " The goal was " no injury secondary to catheter manipulation. " The approaches included " secure catheter to leg with a leg band. "</p> <p>On 5/24/13, there was a doctor's order to insert an indwelling catheter due to no urine output.</p>	F281	<p>needed medication including making the above contacts to the pharmacy, checking the stock medication cabinet in the medication room, checking other facility medication carts for Over The Counter medications only (not prescription medications) contacting the Attending Physician for an alternate if indicated and contacting the Nurse on call at 919-820-3214 or in the facility for further directions. McNeill's Long Term Care Pharmacy 877-642-4966 and Back-up pharmacy Kerr Drug at 919-207-1105</p> <p>In addition to this, an in-service was provided to the Central Supply Clerk by the Director of Nursing on maintaining established PAR levels (PAR is the amount of a medication you need to have on hand to ensure you do not run out while waiting for supply delivery) on over the counter stock medications (OTC's). See the attached Power Point In-service. Exhibit <u>F</u>.</p> <p>Quality Assurance The Director of Nursing will monitor this issue using the Medication Administration QA Tool for monitoring a sample of residents MAR's for omissions and circled medications. See attached monitoring tool. This tool will be completed every week times four weeks then monthly times three months or until resolved by Quality of Life committee. Reports will be given to the monthly Quality of Life Quality Assurance committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Unit Manager, Support Nurse, Business Office Manager, Dietary Manager, Social Worker, MDS Coordinator and others as assigned. See Exhibit G</p>		

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504		
(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 315	<p>Continued From page 9</p> <p>The order also indicated to measure intake and output.</p> <p>The doctor's progress notes dated 5/24/13 indicated that Resident #182 was seen due to diarrhea and poor oral intake. The BUN (blood urea nitrogen) was 45 (normal range 6-23) on 5/21/13. The certified nursing assistant (CNA) noted no urine output. The notes further indicated that indwelling catheter was placed to assess for possible retention and evaluate given concerns for hypovolemia. The notes also revealed to monitor intake and output closely.</p> <p>Review of the June, 2013 intake and output record revealed no documentation of intake. The 24 hour urine output was between 280 - 800 cc.</p> <p>On 5/25/13, there was a doctor's order for D 5 ½ Normal Saline to infuse at 60 cubic centimeter (cc) per hour for 1 liter and for Rocephin (antibiotic) 1 gram (gm) intramuscularly (IM) for 7 days.</p> <p>On 5/26/13, there was an order for D 5 ½ Normal Saline to infuse at 50 cc per hour for 1 liter, which was changed to ½ Normal Saline at 50 cc per hour for 1 liter.</p> <p>On 5/28/13, the laboratory report revealed the BUN level was 27.</p> <p>On 7/24/13 at 10:10 AM and 5:18 PM, Resident #182 was observed with an indwelling catheter in place.</p> <p>On 7/24/13 at 3:25 PM, Nurse #1 was interviewed. She stated that when a resident had no urine output for 8 hours, the doctor was called</p>	F 315	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>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.</p> <p>F 315</p> <p>Corrective Action for Resident Affected for Resident #182, the physician discontinued the foley. For resident # 197 the Physician discontinued the foley. See Exhibit H__.</p> <p>Corrective Action for Resident Potentially Affected All residents who have indwelling foley catheters have the potential to be affected by the alleged deficient practice. On 08-09-13, the Nurse Management Team (Director of Nursing, Unit Manager, Support Nurse) audited all residents and developed a roster of residents who have indwelling foley catheters. Each resident was assessed by their MD for continued use And appropriate justification for the use of their foley catheter on 08-12-13 see exhibit I. In addition to this, the identified residents had their care plans reviewed by the Care Plan Team for appropriate problem, goals and interventions related to foley catheter use on 08-09-13. See exhibit J</p>		

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504
--	---

(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 315	<p>Continued From page 10</p> <p>and an indwelling catheter was inserted. If the urine output was more than 500 cc, the catheter would stay in until the doctor would write an order to remove it. The facility had no policy/guidelines on attempts to remove an indwelling catheter.</p> <p>On 7/24/13 at 5:46 PM, administrative staff #2 was interviewed. She stated that the doctor was called when a resident had no urine output, an indwelling catheter was inserted and if the urine output was more than 500 cc, the doctor would order to leave the catheter in. The facility has no guidelines/policy on when to try to remove the catheter, it was up to the doctor's discretion. Administrative staff #2 further stated that the doctor was informed today (7/24/13) and he came and wrote an order to discontinue the indwelling catheter on 7/25/13.</p> <p>1 b. Resident # 182 was admitted to the facility on 5/20/13 with multiple diagnoses including Congestive Heart Failure and Chronic Kidney Disease. The admission Minimum Data Set (MDS) assessment dated 5/27/13 indicated that Resident #182 had memory and decision making problems. The assessment revealed that Resident #182 had no indwelling catheter.</p> <p>The care plan dated 5/24/13 was reviewed. One of the problems was " I use indwelling catheter daily. " The goal was " no injury secondary to catheter manipulation." The approaches included " secure catheter to leg with a leg band. "</p> <p>On 5/24/13, there was a doctor's order to insert</p>	F 315	<p>Systemic Changes</p> <p>An in-service was conducted on 08-09-13 by the Staff Development Coordinator. Those who attended were all RNs, LPNs, Med Tech's and CNAs, FT, PT, and PRN. The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included:</p> <p>The policies, documentation of intake and output were discussed during the in-service with an emphasis on the following: securing the catheter with a leg band and having justification for the use of a catheter.</p> <p>Quality Assurance</p> <p>The Director of Nursing will monitor this issue using the "Foley Catheter QA Tool for monitoring sampled residents for foley catheter use and foley catheters being secured with a leg band". See attached monitoring tool. This tool will be completed every week times four weeks then monthly times three months or until resolved by Quality of Life committee. Reports will be given to the monthly Quality of Life Quality Assurance committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Unit Manager, Support Nurse, Business Office Manager, Dietary Manager, Social Worker, MDS Coordinator and others as assigned. See Exhibit <u> K </u>.</p>	8-22-13
-------	---	-------	---	---------

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504
--	---

(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 315	<p>Continued From page 11</p> <p>an indwelling catheter due to no urine output.</p> <p>On 7/24/13 at 10:10 AM, Resident #182 was observed during incontinent care. The catheter tubing was not secured to her leg when observed.</p> <p>On 7/24/13 at 10:12 AM, NA (nurse aide) #2 was interviewed. She stated that she was not aware that Resident #182's catheter tubing was not secured because she did not provide the AM care. She added that she normally checks for the leg band during AM care. She indicated that she would get a new leg band and would place it on Resident #182.</p> <p>On 7/24/13 at 5:18 PM, Resident #182's catheter tubing was observed with NA # 3. NA #3 stated that Resident #182's catheter tubing was not secured with a leg band.</p> <p>On 7/24/13 at 5:18 PM, NA #2 was not available fro interview.</p> <p>On 7/25/13 at 5:46 PM, administrative staff #2 was interviewed. She stated that catheter tubing should be secured at all times. She added that nurse's aides check for the leg band during AM care but the checking of the leg band placement was not documented in the medical records.</p> <p>2. Resident # 197 was admitted to the facility on 6/28/13 with the following cumulative diagnoses: cerebral vascular accident, late effect hemiplegia, dysphagia and a urinary tract infection. The admission MDS, dated 7/5/13 stated that she was cognitively intact and was occasionally incontinent. No appliance was used for urinary output.</p>	F 315		
-------	--	-------	--	--

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504	
(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 315	<p>Continued From page 12</p> <p>Her initial hospital laboratory results, 6/27/13 were reviewed. Her BUN level was 16 and her Creatinine was at 0.93, both within normal range.</p> <p>A care plan was developed on 6/28/13, stating that she had a urinary tract infection (UTI) and that she would be free from signs and symptoms of UTI over the next 90 days. Some of her interventions listed included encouraging fluids and the use of a catheter, with positioning the tubing to prevent reflux of urine in bladder.</p> <p>However, the initial Nursing Assessment, dated 7/3/13 stated that Resident # 197 did not have a catheter, but was non-ambulatory.</p> <p>On 7/8/13 the telephone orders in the chart reflected that Lasix (a diuretic) 20 mg (milligram) was ordered for once a day, for three days. A urinalysis performed that day, showed signs of yellow and cloudy urine.</p> <p>The Nurse's Notes were reviewed. On 7/9/13 it was noted that urine was collected via a clean catheter and 130 ml (milliliter) of dark yellow urine was obtained. On 7/10/13, the notes reflected that Resident # 197 remained on anti-biotics to treat the UTI.</p> <p>On 7/15/13, new labs were drawn and Resident # 197's BUN was elevated at 36 but her Creatinine remained within normal limits at 1.05.</p> <p>A Physician Order, dated 7/17/13, instructed in and out catheter if no output on shift, leave if urine output is less than 200. A July, 2013 Physician Progress Note recorded that Resident # 197 had a low intake of fluids which was felt to be the result of a newer order for nectar</p>	F 315		

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27604	
(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 315	<p>Continued From page 13 thickened liquids.</p> <p>Another lab was secured on 7/19/13 and recorded an elevated BUN of 25 and Creatinine at 0.69, within range. A follow up urinalysis collected on 7/20/13, yielded clear, yellow urine.</p> <p>The Nurse's Notes from 7/20/13 at 1:30 pm noted that in and out catheter for urine retention if greater than 300, leave Foley in. At 2:48 pm, the notes indicated that Resident # 197 complained of urgency and that her Foley remained inserted and that a urine specimen was collected.</p> <p>The Intake and Output Record Form was initiated on 7/20/13 and recorded the following urine output: 7/20/13 @ 250 cc (cubic centimeter) 7/21/13 @ 450 cc 7/22/13 @ 550 cc 7/23/13 @ 950 cc</p> <p>On 7/22/13, a new care plan was developed for Resident #197 for the use of a daily catheter. The goal was to receive no injury secondary to catheter manipulation for the next 90 days and an intervention to be used included securing the catheter to leg with leg band. Any signs or symptoms of UTI should be reported to the nurse. Fluids should be provided between meals and at bedtime.</p> <p>On 7/23/13 at 2:13 pm, Nurse #6 was interviewed. She stated that Resident #197 used a catheter for urinary retention.</p> <p>Nurse #1 was interviewed on 7/24/13 at 3:28 pm and reported that Resident #197's catheter was in place due to urinary retention. She stated that when she provided care for Resident #197 earlier</p>	F 315		

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504
--	---

(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 315	<p>Continued From page 14</p> <p>today, the resident told her that her genitalia hurt, so she gave her pain relieving medication. She then commented that yesterday, orders were written to discontinue Resident #197's thickened liquids. Today, she received thin liquids and had out of 600 cc.</p> <p>She explained that the practice was if a resident hadn't voided in over 8 hours, then the standing order for in and out catheter was implemented and if over 500 cc was produced then the catheter should be left in. The catheter should be re-assessed by the nurse and/or doctor the next day or so. A trial catheter use should be documented on the Medication Administration Record (MAR). If the resident continued to not urinate after 8 hours, then the catheter should be re-inserted.</p> <p>On 7/24/13 at 5:05 pm, the physician was interviewed. He stated that he was writing new orders to discontinue the catheter and that it had been in place since last Friday (7/19/13) when Resident #197 didn't voided on a shift (8 hours). He couldn't determine if Resident #197 was dehydrated, even though she drank the thickened liquids poorly, because she was also suffering from constipation due to her pain medication. He also mentioned that he hadn't ruled out that she developed a neurogenic bladder, (a dysfunction of the bladder system caused by damage to the central nervous system) as a result of her stroke. The new order stated that her urine output should be monitored for 72 hours and if problems developed, to re-insert the catheter.</p> <p>On 7/24/13 at 5:30 pm, Resident #197 was visited in her room. Nurse Aide #1 (NA) was present and asked if she secured a leg band to</p>	F 315		
-------	---	-------	--	--

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504
--	---

(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 315	<p>Continued From page 15</p> <p>the catheter to prevent movement. She responded that she worked with Resident #197 in the afternoon and she had not known her to ever use a leg band to secure the catheter. She went to examine Resident #197's leg and verified that a leg band was not in place. Nurse #3 entered the room and stated that Resident #197 did not use a leg band.</p> <p>At 5:35 pm, Resident #197 was interviewed. She stated that earlier that day she had complained that her genitalia was hurting but she did not experience pain now.</p> <p>The Administrative Staff #2 was interviewed on 7/24/13 at 5:41 pm. She commented that all nurse aides get catheter care training during orientation and are expected to ensure that a leg band was in place when providing care and that nurses should be monitoring this as well.</p>	F 315		
F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of</p>	F 425		

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED: 07/25/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504
--	---

(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 315	<p>Continued From page 15</p> <p>the catheter to prevent movement. She responded that she worked with Resident #197 in the afternoon and she had not known her to ever use a leg band to secure the catheter. She went to examine Resident #197's leg and verified that a leg band was not in place. Nurse #3 entered the room and stated that Resident #197 did not use a leg band.</p> <p>At 5:35 pm, Resident #197 was interviewed. She stated that earlier that day she had complained that her genitalia was hurting but she did not experience pain now.</p> <p>The Administrative Staff #2 was interviewed on 7/24/13 at 5:41 pm. She commented that all nurse aides get catheter care training during orientation and are expected to ensure that a leg band was in place when providing care and that nurses should be monitoring this as well.</p>	F 315		
F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of</p>	F 425		

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504		
(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 425	<p>Continued From page 16</p> <p>a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the availability of ordered medications for 2 (Residents # 69 & # 39) of 10 sampled residents. Findings included:</p> <p>1. Resident # 69 was originally admitted to the facility on 11/1/10 with multiple diagnoses including gastro esophageal reflux disease (GERD). The quarterly Minimum Data Set (MDS) assessment dated 5/31/13 indicated that Resident #69 had moderately impaired cognition.</p> <p>The current physician's orders were reviewed. The order dated 3/25/13 revealed that Resident #69 was on Prilosec (proton pump inhibitor used to treat acid induced inflammation and ulcers in the stomach) OTC (over the counter) 20 milligrams (mgs) 1 tablet by mouth daily for GERD.</p> <p>The Medication Administration Records (MARs) for May, June and July, 2013 were reviewed. Resident #69 had missed several doses of Prilosec due to not being available. The resident had missed 5 doses in May (5/27 - 5/31), 4 doses in June (6/14, 6/17, 6/28 & 6/30) and 6 doses in July (7/1 - 7/3 & 7/19 - 7/22).</p> <p>On 7/25/13 at 10:45 AM, the central supply staff was interviewed. She stated that she was the</p>	F 425	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>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.</p> <p>F 425</p> <p>Corrective Action for Resident Affected For Resident #69, medication cart assessed and medication is available for resident per physician orders.</p> <p>For Resident # 39, medication cart reviewed and Medication is available for resident per physicians orders.</p> <p>Exhibit L</p> <p>Corrective Action for Resident Potentially Affected All residents have the potential to be affected by the alleged deficient practice. All residents current MAR's were audited for medications not signed for or circled and noted not available. The affected residents were reviewed for needed order clarifications and had their MD called for clarification and notification if indicated. In addition to this, the medication carts were assessed for the needed medication (if any are identified) and supplied if not on the cart. This was completed by the Nurse Management Team (Director of Nursing, Unit Manager, and Support Nurse) on 8-09-13. See Exhibit <u> M </u>.</p>		

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504		
(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 425	<p>Continued From page 17</p> <p>person responsible in ordering the over the counter medications. She acknowledged that she had issue with Prilosec lately because she just changed company because it was economical and the company would take 2-3 days to deliver. She also added that the pharmacy had stopped sending the Prilosec OTC for the resident. She also stated that she was not aware that the nurses were completely out of Prilosec. She indicated that if she had known, she could buy it from the drug store.</p> <p>On 7/25/13 at 11:15 AM, Nurse # 5 was interviewed. She stated that if the OTC medication was not available in her cart, she always looked at different carts and then checked the medication rooms including the central supply room.</p> <p>On 7/25/13 at 11:35 AM, administrative staff #2 was interviewed. She stated that 200/300 hall had no specific nurse assigned. If the OTC medication was not available in the cart, the staff should be checking the other carts and the central supply room. If still not available, the lead nurse should have been informed so the medication could be obtained from the local drug store.</p> <p>2. Resident #39 was re-admitted to the facility on 5/23/12 with the multiple diagnoses including gastro esophageal reflux disease (GERD), diabetes mellitus adult onset, depression and lower extremity edema. The annual Minimum Data Set (MDS) assessment dated 5/29/13 indicated that Resident # 39 was cognitively intact.</p>	F 425	<p>Systemic Changes</p> <p>An in-service was conducted on 8-13-13 by the Lead Support nurse. Those who attended were all RNs, LPNs, Med Tech's FT, PT, and PRN. The Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included:</p> <p>Medication Administration:</p> <p>When administering medications, the nurse should review the Medication Administration Record (MAR) for the needed medication and then obtain the medication from the cart, stock supply in the medication room, McNeill's Long Term Care Pharmacy or from the back-up pharmacy Kerr Drug (919- 207-1105) If the medication cannot be obtained from either of these sources, the MD should be contacted for an alternate medication if indicated or other orders. At no time should blanks be left on the MAR. If a medication is not administered to the resident, then the block should be initialed by the nurse, circled and document the reason for the omission on the back of the MAR. In addition to this, it is not acceptable practice to initial a medication, circle it and write "medication not available". Every effort should be made to obtain the needed medication including making the above contacts to the pharmacy, checking the stock medication cabinet in the medication room, checking other facility medication carts for Over The Counter medications only (not prescription medications) contacting the Attending Physician for an alternate if indicated and contacting the Nurse on call at 919-820-3204 or in the facility for further directions. McNeill's Long Term Care Pharmacy 877-642-4966 and Back-up pharmacy, Kerr Drug at 919-207-1105</p>	8-22-13	

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504		
(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 425	<p>Continued From page 18</p> <p>The current physician 's orders were reviewed. Resident #39 was on Prilosec (proton pump inhibitor used to treat acid induced inflammation and ulcers in the stomach) OTC (over the counter) 20 milligrams (mgs) 1 tablet by mouth daily for GERD.</p> <p>The Medication Administration Records (MARs) for June and July, 2013 were reviewed. Resident #39 had missed several doses of Prilosec due to not being available. The resident had missed 1 dose in June (6/17) and 3 doses in July (7/19, 7/21 & 7/22).</p> <p>On 7/25/13 at 10:45 AM, the central supply staff was interviewed. She stated that she was the person responsible in ordering the over the counter medications. She acknowledged that she had issue with Prilosec lately because she just changed company because it was economical and the company would take 2-3 days to deliver. She also added that the pharmacy had stopped sending the Prilosec OTC for the resident. She also stated that she was not aware that the nurses were completely out of Prilosec. She indicated that if she had known, she could buy it from the drug store.</p> <p>On 7/25/13 at 11:15 AM, Nurse # 5 was interviewed. She stated that if the OTC medication was not available in her cart, she always looked at different carts and then checked the medication rooms including the central supply room.</p> <p>On 7/25/13 at 11:35 AM, administrative staff #2 was interviewed. She stated that 200/300 hall had no specific nurse assigned. If the OTC medication was not available in the cart, the staff</p>	F 425	<p>In addition to this, an in-service was provided to the Central Supply Clerk by the Director of Nursing on maintaining established PAR levels (PAR is the amount of a medication you need to have on hand to ensure you do not run out while waiting for supply delivery) on over the counter stock medications (OTC's). See the attached Power Point In-service. Exhibit <u> N </u>.</p> <p>Quality Assurance The Director of Nursing will monitor this issue using the Medication Administration QA Tool for monitoring a sample of residents MAR's for omissions and circled medications. See attached monitoring tool. This tool will be completed every week times four weeks then monthly times three months or until resolved by Quality of Life committee. Reports will be given to the monthly Quality of Life Quality Assurance committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Unit Manager, Support Nurse, Business Office Manager, Dietary Manager, Social Worker, MDS Coordinator and others as assigned. See Exhibit <u> O </u>.</p>	8-6-13	

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE 2316 HIGHWAY 242 NORTH BENSON, NC 27504
--	---

(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 425	Continued From page 19 should be checking the other carts and the central supply room. If still not available, the lead nurse should have been informed so the medication could be obtained from the local drug store. Resident #39 was prescribed Amaryl (used to treat blood sugar levels) 1 milligram (mg) 1 tablet by mouth daily for diabetes mellitus. The MARs for June and July, 2013 were reviewed. Resident #39 had missed 1 dose in June (6/15) and one dose in July (7/15). The Administrative Staff #2 was interviewed on 7/25/13 at 10:15 am, she stated that the nurse who signed the MAR on the dates the dose was missing, was no longer employed at the facility. Resident #39 was prescribed Lasix (used for fluid retention) 40 mg, 1 tablet by mouth daily for edema. The MAR for June, 2013 was reviewed. Resident #39 missed 1 dose of Lasix on 6/17. The Administrative Staff #2 was interviewed on 7/25/13 at 10:15 am; she stated that the nurse who signed the MAR on 6/17/13 was no longer employed at the facility.	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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	F 431		

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2316 HIGHWAY 242 NORTH BENSON, NC 27504		
(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 20</p> <p>records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to discard expired medications and to date multi-dose medications when opened on two of four medication carts (400/500 hall cart and 700/800 hall cart), failed to date multi-dose vials of medication in two of three medication refrigerators (100/200/ 300 hall and 400/500 hall) and failed to discard expired</p>	F 431	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>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.</p> <p>F 431</p> <p>Corrective Action for Resident Affected For Resident # 11, their Humalog Flex Pen and the Advair Diskus were discarded on 7-25-13 by director of nursing. AdvairDiskus was a therapeutic substitution and not in use and the resident had multiple flex pens that they were able to use.</p> <p>For Resident # 57 Refresh Optive Eye drops was discarded on 7-25-13 by the director of nursing and new supply was ordered and received 8-5-13.</p> <p>For the affected expired or undated medications: The Zinc Sulfate, Aspirin, Pro-Stat, Apilsol, and influenza vaccine were all discarded on 7-25-13 by the Director of nursing. Exhibit P</p> <p>Corrective Action for Resident Potentially Affected All residents have the potential to be affected by the alleged deficient practice. On 8-12-13 all medication carts, medication refrigerators and medication rooms were audited for expired or undated medications This was completed by the Nurse Management Team (Director of Nursing, Unit Manager, and Support Nurse). See Exhibit Q</p>		

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/25/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504
--	---

(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 21</p> <p>vaccines by the expiration date in one of three medication refrigerators (100/200/300 hall medication room). The findings included:</p> <p>The facility policy titled " (name of the pharmacy) Long Term Care Pharmacy Recommended Storage for Selected Items" stated, in part, "all insulins except Lantus should be discarded 28 days not refrigerated; Advair Diskus—discard discus 1 month after removal from pouch. All injections—good for only 30 days in refrigerator if it is a multi-dose vial, unless otherwise listed."</p> <p>1. On 7/24/13 at 2:00 PM., the 700/800 medication cart was observed. One bottle of zinc sulfate 220 mg. (milligrams) was opened with expiration date 4/13. There was also one bottle of ASA (aspirin) 325 mg tablets that contained 31 tablets with expiration date 5/13. One bottle of Pro-Stat was opened and undated. Nurse #1 stated the pharmacy checked the carts for expired medications. She stated she also checked the bottles for the expiration date but had not used either of those medications that day. Nurse #1 stated she was not aware that the Pro-Stat should be dated when it was opened.</p> <p>2. On 7/24/13 at 2:30 PM., the two medication carts for 400/500 halls were observed. There was an opened Humalog flex-pen for Resident #11 dated 06/08/13. An Advair Diskus for Resident #11 was opened and undated. A bottle of Refresh Optive eye drops for Resident #57 was noted with an expiration date 4/2012. A bottle of Pro-stat was opened and undated. Nurse #2 stated she was not aware that the Pro-Stat should be dated when opened. She also stated the Advair discus should have been dated when opened and the insulin flex-pen should</p>	F 431	<p>Systemic Changes</p> <p>An in-service was conducted on 8-8-13 by the Lead Support Nurses. Those who attended were all RNs, LPNs, Med Tech's FT, PT, and PRN. The Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included:</p> <p>The policy for medication storage: Exhibit <u>R</u>.</p> <p>Quality Assurance</p> <p>The Director of Nursing will monitor this issue using the Med Drawer Clean-up tool to monitor for expired medications and medications that are not dated. See attached monitoring tool. This tool will be completed every week times four weeks then monthly times three months or until resolved by Quality of Life committee. Reports will be given to the monthly Quality of Life Quality Assurance committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Unit Manager, Support Nurse, Business Office Manager, Dietary Manager, Social Worker, MDS Coordinator and others as assigned. See Exhibit S.</p>	F-22-13
-------	--	-------	--	---------

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

PRINTED: 08/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/25/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27604		
(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 22 have been discarded 28 days after it was opened.</p> <p>3. On 7/24/13 at 2:25 PM., the medication refrigerator on 400/500 hall was observed. One bottle of Aplisol (Tuberculin injection) was opened and undated. Nurse #2 stated the medication should have been dated when opened.</p> <p>On 7/24/13 at 4:38 PM., Administrative staff #2 stated all multi-dose vials, Advair discus and Pro-Stat should have been dated when opened. She also said all expired medications should have been discarded immediately.</p> <p>4. On 7/24/13 at 3:20 PM, 4 multi-dose vials of influenza vaccine with an expiration date of 6/13 were observed in the medication refrigerator within the 100/200/300 hall medication room. Nurse #6 was interviewed at this time and acknowledged that the vials had expired and should have been discarded. She discarded the vials at that time.</p> <p>On 7/24/13 at 4:30 PM Administrative Staff #2 was interviewed. She indicated that staff should have removed the influenza vaccine when it expired. She added that a new batch of vaccine was expected for the upcoming influenza season and she did not believe the old vaccine from the previous season would have been used.</p>	F 431			

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

PRINTED: 08/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	SEP 06 2013 CONSTRUCTION SECTION	(X3) DATE SURVEY COMPLETED 08/23/2013
--	--	---	-------------------------------------	--

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504
--	---

(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 000	INITIAL COMMENTS	K 000	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 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4	K 022		

This STANDARD is not met as evidenced by:
A. Based on observation on 08/23/2013 the exit doors from the secured unit into the service hall was disguised to look like a book case.

K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1		K 022. The exit door was painted one color to be readily identified as an exit door by the Maintenance dept.	09-06-13
---------------	---	--	--	----------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rymna Momo</i>	TITLE <i>LVitA</i>	(X6) DATE <i>9-4-13</i>
--	-----------------------	----------------------------

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.

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

PRINTED: 08/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504	
(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 029	Continued From page 1	K 029	K 029 The dietary dept. was in - serviced By the Dietary Manager on 8-29-13 The Dietary Manager will monitor using A QI tool to ensure the door is not Propped open for weekly for 4 weeks, Monthly for 3 months. The QI Committee will review the results At them monthly QI Meeting for The need of continued monitoring and Initiate action plans as needed.	09-06-13
K 038 SS=D	This STANDARD is not met as evidenced by: A. Based on observation on 08/23/2013 the door to the dry storage room in the kitchen was held open. 42 CFR 483.70 (a) 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 on 08/23/2013 the inside door release devices for the cooler and the freezer were not operable.	K 038	K 038 A The inside of the freezer door Release were made operable by the Maintenance Dept. adding a block of Wood to prevent the shelves from Preventing the inside door release Device from working . K038 B. The lock on the Alzheimer's Gate was moved down within the 34 and 48 inch guideline from the Floor.	09-06-13
K 061 SS=D	42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the vaives are closed. NFPA 72, 9.7.2.1	K 061		09-06-13

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

PRINTED: 08/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/23/2013
--	--	---	--

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN	STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504
--	---

(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 061	Continued From page 2	K 061	K 061 The ball valve controlling the flow switch for the new addition sprinkler system was corrected with a supervised line by Crossroads Fire Protection INC.	09-13-13
K 062 SS=D	<p>This STANDARD is not met as evidenced by: A. Based on observation 08/23/2013 the ball valve controlling the flow switch for the new addition sprinkler-system was not supervised.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: A. Based on observation on 08/23/2013 the sprinkler system had not had the (5) five year obstruction test.</p>	K 062	<p>DISPOSE</p> <p>K 062 The automatic sprinkler system was serviced with a 5 year obstruction test by Crossroads Fire Protection INC.</p>	09-13-13