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

PRINTED: 02/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	ECONTRIBICTIONS 2012	(X3) DATE SU COMPLE	
		345309	B. WING			C 19/2012
LIBERTY		HAB CTR OF HALIFAX CTY	/ 10 Wi	ET ADDRESS, CITY, STATE, ZIP CO I CAROLINE AVENUE ELDON, NC 27890	DE. ∠,Ĵ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
SS=D	to develop, review and comprehensive plan of the facility must dever plan for each resident objectives and timetal medical, nursing, and needs that are identificassessment. The care plan must do to be furnished to attain highest practicable physychosocial well-being \$483.25; and any service be required under \$48 due to the resident's e \$483.10, including the under \$483.10(b)(4). This REQUIREMENT by: Based on record reviet facility failed to develop with behavior problems and at risk for pressure. The findings included: 1a. Resident #5 was of facility on 12/15/11 with Hypertension, Hyperlip II, and Sleep Apnea.	results of the assessment of revise the resident's of care. Itop a comprehensive care that includes measurable ples to meet a resident's mental and psychosocial and in the comprehensive escribe the services that are in or maintain the resident's ysical, mental, and any as required under incest that would otherwise 3.25 but are not provided exercise of rights under right to refuse treatment is not met as evidenced ews and staff interviews the pa Care Plan for a resident as was at high risk for falls a sores. (Resident #5).	F 279	This Plan of Correction is the allegation of compliance. Preparation and/or execution does not constitute admission provider of the truth of the factorial set forth in the statement of decorrection is prepared and/or it is required by the provision. F-279 Corrective Action for Reservice Action for R	of this plan of correction or agreement by the stalleged or conclusion ficiencies. The plan of executed solely because of federal and state land developed on problems of being fer and behaviors. Ident Potentially thial to be affected clice. Residents ative Nurses by sidents have a care at risk for falls, for swere addressed of on 2/8/12 by ministrator, DON, cial Services and Activities are of each resident after completing the ortant to work the dot opposed to care Coordinator, DON eveloping the care cted on 2/9/12 by	02/13/12
TO TOKE D	WEG LOK S OK SKANA AIDERASE	PPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X8) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED C

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SUR COMPLETO	£D
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	ROVIDER OR SUPPLIER	EHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP C 101 CAROLINE AVENUE WELDON, NG 27890		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC GROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X6) COMPLETIO DATE
F 279	Review of the facility's Falls dated 12/15/11 score was 9. According assessment a score for considered a high risk Review of the Minimu Assessment triggered of the Care Area Asses "New Care Plan start 12/29/11. Review of the Minimu Problem Area dated 12 for Falls, read, "Requit transfers and tolleting for physical support. Of history of falls, Diabet Hypertension, Seizure placement. He is cont Risk factors include in increased agitation, in behaviors, etc." Under "He will be referred to nursing. Will proceed his risks for falls and increased agitation of injuries: Coming out of bed act to floor and lowered. Numediate actions tak During observations the	s Assessment Risks for moted Resident #5's fall risking to the falls risk from 7 to 18 a resident was a for falls. Im Data Set Care Area 1/29/11 noted the Care Area 1 falls. The location and date essment Information, read, ed. "Resident assessment Information, read, ed. "Resident assessment with using two or more persons contributing factors include es Mellitus, Gout, ed. Disorder and Peg Tube inent of bowel and bladder. Spirites related to falls, icreased negative for Care Plan Considerations: therapy and restorative to care plan and minimize nijuries." In part dated 1/3/12, Narrative of incident and "Resident very confused. Toss siderail, CNA assisted to apparent injury." In en: "Fall mat in place."	F 2	This Plan of Correction is the allegation of compliance. Preparation and/or execution does not constitute admission provider of the truth of the faset forth in the statement of a correction is prepared and/or it is required by the provision. Those who attended all RI FT, PT, and PRN. Any in who did not receive in-service importance of the care plan provide information about for the resident. Also inclusion of risk areas for the interventions for the resident. This information has been standard orientation training in-service refresher course and will be reviewed by the Process to verify that the consultance of the care plan and that all residents risk for pressure ulcers or the plan and that all residents risk for pressure ulcers or the problem for this area. 10% reviewed each week. See tool. This will be done week months or until resolved by committee. Reports will be Quality of Life- QA committee action initiated as appropris	in of this plan of correction or agreement by the cots alleged or conclusions deficiencies. The plan of a executed solely because as of federal and state law. Ns. LPNs, and CNAs, nhouse staff member vice training will not albring has been to topics included the n and how it can resident care specific kied were the he resident and sont. Integrated into the ag and in the required as for all employees a Quality Assurance change has been MDS Coordinator g the "Survey QA Planned for The monitoring will sidents have a care with behaviors or at falls have a care plan to of residents will be attached monitoring only the stree of QOL/QA as given to the weekly tee and corrective	

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI	ULTIPLE CONST	RUCTION	(X3) DATE SU COMPLE	
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	On 1/17/12 a review of the facility's Care Plan no care plan. During an interview or Minimum Data Set (M MDS Consultant reversessident #5's Care Plantated since they were #5's care plan, they we that day. She stated the original care plan and During another interviethe MDS Consultant in have fallen through the interim care plan was #5 was initially admitted she did not know why the team was not in the During an interview or shift Nursing Assistant Resident #5 had a beta falls. She revealed she fall interventions for Resident #5 had a beta fall interventions for Resident #5 had a beta fall intervention for falls was not familiar with his he would ask the head intervention for falls was bed. She stated she did Resident #5. She stated when she assisted him there was no information.	of Resident #5's record and in book revealed there was in 1/18/12 at 4:30PM with the iDS) Coordinator and the aled they could not find lan. The MDS Consultant is not able to find Resident rote the care plan again on hey could not find the signature sheet. ew on 1/18/12 at 5:15PM, stated the care plan must be cracks. She stated an completed when Resident it is completed when Resident it is computer system. In 1/18/12 at 12:05PM, 1st it (NA) #1, revealed it is alarm to alert staff during it is along a did not know of any other resident #5. She added that imployed with the facility and low to care for a resident, and nurse. In 1/18/12 at 4:30PM, and Resident #5's as a pressure alarm on his id know about a fall mat for ead she had not used one	L.	279			

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X6) COMPLETION DATE
	"you learn as you go." 1b. Resident #5 was facility on 12/15/11 will hypertension, Hyperli II, and Sleep Apnea. Review of the facility's Sore Potential dated 18's pressure sore risl According to the press score of 7 to 39, it was pressure sore protocoon Review of the Minimur Assessment dated 12's Assessment triggered location and date of the Information, read, "New Weekly wound review. Review of the Minimur Problem Area dated 12's for Pressure Ulcers, repressure ulcer on his leadnitted with. He is all bladder and wears add. He requires extensive toileting using two or mphysical support. He at that is now healed. He skin breakdown and of with skin integrity." Ca read, "He will be referredlinic as needed. Will peminimize his risk for furnishing the significant in the skin for furnishing the significant integrity."	originally admitted to the th diagnoses including pidemia, Diabetes Mellitus Assessment of Pressure 12/15/11 noted Resident of Pressure 12/15/11 noted Resident of Pressure 12/15/11 noted Resident of Pressure 12/15/11 noted to follow I. In Data Set Care Area 12/11 noted the Care Area pressure sores. The e Care Area Assessment of Pressure Pressure Sores. The e Care Area Assessment of Pressure Pressure Sores. The e Care Area Pressure Sores. The e Care Area Assessment of Pressure Pressure Sores. The e Care Area Pressure Sores. The e Care Area Pressure Sores. The e Care Area 2/29/11 and, "He has a stage two eff buttock that he was so incontinent of bowel and all briefs. weight bearing assist with	F	279			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SE COMPLE	TED
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	the facility's Care Plar no care plan. During an interview or Minimum Data Set (M MDS Consultant reversedent #5's Care Platated since they were #5's care plan, they we that day. She stated the original care plan and During another interviethe MDS Consultant shave fallen through the interim care plan was #5 was initially admitted she did not know why the team was not in the Ic. Resident #5 was of facility on 12/15/11 with Hypertension, Hyperlip II, and Sleep Apnea. Review of the Minimur Assessment triggered The location and date Assessment Information started. " On 1/17/12 a review of the facility's Care Plano care plan.	n 1/18/12 at 4:30PM with the DS) Coordinator and the aled they could not find an. The MDS Consultant on the able to find Resident rote the care plan again on ney could not find the signature sheet. Bew on 1/18/12 at 5:15PM, tated the care plan must be cracks. She stated an completed when Resident and to the facility. She stated the care plan developed by the computer system. Driginally admitted to the hidiagnoses including bidemia, Diabetes Mellitus The Data Set Care Area for Behavioral Symptoms. Of the Care Area for, read, "New Care Plan Resident #5's record and in book revealed there was		279			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	CONSTRUCTION	(X3) DATE SU COMPLET	ED
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F 280 SS=D	to be touched. Na#2 behaviors of trying to him near the nurse 's he settled down. An interview on 1/18// Minimum Data Set (MDS Consultant reve Resident #5 's Care stated since they wer #5 's care plan, they that day. She stated to original care plan and During another interv the MDS Consultant have fallen through th interim care plan was #5 was initially admitt she did not know why the team was not in th 483.20(d)(3), 483.10(PARTICIPATE PLAN The resident has the incompetent or other incapacitated under th participate in planning changes in care and in A comprehensive car within 7 days after the comprehensive asses interdisciplinary team physician, a registere for the resident, and of	combative and did not like stated Resident #2 also had get out of bed and staff kept is station to watch him until 12 at 4:30PM with the MDS) Coordinator and the saled they could not find Plan. The MDS Consultant to not able to find Resident wrote the care plan again on they could not find the disignature sheet. It won 1/18/12 at 5:15PM, stated the care plan must be cracks. She stated an accompleted when Resident the care plan developed by the care plan developed by the computer system. It is RIGHT TO NING CARE-REVISE CP or ight, unless adjudged wise found to be the laws of the State, to g care and treatment or treatment.	F 280			

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		MEDICAID SERVICES				<u> </u>	NO. 0938-0391
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F 280	Continued From page 8			- 20			
1 200	+ ++++++++++++++++++++++++++++++++++		r	280	o _l		
		showed that the resident was y with one unstageable	of white commensus				
	1						
1		ician 's Telephone Orders			1		
West	dated 12/21/11 revea indwelling urinary catl		THE STATE OF THE S				
	The Nurse's Notes s	showed that an indwelling	-				į
		Inserted on 12/21/11 at 6:03					
	PM. The resident was		-		***************************************		
	catheter care on 01/1						
	The resident's Care						
	contained no informat indwelling urinary cath	ition about the resident 's heter.					:
	The Administrator stat						
	01/19/12 at 2:15 PM t	that the previous Director of					
		also the MDS Nurse. The	1				
1		that the DON would take the					
I		eir daily meetings where they					
		n resident 's conditions and . The Administrator stated					
		rifle Administrator stated rere updated at this time.			İ		
		ited that the previous DON					
	left around the first of	December, 2011 and a new					
		that left after 2 weeks. The					ĺ
	Administrator stated th	hat the facility 's Nurse					
	Consultants came in to	to make sure that all of the					
		o date. The Administrator					-
		S Nurse was currently being					
	trained and was suppr	osed to be reviewing new					
	orders daily and updat	ating all resident 's Care					
		ator did not explain why this					
1		had not been updated.					
F 314	483.25(c) TREATMEN	NT/SVCS TO	F:	314	1		

SS=D PREVENT/HEAL PRESSURE SORES

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

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		345309	B. WING_		01/19/2012
	ROVIDER OR SUPPLIER	EHAB CTR OF HALIFAX CTY	sı	TREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 280	the resident, the residegal representative; and revised by a team each assessment. This REQUIREMENT by: 1a. Resident #6 was 12/03/11 and had diag Joint Replacement (H Heart Failure, Cardior Obstructive Heart dise Fibrillation, Pacemake The resident 's Care pressure ulcers as a pthat included monitoric weekly skin assessment wheelchair and turning The Admission Minimum Assessment dated 12 resident was cognitive extensive assistance for transfers. The MDS shadmitted to the facility pressure ulcer. The Care Area Assessulcers dated 12/16/11 was admitted to the facility pressure ulcer.	acticable, the participation of dent's family or the resident's and periodically reviewed in of qualified persons after. Is not met as evidenced admitted to the facility on gnoses including Aftercare lip Fracture), Congestive myopathy, Chronic ease, Hypertension, Atrial er and Osteoporosis. Plan dated 12/03/11 listed problem with approaches ing of nutritional status, ents, chair cushion while in g and repositioning. JOS/11 showed that the ely intact and required for bed mobility and howed that the resident was with one unstageable sment (CAA) for pressure showed that the resident acility with a pressure ulcer direquired staff assistance	F 28	This Plan of Correction is the center's a allegation of compliance. Preparation and/or execution of this plut does not constitute admission or agreed provider of the truth of the facts alleged set forth in the statement of deficiencies correction is prepared and/or executed it is required by the provisions of federal F280 Corrective Action for Resident African Resident # 6's care plan was update problems of heel protectors and info concerning the resident's urinary care Corrective Action for Resident Po Affected All residents with heel protectors and catheters have the potential to be afthis alleged deficient practice. Residented by Administrative Nurses is ensure that every resident that had in protectors or a urinary catheter were in their care plans. Systemic Changes An in-service was conducted on 2/8/Consultant for the Administrator, DO MDS Coordinator, Social Services Deletary Manager and Activities Directive importance of updating the care of the Interdisciplinary Care Plan Tesupport staff mentioned above who described in the care of the inservice training will not be work until training has been completed MDS Coordinator, DON and or SDC responsible for bringing the care plan our morning stand-up Monday througand so that care plans are updated and so that care plans are updated a	an of correction ment by the if or conclusions is. The plan of solely because all and state lary. 02/13/12 fected ad with the formation theter. ctentially d urinary fected by dents were by 2/10/12 to heel addressed /12 by Nurse by, SDC, birector, ctor about plan. Any am or did not allowed to ed. The will be in books to gh Friday

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

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		345309	B. WNG			01/11	9/2012
	OVIDER OR SUPPLIER	EHAB CTR OF HALIFAX CTY	, •	11	EET ADDRESS, CITY, STATE, ZIP CODE 01 CAROLINE AVENUE /ELDON, NC 27890		
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F 280	showed an order date protectors to heels to was no information or to include the use of I The Administrator stated to 2:15 PM Nursing (DON) was a Administrator stated to Care Plan book to the discussed changes in reviewed new orders Administrator stated to updated at this time. That the previous DOI December, 2011 and hired that left after 2 stated that the facility in to make sure that a to date. The Administrator did not Care Plan had not be 1b. Resident #6 was 12/03/11 and had dia Joint Replacement (Heart Failure, Cardio Obstructive Heart dis Fibrillation, Pacemak The Admission Minim Assessment dated 12	cian's Telephone Orders ed 12/20/11 that read: Heel relieve pressure. "There in the resident's Care Plan neel protectors. Ited in an Interview on that the previous Director of ilso the MDS Nurse. The hat the DON would take the eir daily meetings where they is resident's conditions and for the residents. The hat the Care Plans were The Administrator stated N left around the first of a new MDS Nurse was weeks. The Administrator 's Nurse Consultants came all of the Care Plans were up rator stated that a new MDS being trained and was wing new orders daily and is Care Plans. The explain why the resident's een updated. admitted to the facility on gnoses including Aftercare lip Fracture), Congestive myopathy, Chronic ease, Hypertension, Atrial er and Osteoporosis. aum Data Set (MDS) 2/09/11 showed that the ely intact and required	F	280	This Plan of Correction is the centerallegation of compliance. Preparation and/or execution of this does not constitute admission or agree provider of the truth of the facts allest forth in the statement of deficient correction is prepared and/or executif is required by the provisions of feet. The in-service topics included the for heel protectors and urinary cabe updated and revised to include care of the resident and treatment care and treatment of the resident and treatment or the resident and the care proformation has been integrated orientation training of any new in Care Plan Team Members and in in-service refresher courses and by the Quality Assurance Process the change has been sustained. Quality Assurance The Director of Nursing or MDS monitor this issue using the "Sur Updating Care Plans for Heel Proformation training the care of the residents will be reviewed with eximple the care of the residents will be reviewed with eximile the done weekly times three resolved by QOL/QA committee, given to the weekly Quality of Lift committee, and corrective action appropriate.	s plan of correction reement by the ged or conclusions cies. The plan of ted solety because deral and state lass elevations at the care plans in the conclusion of the terdisciplinary in the required will be reviewed at the verify that Coordinator will very QA Tool for otectors and lang will include at the distinct of the terdisciplinary in the required with heel and revised to esident as ing tool. 10% of each audit. This months or until Reports will be e- QA	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WNG 01/19/2012 346309 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 101 CAROLINE AVENUE LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY **WELDON, NC 27890** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 F 314 Continued From page 9 This Plan of Correction is the center's credible allegation of compliance. Based on the comprehensive assessment of a resident, the facility must ensure that a resident Preparation and/or execution of this plan of correction who enters the facility without pressure sores does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions does not develop pressure sores unless the set forth in the statement of deficiencies. The plan of individual's clinical condition demonstrates that correction is prepared and/or executed solely because they were unavoidable; and a resident having it is required by the provisions of federal and state law pressure sores receives necessary treatment and services to promote healing, prevent infection and 02/13/12 F - 314prevent new sores from developing. Corrective Action for Resident Affected Resident #5's treatment for his pressure area was This REQUIREMENT is not met as evidenced changed to a hydrocolloid dressing on 1/20/12 bv: and heels were floated to provide pressure relief Based on observation, record review and staff to heels on 1/20/12. . Resident #5 heels are to be interviews the facility failed to apply a barrier floated while in bed or in geri-chair. A reminder cream to a resident's buttocks and failed to float was sent to the Certified Nursing Assistant's the resident's heels for 1 of 4 residents reviewed Smart Charting for providing floating heels to for pressure ulcers (Resident #5). The facility also Resident #5 on 2/9/12 A reminder was sent to the Certified Nursing Assistant's Smart Charting for failed to apply heel protectors for 1 of 4 residents providing floating heels to Resident #5 on 2/9/12. reviewed for pressure ulcers (Resident #6). For Resident #6 heel protectors were applied on The findings include: 1/19/12. A reminder was sent to the Certified Nursing Assistant's Smart Charting for providing 1a. Resident #5 was admitted to the facility on heel protectors to Resident #6 on 2/9/12. 12/15/11 and had diagnoses including Intracranial Corrective Action for Resident Potentially Hemorrhage with severe aphasia, Seizures, Affected Hypertension, Diabetes Mellitus and Arthritis. All residents with potential to be affected by this The Admission Minimum Data Set (MDS) alleged deficient practice were reviewed by Assessment dated 12/22/11 showed that the Administrative Nurses by 2/9/12 to identify every resident that had an order for heel protectors and resident had short and long term memory loss, those residents who needed their heels floated poor decision making skills requiring cues and were identified. supervision and had physical behaviors directed All residents who need their heels floated were

at others such as hitting, kicking and grabbing.

extensive assistance with bed mobility, transfers

and toileting and required total assistance with

hygiene and bathing. The MDS showed that the

The MDS showed that the resident required

ensured that floating of heels where on their care

plan and reminders were sent to Smart Charting

identified and ensured that heel protectors were

updated on their care plan and reminders were

for Certified Nursing Assistants by 2/9/12. All residents with orders for heel protectors were

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

CENTER	S FOR MEDICARE &	MEDICAID SEIVICES				(X3) DATE SUR	€.V
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIP	LE CONSTRUCTION	COMPLETE	
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBERG	A. BUI	LDING		C	
			B. WIN	lG		-	/2012
		346309				01/18	12012
NAME OF PR	OVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
I IRERTY	COMMONS NSG AND RE	EHAB CTR OF HALIFAX CTY		1	O1 CAROLINE AVENUE		
LIDENTI					VELDON, NC 27890		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREP TAG	ΙX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILO BE	(X5) COMPLETION DATE
F 314		Continued From page 10 esident was frequently incontinent of bowel and			This Plan of Correction is the center's credible		
	resident was frequen	try incontinent or bower and howed that the resident was		:	allegation of compliance.		,
	at rick for developing	a pressure ulcer and had an					
	unhealed stage II pre	essure ulcer that was present			Preparation and/or execution of this pl does not constitute admission or agree	an of correction ment by the	
	on admission.	unhealed stage II pressure ulcer that was present on admission.			provider of the truth of the facts alleged set forth in the statement of deficiencies	d or conclusions	
	A review of the Physician 's Telephone Orders showed an order dated 12/23/11 that read: "D/C (discontinue) wet dressing to sacrum and apply Calmaseptine barrier cream to inner top buttock area Q (every) shift." Calmoseptine provides a physical moisture between the provided of the contract of the contr				correction is prepared and/or executed it is required by the provisions of feder	l solely because	
					All residents with treatments were in	dentified and	
					information sheets printed off for ea	ich type of	
					I treatment being performed for resid	ients.These	
					information sheets were placed in a the treatment cart on 2/9/12.	notebook on	
	from intact and injure	ed skin.	1		the treatment cart on 2/9/12.		
	The CAA for Pressur	e Ulcer dated 12/29/11			Systemic Changes		
		dent was admitted with a			An in-service was conducted on 2/	10/12 by the	
	stage II pressure ulc	er on the left buttock and			Staff Development Coordinator and	1	
		r skin breakdown. The CAA			Administrator. Those who attended	i all RNs,	
	read: "Will proceed	to care plan and minimize			LPNs, and CNAs, FT, PT, and PRI house staff member who did not re	v. Aby in- ceive in-	
	his risk for further sk	in break down. "			service training will not be allowed	to work until	
	There was not a con-	n atom for properties tileare for			training has been completed. The	in-service	
	Resident #5.	e plan for pressure ulcers for			topics included the requirement to guidelines for treatments as set for	rollow th by the	
	Resident #0.		1		manufacturer and the initiation of a	Treatment	
	A Weekly Wound Re	eview sheet dated 01/10/12			Information Notebook that will be k	ept on the	
	showed a stage II pr	essure ulcer on the left			treatment cart, that all residents wheel breakdown will have their hee	io are at risk to le floated and	ľ
	buttocks that measu	red 4 cm (centimeters) long			that if heel protectors must be appl	led as ordered	
	and 3.8 cm wide. A	note under Additional			This information has been integrate	ed into the	
	description or docum	nentation read: "Instructed			orientation training of any new Inte	rdisciplinary	
		se camolseptine ointment as			Care Plan Team Members and in t service refresher courses and will	ne required in-	Ì
	a barrier cream. "				the Quality Assurance Process to	verify that the	
	A Markly Maund D	eview sheet dated 01/18/12 at	1		change has been sustained.		
	O'AO AM abound the	at the resident had a Stage II			Quality Assurance		1
	Pressure wound on	the left buttocks measuring 3					
	cm (centimeters) in	length and 2 cm in width.			The Director of Nursing or SDC wi	II monitor this	
	Incontinence manage	ement with barrier ointments			issue using the "Survey QA Tool f	or Floating	
	was listed as one of	the interventions for healing.			Heels/Use of Heel Protectors" and Tool for Treatment Accuracy".	QUIVOY WA	
	1	·	1		TOOLINE LIAMACIONE LIAMACON .		1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING. 01/19/2012 345309 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **101 CAROLINE AVENUE** LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY WELDON, NC 27890 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY F 314 Continued From page 11 F 314 This Plan of Correction is the center's credible allegation of compliance. The Treatment Administration Record for January 2012 had an entry that read: "May apply Preparation and/or execution of this plan of correction Calmaseptine barrier cream to inner top buttocks does not constitute admission or agreement by the q (every) shift." There were 8 shifts on the MAR provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of that were not initialled as being done including the correction is prepared and/or executed solely because 7AM to 3PM shift on 01/18/12. it is required by the provisions of federal and state law Nursing Assistant (NA) #1 and NA #3 was The monitoring will include verifying that heels are observed to check Resident #5 for incontinence floated for those identified, heel protectors used on 01/18/12 at 11:37 AM. The resident was dry as ordered and that treatments are applied as and did not require incontinence care. There was ordered. See attached monitoring tools. This will be done on 5 residents 5 times a week for two an open area on the resident's left upper weeks and then 5 residents weekly for three buttocks that was red and inflamed, without months or until resolved by QOL/QA committee. drainage. There was no cream observed on the Reports will be given to the weekly Quality of Life wound. The NAs reapplied the incontinent brief QA committee and corrective action initiated as on the resident and did not apply a barrier cream. appropriate. During the observation, the resident was observed to be cooperative without behaviors. On 01/18/12 at 11:54 AM, the Nurse (Nurse #4) assigned to Resident #5 stated in an interview that the resident did not currently have any skin breakdown. NA #4 stated in an interview on 01/18/12 at 12:05 PM that the resident had a spot on his bottom that was healing and they were putting a thick barrier cream on it. On 01/18/12 at 2:35 PM the Staff Development Coordinator stated in an interview that she had instructed the NAs to keep a thick layer of the calmoseptine cream over the pressure area and to not completely wipe it off during incontinent care and to reapply a thick layer of the cream over the area after each incontinent episode.

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CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 345309 01/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **101 CAROLINE AVENUE** LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY **WELDON, NC 27890** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 | Continued From page 12 F 314 On 01/18/12 at 2:40 PM the Director of Nursing (DON) stated in an interview that the resident had an open area on his sacrum that they were putting calmoseptine barrier cream on after each incontinent episode. The DON stated that the NAs had been instructed to keep a thick layer of cream over the area and to not completely wash it off during incontinent care. The DON stated that when the NAs checked for incontinence at 11:37 that morning they should have applied the calmoseptine cream. On 01/18/12 at 3:05 PM, NA #1 who was assigned to the resident stated in an interview that she does not apply the Calmoseptine barrier cream that the nurses did that. The NA stated that the nurse changed the resident first thing this morning. On 01/18/12 at 3:15 PM Nurse #4 stated in an interview that she changed the resident 's incontinent brief that morning but did not apply calmoseptine barrier cream because the resident was combative. On 01/19/12 at 8:48 AM, NA #5 stated in an interview that after each incontinent episode she applied a thick barrier cream over the open area on the resident 's bottom. On 01/19/12 at 2:30 PM an interview was conducted with the Administrator and the DON. The DON stated that there was no barrier cream over the resident's pressure area when she looked at it yesterday. The Administrator stated that they have a computerized system that gives the NAs an Assigned Task List that tells them how to care for a resident. .

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345309	B. WiN	G		01/	19/2012
	OVIDER OR SUPPLIER	REHAB CTR OF HALIFAX CTY	•	101	ET ADDRESS, CITY, STATE, ZIP CODE CAROLINE AVENUE LDON, NC 27890		
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F 314	On 01/19/12 at 2:37 DON was observed List for Resident #5. the tasks list to instr Calmoseptine barrie pressure ulcer on hi incontinent episode. some of the informa from the Care Plan b. Resident #5 was 12/15/11 and had di Hemorrhage with se Hypertension, Diabe The Admission Mini Assessment dated resident had short a poor decision makir supervision and had at others such as hi The MDS showed ti extensive assistand The CAA for Pressu showed that the res stage II pressure ul was at risk for further si There was not a ca Resident #5. A review of the Phy showed an order de	PM the Administrator and the to review an Assigned Tasks. There was no information on uct the NAs to apply or cream to the resident's so bottom after each. The Administrator stated that tion on the Tasks List comes admitted to the facility on agnoses including Intracranial ever aphasia, Seizures, etes Mellitus and Arthritis. The Administrator stated that tion on the Tasks List comes admitted to the facility on agnoses including Intracranial ever aphasia, Seizures, etes Mellitus and Arthritis. The Administrator stated that the indianate aphasia, Seizures, etes Mellitus and Arthritis. The Administrator stated that the indianate including Intracranial ever aphasia, Seizures, etes Mellitus and Arthritis. The Administrator stated that the indianate including Intracranial ever aphasia, Seizures, etes Mellitus and Arthritis. The Administrator stated that the indianate including Intracranial ever aphasia, Seizures, etes Mellitus and Arthritis. The Administrator stated that the indianate including Intracranial ever aphasia, Seizures, et including Intracranial ever aphasia, Seizures,	F	314			

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P.015

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING C B. WING 345309 01/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **101 CAROLINE AVENUE** LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY **WELDON, NC 27890** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 Continued From page 14 F 314 pillows to keep pressure off. " A Weekly Wound Review dated 01/10/12 showed that the resident had a stage II pressure area on the right heel that measured 4 cm long and 3.8 cm wide. A section on the Weekly Wound Review sheet titled Interventions for healing listed multiple possible interventions. The intervention " Float heels " was not marked as an intervention for healing the heel pressure area. A section on the Weekly Wound Review sheet titled Document conditions that would affect wound healing showed that the resident refused repositioning. The Additional description or documentation read: " Heel blister from friction and shear by repetitive scrubbing heel on the bed and chair. Blister dry and intact. " On 01/17/12 at 11:00 AM, Resident #5 was observed sitting in a geri-chair near the nurses ' station. The resident was calm and resting with his eyes closed. The resident was reclined in the geri-chair, had on white socks and both heels were resting on the foot rest of the geri-chair. There were no pillows under the resident 's

On 01/17/12 at 4:15 PM the resident was observed to be reclined in a geri-chair in his room. The resident was calm and a family member was talking with the resident. The resident was observed to have on socks and both heels were resting on the foot rest of the chair.

9:53 AM showed that the resident had a non-stageable pressure ulcer on the right heel that measured 4cm long and 3.8 cm wide. The

A Weekly Wound Review sheet dated 01/18/12 at

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING B. WING 01/19/2012

	345309		D. WIN	B. WNG		01/19	
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890					
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	not include floating of Additional description Really question if this peel off. Will continue NA #1 and NA #3 weresident from the bed at 11:40 AM. NA #3 s float the resident 's h resident would allow I resident 's socks and observed with a dried of the area was clear dark underneath the state of the Areapplied the resident was left redin both heels resting on under the heels of the observation, the resid combative and did no In a separate interview NA #1 stated that Resigeri-chair most of the she would use a pillov prop up the resident 'pressure sore. On 01/18/12 at 12:14 interview that the residing theel and they we heels to keep the president in thad socks on his feet	ing on the review sheet did the resident's heels. or documentation read: is eschar or skin that will to monitor." 'e observed to transfer the to a geri-chair on 01/18/12 tated that the staff would eels on pillows when the hem to. NA #3 removed the I the right heel was circular area. The top half and the bottom half was skin. The area was intact. resident's socks and the ning in the geri-chair with the foot rest without pillows reet. During the ent was calm, was not t resist care. I v on 01/18/12 at 12:05 PM, sident #5 was up in his time. The NA stated that v every now and then to s feet because of his PM, Nurse #5 stated in an dent had an area on the tre floating the resident's source off.	F	314			

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

AND PLAN OF CORPECT	INCIES		(4)		LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING B. WING			COMPLETI	
		345309				C 01/19/2012	
NAME OF PROVIDER O		EHAB CTR OF HALIFAX CTY		10	LEET ADDRESS, CITY, STATE, ZIP CODE 01 CAROLINE AVENUE VELDON, NG 27890		
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTIVE		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE	
residen and the On 01/robserve feet we only pill residen On 01/robserve Adminiscomput an Assi for the On 01/r DON we List for the tast residen some of 's Care 2. Resi 12/03/r Joint R Heart F Obstruct Fibrillat The respressed that individed wheeld	resident was 19/12 at 8:48 a d lying in bed re resting on t low on the bed t's head. 19/12 at 2:30 I ted with the A strator stated i derized system gned Task Lis resident. 19/12 at 2:37 I as observed t Resident #5. as list to instru t's heels. The f this informate Plan. dent #6 was a 1 and had dia eplacement (F failure, Cardio ctive Heart dis ion, Pacemak sident's Care re ulcers as a duded monitor skin assessm hair and turnin	amily member was visiting resting quietly. AM Resident #5 was a steep. The heels of both the mattress of the bed. The distribution was the one under the distribution of the was the one under the was distributed to the NAs with state that tells them how to care distribution on the was no information on the was not th	L,	314			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		JCTION	(X3) DATE SURVEY COMPLETED	
\$		345309	B. WNG			C 01/19/2012	
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY			STREET ADDRES 101 CAROLIN WELDON, N				
(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 314	resident was cognitive extensive assistance transfers. The MDS s admitted to the facility pressure ulcer. The Care Area Assess ulcers dated 12/16/17 was admitted to the factor on the sacral area and to move sufficiently to the extensive of the Physis showed an order date Heel protectors to her common of the extensive of the resident of the resident of the resident of the resident of the extensive was conducted to the extensive wa	#/09/11 showed that the ely intact and required for bed mobility and howed that the resident was a with one unstageable sment (CAA) for pressure showed that the resident acility with a pressure ulcer direquired staff assistance arelieve pressure. Ician's Telephone Orders and 12/20/11 that read: "els to relieve pressure." AM the resident was an bed with no heel dent's feet. AM Resident #6 was with the heels of her feet us. There were no heel dent's feet or pillows under During the observation an ted with an individual in the she was a sitter and sat us a week from 8 AM until 2 if that the staff usually put uses on the resident but did res. During the interview room. The Nurse was	F3	14			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
		345309	B. WNG		C 01/19/2012			
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY			4	10	REET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE NELDON, NC 27890			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	resident's feet. On 01/19/12 at 9:46 A conducted with the nu assigned to the reside shift. NA #6 stated the bed she usually floate pillows. When asked it protectors, the NA sta NA stated that at the bid not check to see if resident's feet. The Napplied the heel protector and had not removed resident's feet since in the Administrator stated 01/19/12 at 2:15 PM the were put into place surfurses pass along the the next shift and the reabout the changes. An interview was cond Administrator and the PM. The Administrator and the PM. The Administrator computerized system to an Assigned Task List for the resident. On 01/19/12 at 2:37 Pi DON was observed to List for Resident #6. The tasks list to instruct protectors to the resident.	at an interview was prising assistant (NA #6) and on the 7 AM to 3 PM at when the resident was in do the resident 's heels on the resident used heel ted: "Sometimes." The programme of the resident was in the protectors were on the last attention of the resident 's feet the protectors from the last when new interventions of the beginning of her shift. In an interview on the last when new interventions of as heel protectors, the information to the nurse on the last with the DON on 01/19/12 at 2:30 attention to the NAs with that tells them how to care the Administrator and the review an Assigned Tasks there was no information on the NAs to apply heel and 's feet. The last some of this information	F	314				

FORM CMS-2567(02-99) Previous Versions Obsolete .

Event ID: 9UJT11

Facility ID: 923118

If continuation sheet Page 19 of 19