STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and family, the facility failed to notify the Responsible Party of an abuse investigation for 1	F 157	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. **F 157** **Corrective Action for Resident Affected** Resident #1: Family member of resident number 1 was notified by the Administrator on 9-18-13 of the allegation of abuse. 9-18-13	

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

Lynda Monroon — LNHA — 10-25-13

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

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F 157	Continued From page 1 of 1 resident (Resident #1) who alleged attempted rape by a facility employee. The findings included: Resident #1 was admitted to the facility on 6/5/13. Diagnoses included hemiplegia, vascular dementia and Alzheimer ' s disease. The quarterly Minimum Data Set (MDS) dated 9/12/13 revealed the resident had severe cognitive impairment, required extensive assistance with toileting and personal hygiene and was always incontinent of bowel and bladder. The printed care plan, dated 8/9/13 included a problem of periods of agitation. An intervention, undated, was handwritten on the care plan: " If I become resistive to care, please leave, and come back later to re-attempt care. " Review a 24-Hour Initial Report dated 9/11/13 revealed on 9/10/13 on 2nd shift, Resident #1 stated he was in bed sleeping when a male came up, grabbed him by the left wrist. The Report indicated the resident alleged the male was trying to rape him. " An incident report dated 9/12/13 at 12:31 AM indicated Nurse #1 saw Resident #1 at the nurses ' station. The resident had a skin tear on his left dorsal wrist. The resident said he did not know what happened. The report indicated the Responsible Party (RP) was notified at 4:00 PM (9/11/13). During an interview on 10/15/13 at 3:16 PM, Nurse #1 indicated that on the night of 9/10/13, some time after 11:00 PM, he was getting off duty and saw Resident #1 by the nurses ' station. The resident had a skin tear on his left wrist. Nurse #1 stated he asked the resident what happened and	F 157	**Corrective Action for Resident Potentially Affected** All residents have the potential to be affected. On 09/20/13, the hall nurses under the direction of the Quality Assurance Nurse Consultant assessed all current residents for signs of injuries of unknown origin and signs of abuse. This was accomplished by the hall nurse with the assistance of the CNA as needed assessing all residents on their hall for signs of injuries of unknown origin such as new bruises or new skin tears or abuse. 9-20-13 o **Observing for lacerations.** o **Observing for swelling and discoloration.** o **Observing for pain.** o **Observing for abduction, adduction, shortening or improper position of extremities.** No residents were identified with signs or allegations of abuse. On 10-25-13 a review of all allegations of abuse was completed by the Director of Nursing to ensure that all reports had been reported timely to the family members. There were no allegations of abuse reports that the family had not been notified of the allegation of abuse. 10-25-13 On 10-30-13 all allegations reported from 9-11-13 to 10-30-13 were reviewed by the Director of Nursing to ensure that all families had had notification. All family members had been notified of the allegations of abuse. 10-30-13	

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F 157	Continued From page 2 the resident replied he did not know. Nurse #1 said Resident #1 had skin tears in the past and he thought this was an old tear that had opened up. Nurse #1 indicated he did not write an incident report until the following day and also called the RP the following day. Nurse #1 stated he became aware of the alleged attempted rape on 9/11/13 and that he had written a statement per the administrator ' s request. The Nurse said when he called the RP he only reported the skin tear since he was not aware of what was occurring with the abuse investigation. During an interview on 10/15/13 at 5:00 PM, the administrator indicated her expectation was for Nurse #1 to inform the RP about the alleged abuse when he notified the RP of the skin tear.	F 157	**Systemic Changes** A Nursing Department in-service was held on 10/30/13 for all full-time and part-time RN's and LPN's on notifying the resident's responsible party of all allegations of abuse when they are reported and to immediately report all allegations of abuse to the Director of Nursing and the Administrator. The in – service covered observing residents for behaviors that may indicate abuse such as, a new onset of withdrawal,crying, signs of fearfulness, or verbal reports of abuse. When any signs of abuse are noted the resident should be interviewed.The staff development coordinator will ensure that any staff nurse who does not complete the in-service training by 11/08/13 will not work until the training is 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 QualityAssurance Process to verify that the change has been sustained.	10-30-13 11-08-13
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, police interview, facility policy and facility document review, the facility failed to immediately report an alleged attempted rape to the local authorities for 1 of 1 resident (Resident #1), and failed to submit a 24 hour report timely for 1 of 3 residents (Resident #2). The findings included:		**Quality Assurance** The Incident follow up monitor will be completed weekly times 4 weeks then monthly times 3 months to monitor timely reporting of allegations to the State, Police Department and responsible party. This will be completed by the Quality Assurance Nurse. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate. The Quality of	

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

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F 226	Continued From page 3 1. The facility policy entitled " Abuse Prohibition " , last revised 9/13, read in part, " If sexual abuse is suspected, do not bathe the resident or wash the resident ' s clothing or linen. Do not take items from the area in which the incident occurred. Call the police immediately. " Resident #1 was admitted to the facility on 6/5/13. Diagnoses included hemiplegia, vascular dementia and Alzheimer ' s disease. The quarterly Minimum Data Set (MDS) dated 9/12/13 revealed the resident had severe cognitive impairment, required extensive assistance with toileting and personal hygiene and was always incontinent of bowel and bladder. The printed care plan, dated 8/9/13 included a problem of periods of agitation. An intervention, undated, was handwritten on the care plan: " If I become resistive to care, please leave, and come back later to re-attempt care. " Review of a 24-Hour Initial Report, dated 9/11/13, revealed on 9/11/13 Resident #1 reported to the administrator that on 9/10/13 2nd shift, he was in bed sleeping when a male came up and grabbed him by the left wrist. The Report indicated the resident alleged the male was trying to rape him. During an interview on 10/15/13 at 8:40 AM, the administrator stated after the resident reported attempted rape she immediately began an investigation. The administrator said the resident repeatedly stated he had not been raped. The administrator indicated she called the police and was advised to fax the report. She stated she faxed it on 9/11/13 but the police had no record of receiving it. The facility provided a facsimile confirmation indicating the Report was	F 226	Life Committee consists of the Administrator, Director of Nursing, Support Nurses, Business Office Manager, and Social Worker. 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.	

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F 226	Continued From page 4 transmitted to the State on 9/11/13 but no confirmation of transmittal to the Police Department on 9/11/13. The 5-Working Day Report was transmitted to the State and the Police Department on 9/16/13 as indicated on separate transmittal confirmation sheets. The Report conclusion was the accused male employee forcefully pulled down the resident ' s pants against the resident ' s wishes in order to provide incontinent care. While attempted rape was not substantiated, the employee was terminated for abuse. During an interview on 10/15/13 at 1:29 PM, the detective indicated she had been working with the facility since April, 2013, and the facility communicated with her by faxing their 24 Hour and 5-Working Day Reports. The detective stated she was made aware of the attempted rape allegation on 9/16/13 via the 5-Working Day Report, having not received a 24 Hour Report. The detective said she was alarmed because of the delay in receiving such a serious allegation, and met with the facility. She stated the facility will now call 911 immediately with suspicion of a crime. 2. Resident #2 was admitted to the facility on 11/20/07. Diagnoses included adult failure to thrive and dementia. A 24-Hour Report dated 10/7/13 revealed that a bruise of unknown origin was reported on 10/4/13 and investigation was begun. A facsimile transmittal confirmation revealed the 24-Hour Report was transmitted to the State on 10/7/13. During an interview on 10/14/13 at 5:15 PM, the	F 226	**Corrective Action for Resident Affected** Family member of resident number 1 was notified by the Administrator on 9-18-13. The initial 24 hour report for resident number 1 was faxed to the state and the Benson Police Dept. on 9-11-13 by the Administrator. The 5 day report for resident number 1 was faxed to the state and Benson Police Department on 9-16-13. The Administrator talked to The Chief of Police on 9-18-13 and An appointment was made for the Following day for him to review the Investigation. On 9-19-13 the Administrator met with the Chief of Police to review the results of the investigation. On 9-20-13 the Chief of Police met with the Regional Director of Operations and a plan was put in place that all suspected allegations of abuse that involved criminal intent would be called into the Police Department utilizing 911. The 24 hour and the 5 day reports would be faxed into the Police Department after the 911 notification. For resident #2, on 10/07/13, the 24 hour report was faxed into the State when it was noted that it had not been done by the Director of Nursing. This was completed by the Administrator.	9-18-13 9-11-13 9-16-13 9-18-13 9-19-13 9-20-13 10-7-13

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F 226	Continued From page 5 administrator and corporate nurse indicated the Report had not been transmitted timely due to a miscommunication. They believed the director of nursing was going to fax it but she got sick. On Monday, 10/7/13 they realized it had not been faxed so they faxed it immediately. They added that their usual practice was to fax the Report within 24 hours.	F 226	**Corrective Action for Resident Potentially Affected** All residents have the potential to be affected. On 09/20/13, the hall nurses and the C.N.A's under the direction of the Quality Assurance Nurse Consultant assessed all current residents for signs of injuries of unknown origin and signs of abuse Nursing staff observed the following;	9-20-13

- **Observing for lacerations.**
- **Observing for swelling and discoloration.**
- **Observing for pain.**
- **Observing for abduction, adduction, shortening or improper position of extremities.**

No residents were identified with signs or allegations of abuse. . The Social Worker interviewed residents on the same hall that are alert and oriented to make sure there were no concerns or unidentified allegations of abuse. There were no identified concerns. On 10-30-13 all alert and oriented residents were interviewed by the Administrator for concerns regarding abuse. There were no concerns identified. On 10-25-13 a review of all allegations of abuse since 10-1-13 was completed by the Director of Nursing to ensure that all reports had been reported timely to the state/police department as appropriate and to the responsible parties. All allegations of abuse had been reported timely to the police department and/ or state agency and to the responsible party. On 10-30-13 all allegations of abuse reported from 9-11-13 to 10-30-13 were reviewed by the Director of Nursing with all allegations being reported timely to the state/police department and the responsible party was notified timely.

10-30-13

10-25-13

10-30-13

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F 226	Continued From page 5 administrator and corporate nurse indicated the Report had not been transmitted timely due to a miscommunication. They believed the director of nursing was going to fax it but she got sick. On Monday, 10/7/13 they realized it had not been faxed so they faxed it immediately. They added that their usual practice was to fax the Report within 24 hours.	F 226	**Systemic Changes** All residents who alleged abuse could potentially be affected by the alleged deficient practice. On 09/19/13, in-service training was initiated by the Administrator, Quality Assurance Nurse consultant and Staff Development Coordinator to all full time and part time RN's, LPN's and CNA's on types of abuse, reporting abuse and Elder Justice Act reporting requirements and reporting changes in condition. The staff development coordinator ensured that any staff nurse who did not complete the in-service training by 09/23/13 did not work until the training was completed. In addition to this on 10/21/13 the Administrator and Director of Nursing were in-serviced by the Regional Director of Operations on what to immediately report to the state and the Benson Police Department and on abuse reporting requirements to the state and Police Department. This information has been integrated into the standard orientation training for the Administrator and Director of Nurses positions and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	9-19-13 10-21-13

Page 07

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Page 08