PRINTED: 07/16/2012

STATEMENT OF	F DEFICIENCIES	MEDICAID SERVICES			OMB NO	
	ATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIERCLIA O PLAN OF CORRECTION DE IDENTIFICATION NUMBER		(X2) MULTIP A BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	. <u></u>	345309	B WNG		06/28	/2012
	OMMONS NSG AND RE	HAB CTR OF HALIFAX CTY	10	EET ADDRESS, CITY, STATE, ZIP CODE 01 CAROLINE AVENUE VELDON, NC 27890		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIECT OF THE APPROPRIEC	ULD BE	(X5) COMPLETION DATE
	483.10(b)(5) - (10), 48 RIGHTS, RULES, SE	33.10(b)(1) NOTICE OF RVICES, CHARGES	Γ 156	This Plan of Correction is the center's allegation of compliance.	credible	. <u>—</u>
; ; ;	and in writing in a lang understands of his or regulations governing responsibilities during	guage that the resident her rights and all rules and resident conduct and the stay in the facility. The	RECEIVED AUG 0 2 2012	Preparation and or execution of this p does not constitute admission or agree provider of the truth of the facts allege selforth in the statement of deficiencie correction is prepared and or execute it is required by the provisions of fede	onent by the ed or conclusions es. The plan of d solely because	· ··
r ę	notice (if any) of the S §1919(e)(6) of the Act made prior to or upon	t. Such notification must be admission and during the	W WI U.V.	F156 Notice of Rights Corrective Action for Reside	nt Affected	07/28/12
{ V	any amendments to it writing.	ipt of such information, and , must be acknowledged in	The second secon	A print out of how to apply for and Medicaid benefits was pos 06/27/12 by the administrator	sted on	ī.,
6 C f i' f , v	entitled to Medicaid be of admission to the nu- resident becomes elig tems and services that facility services under which the resident ma	m each resident who is enefits, in writing, at the time irsing facility or, when the lible for Medicaid of the at are included in nursing the State plan and for my not be charged; those set that the facility offers		main dining room. Corrective Action for Reside Potentially Affected All residents have the potentia affected by this practice. See caction below.	nt I to be	
t ii t	the amount of charges nform each resident v	dent may be charged, and so for those services; and when changes are made to secified in paragraphs (5) ection.	,	Systemic Changes The "how to apply for Medical Medicald" was posted in frame the wall by the maintenance di	es mounted to	
ļ,a · ti	at the time of admission of the resident's stay, of	m each resident before, or on, and periodically during services available in the	1	06/27/12 to prevent them from removed.		
į li		for those services, for services not covered the facility's per diem rate.		Quality Assurance The Administrator will monito using the "Survey QA tool".	or this issue	
	The facility must fumisegal rights which incli	sh a written description of udes:		Į.	1	,, d

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 nazzing homes, the above findings and plans or 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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DEPART	MENT OF HEALTH A	HEALTH AND HUMAN SERVICES FORM APPROVED					
FNTER	S FOR MEDICARE &	MEDICAID SERVICES		OMB NO 0938-0391			
ATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPL A BUILDING	E CONSTRUCTION	COMPLETED		
	<u> </u>	345309	B WNG		06/28/2012		
	OVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE			
IBERTY	COMMONS NSG AND R	EHAB CTR OF HALIFAX CTY	W	ELDON, NC 27890		_	
(X4) ID PREFIX TAG	/EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OLD BE COMPLETION	•	
; 15E	A description of the opersonal funds, under section; A description of the for establishing eligit the right to request a 1924(c) which deternon-exempt resource institutionalization are spouse an equitable cannot be considered toward the cost of the medical care in his of down to Medicaid eligible. A posting of names, numbers of all pertires.	requirements and procedures bility for Medicaid, including an assessment under section mines the extent of a couple's es at the time of a datributes to the community share of resources which de available for payment in the process of spending	F 156	Plus Plan of Correction is the center's allegation of compliance Preparation and or execution of this p does not constitute admission or agree provider of the truth of the facts alleges to firth in the statement of deficiency correction is prepared and or execute it is required by the provisions of fede. The monitoring will include v that the "How to apply for Me Medicaid" posting is still hang frame by the dining room. Se monitoring tool. This will be for three months or until resol QOL/QA committee. Reports to the weekly Quality of Lifecommittee and corrective active appropriate. The QOL/QA committee and propriate.	elan of correction coment by the cond or conclusions cs. The plan of d solely because ral and state left erification dicare and ging in the e attached done weekly ved by will be given QA on initiated as	73.	
,	agency, the State lic ombudsman progra advocacy network, a unit; and a statement complaint with the Stagency concerning misappropriation of facility, and non-condirectives requirement. The facility must conspectified in subpart related to maintaining procedures regarding requirements included.	censure office, the State m, the protection and and the Medicaid fraud control int that the resident may file a state survey and certification resident abuse, neglect, and resident property in the inpliance with the advance		main quality assurance comm have regularly scheduled mee which are attended by the Adr Director of Nursing, other nur and dietary manager. It will also be reviewed in Que committee attended by the Madministrator, Director of Nervices, Dietary Manager, Edirector and Activities Director and Activities Director.	ittee. They ting weekly ministrator, se managers, sarterly QOL/QA ledical Director, ursing, Social		

Facility ID 923116

concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				1		
STATEMENT OF DEFICIENCIES APPLOY AN OF CORRECTION LE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1, ,	LDING	NSTRUCTION	(73) DATE SURVEY COMPLETED		
	-	345309	8 WI	NG		06/	28/2012	
	OVIDER OR SUPPLIER	REHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP COD 101 CAROLINE AVENUE			- 	
LIBERTY	LOWWORD WAR KAIN L	CEMAD CIK OF MACH AN OTT		WELDO	DN, NC 27890			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TAI	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	COMPLETION DATE	
F 156	Continued From pag	iē 3	F	156				
	includes a written de	escription of the facility's It advance directives and						
	The facility must info name, specialty, and physician_responsib	orm each resident of the d way of contacting the le for his or her care.				•		
	written information, applicants for admis information about he Medicare and Medic	ominently display in the facility and provide to residents and ision oral and written by to apply for and use caid benefits, and how to previous payments covered by						
	by: Based on observatifacility failed to post	IT is not met as evidenced ions and staff interview, the information on how to apply edicaid benefits for all						
	Findings include:							
	at 4 PM revealed por displayed in picture main dining room for members to view. revealed no information	5/12 at 1:30 PM, and 6/27/12 osted information was frames on a wall outside the or residents and family Review of the postings ation on how to apply for benefits was posted.	·					
:	6/27/12 at 5:28 PM	with the Administrator on the Administrator stated the pected to be posted outside						

Facility ID 923116

the main dining room with all of the other required

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CENTERS	S FOR MEDICARE & MEDICAID SERVICES			TO CONSTRUCTION	(X3) DATE SURVE	EY
TATEMENT C	F DEFICIENCIES - (X1) PROVIDER/SUPPLIERICLIA			IPLE CONSTRUCTION	COMPLETED	
ND PLAN OF	CORRECTION	A BUIL	LOIN	NG		
	345309	B WN			06/28/	2012
NAME OF PR	OVIDER OR SUPPLIER		\$1	TREET ADDRESS, CITY, STATE, ZIP CODE		
	· · ·			101 CAROLINE AVENUE		
LIBERTY (COMMONS NSG AND REHAB CTR OF HALIFAX CTY	<u></u>	上	WELDON, NC 27890	TION	(×5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETION DATE
				,		
r 156	Continued From page 3	F	15	56 Plus Plui of Correction is the center allegatum of compliance.	ver, tille	
	postings. The Administrator stated she was unaware the postings were not on the wall available to residents. 483.10(j)(1)&(2) RIGHT TO/FACILITY	F	= 17	Preparation and or execution of this does not constitute admission or agrifact provider of the truth of the facts alley set forth in the statement of deficient correction is prepared and or execut it is required by the provisions of fea	rement by the ged or conclusions yes. The plan of ged solely because	
				F 172 Ombudsman		0.,20,1
	following:			Corrective Action for Resid	lent	
	Any representative of the Secretary;			Affected		
	Any representative of the State; The resident's individual physician;			The administrator spoke to re 20 and 36 on 07/19/12 to info the ombudsman name and co	orm them of	
				information.		
	The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965); The agency responsible for the protection and advocacy system for developmentally disabled			Corrective Action for Residence Potentially Affected All alert and oriented residence potential to be affected by the	nts have the	
	individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);			On 07/19/12, 07/20/12, and social services director met and oriented residents to infethe ombudsman name and c	with all alert orm them of	
	The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally III Individuals Act);			information. A print out of information was also provid They were also told that the contact information for the	the ed to them. name and ombudsman is	
	Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and			located outside of the main and at each nurses 'station.	ammy room	i I
	Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of					: :

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DEPARTME	NT OF HEAL	1A HT	ID HUMAN SERVICES				O. 0938-039
CENTERS I STATEMENT OF AND PLAN OF CO	DEFICIENCIES		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M	JITIPLE CONSTRUCTION DING	(X3) ĐẠTE SI CƠMPLE	
i		٠.	345309	B WIN	G	06/	28/2012
	MMONS NSG		EHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP COL 101 CAROLINE AVENUE WELDON, NC 27890)E	
(X4) ID PREFIX TAG	(EACH DE	FICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ADADE DEFERENCES IN T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION ĐATE
	<u></u>	-7:14			•		

F 172 Continued From page 4 the resident.

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

This REQUIREMENT is not met as evidenced

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

Findings include:

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

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

Resident #36 was admitted to the facility on 1/9/0 Review of the resident's most recent MDS, a quarterly assessment of 4/10/12, revealed the resident was cognitively intact.

During an interview with the Resident #36 on 6/28/12 at 8:02 AM, the resident stated she didn't F 172

This Plan of Correction is the correct constitle allegation of compliance.

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

Systemic Changes

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

Quality Assurance

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

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CDARTMENT OF	ਜ਼ਿਸ਼ TH A	ND HUMAN SERVICES				FORM OMB NO	APPROVED 0938-0391
CENTERS FOR ME ATEMENT OF DEFICIENCE D PLAN OF CORRECTION	DICARE &	MEDICAID SERVICES (X1) PROVIDER/USUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M		CONSTRUCTION	(X3) DATE SUR COMPLETI	IVEY
- ".	15 5	345309	B WIN	ıG		06/2	8/2012
LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		101 CAROLINE AVENUE WELDON, NC 27890 ID PROVIDER'S PLAN OF CORRI		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR	OOLO BE		
F 172 Continue know who Ombuds to Residen 6/9/12. dated 6/ cognitive During at 7:54 know whow to residen discuss admissishe we not reman Oml During 6/28/12 helped Reside reported did, an Activity discuss Directed.	in the Ombinan was, of the Ombinan was, of the Ombinan The ent Council er anyone of the the treported san interview. AM, the resident to a Res	Judsman was, what the property of the property	•	172	The Plane of Compliance. Preparation and or execution of this pages not constitute admission or agree provider of the truth of the facts alleg set forth in the statement of deficiency correction is prepared and or execute it is required by the provisions of fede. The QOL/QA committee is the quality assurance committee. regularly scheduled meeting which are attended by the Addirector of Nursing, other numanagers, and dietary manager twill also be reviewed in Queommittee attended by the Administrator, Director of Nervices, Dietary Manager, Editor and Activities Director and Activities Director and Activities Director.	olan of correction of correction of correction of conclusion of solely because or all and state for the plan of th	L/QA etor, ial
at Res month	ident Coun	cil meetings every couple of lot able to report when the					. _{_27} = .

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

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	NEITH OF THEMES					OMB NO	<u> </u>
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X1)-PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVE COMPLETED	
	- 	345303	в мис	;		06/28/	2012
	OVIDER OR SUPPLIER -				T ADDRESS, CITY, STATE, ZIP CODE CAROLINE AVENUE		
LIBERTY C	OMMONS NSG AND R	EHAB CTR OF HALIFAX CTY		WEI	LDON, NC 27890		
(X4) ID PREFIX TAG	JEACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	·	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDED TO THE APPRIOR OFFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 172	Continued From pag	e 6	F '	172	This Plan of Correction is the center's allegation of compliance.	eredible	
F 248 SS=D	6/30/12 at 3:51 PM, expected the Activity Ombudsman at Resi the residents could conformation from par was given to newly a 483.15(f)(1) ACTIVI INTERESTS/NEEDS The facility must proof activities designed the comprehensive as	t of the admission packet that admitted residents . TIES MEET	F	248	Preparation and or execution of this p does not constitute admission or agree provider of the truth of the facts allege set forth in the statement of deficiencial is required by the provisions of federal is required by the federal is required	ent by the end or conclusions ex. The plan of d solely because ral and state law. ent ed for July tivities are on the ctivities	07/28/12
	by: Based on observati interviews the facilit program of evening #28 and #83) of 20 activities. Findings Include:	IT is not met as evidenced ions, record reviews and staff y failed to provide an ongoing activities for 3 (Resident #11, residents reviewed for			Corrective Action for Reside Potentially Affected All residents who participate in have the potential to be affect practice. See corrective action actions that also impacted the potentially affected. Systemic Changes	in activities ed by this os for	
	#11 room revealed after 4:00 PM on the calendar. An interview with the 6/27/12 at 4:19 PM	6/26/12 at 3:56 pm in Resident there were no activities listed e June 2012 activities The Activities Director on revealed she was planning to vie night like she did tast		,	An in-service was conducted activity coordinator on 06/29/07/19/12 by the administrator the importance of weekend at activities.	/12 and r to explain	

, summer. There were some singing groups that

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	S COD MEDICADE S				OMB NO 0938-0391	
	S FOR MEDICARE & DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	CORRECTION	IDENTIFICATION NUMBER	A BUILDING		COMPLETED	
	417	345309	B WNG		06/28/2012	
NAME OF PR	OVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE		
LIDEDTY	TO MULA SOU SUCCESSION PI	EHAB CTR OF HALIFAX CTY	l l	CAROLINE AVENUE	."	
LIBERTI			WE	LDON, 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 SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ITD BE CONSTELLOR	
			•			
F 248	Continued From page	e 7	F 248	This Plan of Correction is the center's	eredible in the second	
	come in the evening,	which was usually at 7:00		allegation of compliance.		
	PM			Preparation and or execution of this p	lan of correction 💢 📜	
		07/40 -4 5:05 DM revooled		does not constitute admission or agree	ment by the 🤭 📴	
		27/12 at 5:05 PM revealed ies calendar was posted in		provider of the truth of the facts allege set forth in the statement of deficiencie	s. The plan of	
	the restorative dining	room. The latest activity		correction is prepared and or executed	l solely because	
	indicated was at 4:00) PM for this month		it is required by the provisions of feder	al and state law.	
	An observation on 6/	27/12 at 4:05 pm revealed			· · · · · · ·	
	the June 2012 activit	y calendar posted in the		Strategies to increase the numb	er of	
	hallway outside of th	e main dining room. There		evening activities were identifi include calling on churches, sp	eaking to	
		in on 6/15/12 that a visiting		community college to see if the	ev have anv	
	group was scheduled	d at 7:00 PM.		fraternities that need communi	ty services	
	A consed covious of th	e activity calendars from		hours and could volunteer in th		
	January 2012 to Jun	e 2012 was conducted. The		evenings. The activity director		
	latest activity listed w	vas at 4:00 PM.		instructed to verify every more	ing that	
	•			evening activities were comple	eted by	
l	An interview with the	Activity Volunteer #1 on		talking to residents and staff.	Monday	
	6/28/12 at 11:31 AM	revealed he only assists with		through Friday at the Departm		
		day, due to he goes to school		Morning Meeting, the Activities	es auguing	
	in the evenings.			Coordinator will report on the activities scheduled for the fol	evening Iowina	
	An interview with Ac	tivity Volunteer #2 on 6/29/12		days along with any issues ide	ntified	
	at 10:15 AM reveale	d she volunteered on		during any program.		
	Tuesday and Friday	's from 8 AM-3 PM. There		during any program.		
	was a movie night a	ctivity done at 6:30 PM. She		This information has been inte	grated into	
	has gone with the A	ctivity Director in the past to		the standard orientation trainir		
	the movie night. The	e last time the Activity ted the movie night was over		the required in-service refresh	er courses	
	six months ago. She	e was not sure of why the		for all employees and will be t	eviewed by ,	
,	movie night had stor	oped. There was a singing		the Quality Assurance Process	to verify	
1	group that would vis	it in the evening. It has been		that the change has been susta	ined.	
	over six months sind	e this group has come.	:		ON ENG	
	1.00	A . II 11 - Pro- alan 0/00/40			l ·	
	An interview with the	Activity Director on 6/29/12			•	
1	; at 3:35 PM revealed	she had completed a three			1	

i month activity training course at a local

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DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES				FORM APPROVED OMB NO 0938-0391
STATEMENT C	S FOR MEDICARE & PORTION	MEDICAID SERVICES (X1) PROVIDENSUPPLIERICHA IDENTIFICATION NUMBER	(X2) MU		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345309	B WN	3		08/28/2012
	OVIDER OR SUPPLIER	AND REHAB CTR OF HALIFAX CTY WELDON, NC 27890				
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	IDSE COMPLETION
F 248	evening activities		F	248	This I'am of Correction is the cemer's eallegation of compliance. Preparation and or execution of this pleas not constitute admission or agreed provider of the truth of the facis alleges set forth in the statement of deficiences correction is prepared and or executed it is required by the provisions of feder Quality Assurance The Administrator will monito using the "Survey QA Tool", monitoring will include verifyit evening activities are schedule completed as scheduled. See a monitoring tool. This will be executed by QOL/QA committee. Report of the weekly for three months or unit by QOL/QA committee. Report of the weekly Quality of committee and corrective actions appropriate. The QOL/QA is the main quality assurance of They have regularly scheduled weekly which are attended by Administrator, Director of Nunitse managers, and dietary in	an of correction ment by the d or conclusions s. The plan of I solely because ral and state lan The ing that the d and attached done til resolved orts will be I Life- QA on initiated committee committee d meeting the trsing, other

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

were an issue. There were a lot of rehabilitation

residents that would come to evening activities.

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

The facility must provide housekeeping and

F 253

It will also be reviewed in Quarterly QOL/QA

committee attended by the Medical Director, Administrator, Director of Nursing, Social

Services, Dietary Manager, Environmental

Director and Activities Director

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		ND HUMAN SERVICES			<u> </u>	OMB NO	0938-0391
		MEDICAID SERVICES (X1) PROVIDERISUPPLIERICLIA	(X2) Mill	TIPLE	CONSTRUCTION	(X3) DATE SURV	
STATEMENT C AND PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER	A BUILD			COMPLETED	•
		345309	8 WNG			06/28/	2012
NAME OF PR	OVIDER OR SUPPLIER		s		T ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	CONNICAS NSG AND I	REHAB CTR OF HALIFAX CTY			CAROLINE AVENUE		
LIBERTY	·			MAF	PROVIDER'S PLAN OF CORRECT	TION	(XS)
(X4) ID PREFIX TAG	/EACH DESIGEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION— DATE
			,	-			
F 253	Continued From pa		F 2	53	This Plan of Correction is the center's allegation of compliance.	credible	# 2.1.
	maintenance service	es necessary to maintain a					
	sanitary, orderly, ar	nd comfortable interior.			Preparation and or execution of this p does not constitute admission or agree	lan of correction ment by the	,;
	100 AT				- we water of the truth of the facts aflegs	ed or conclusions	un number (m)
	This REQUIREMEN	NT is not met as evidenced			- cor book in the statement of delictency	ex. The plan of	1-(-)
	pv. 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2				correction is prepared and or execute it is required by the provisions of fede	ral and state law.	:
	Based on observa	tions, staff interviews, and				<u>-</u>	
	record reviews, the	facility failed to maintain 2 of			F253 Housekeeping and mai	ntenance	07/28/1
	2 common snower	room floor in clean condition; maintain resident bathroom					.72.
	walls in good cond	tion in 3 resident bathrooms			Corrective Action for Reside	ent	- 15
	(rooms 101, 106, a	nd 119) of 14 bathrooms; the			Affected		<u>. —</u>
,	facility failed to ma	intain doors in 6 resident			Effective 07/25/12 the admini	etrator and	=
	rooms (rooms #10	1, 102, 104, 106, 107, and			maintenance director verified	that the	
	121) of 25 resident	rooms in good condition,			following task have been com	oleted. In	
	bathroom walls in	3 rooms (rooms 101, 106, and it room wall (room 111) of 25			the shower room # 1 these are	as were	
	resident rooms in	rood condition			cleaned (including grout and	rust stains):	
	resident rooms in t	god condition.			shower wall, under the safety	rail,	
	Findings include:				shower head wall, floor tiles,	areas under	
					soap dispenser, corner of the	knee wall	
ļ	During an observa	tion on 6/28/12 at 8:22 AM of			and adjourning wall of the sho	ower, both	
	Shower Room #1.	a line of rust-colored staining			heater front covers. Shower r	oom # 2	
<u> </u>	was observed on t	he shower 's tile wall for 1 tile			had the grout cleaned between	n the drain	
	and 2 inches of the	e next tile. Another line of rust			and the shower head wall, the	base of the	
	colored staining w	as observed under the safety			wall beside the commode, and	d Hoor	
	rail nearest to the	shower control. Blackened ut for 22 tiles was noted on the			tiles. In both shower rooms f	acility	
	pulio up in the gro	The corners of the shower			contracted with Carolina Caro	e to clean	
	Shower near wall.	d having had a blackened build			tile and grout. This was com	pieted on	
	. un in the grout ha	tween tiles. Large areas of floor			07/18/12. Also the tile at the	Dase of the	
ĺ	tiles in the shower	floor were observed with			entrance wall was replaced.	KOOM IVI	•
	: blackened matter	in the grout lines. Marked			had repairs to the bathroom d	oor and	
1	areas on the wall	under the soap dispenser had a			closet doors.		
	light tan color stre	aking down the wall on 6 tiles					
	and 1/3 of anothe	r. Build up of blackened matter	•				=
	, was noted in the	corner of the knee wall and					1
	adjoining wall of t	he shower. Both of the wall					1

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OCHTERS FOR	MEDICADE &	MEDICAID SERVICES		OMB NO 0938-039			
TATEMENT OF DEFIC ND PLAN OF CORREC	IENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DATE SURV COMPLETED		
		345309	B WING		06/28/	2012	
NAME OF PROVIDER		EHAB CTR OF HALIFAX CTY	101	ET ADDRESS, CITY, STATE, ZIP CODI CAROLINE AVENUE LDON, NC 27890	E		
(X4) ID		FATEMENT OF DEFICIENCIES	ID PREEIX	PROVIDER'S PLAN OF C		(X5) COMPLETION	

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F 253 Continued From page 10

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TAG

heater front covers were brown over the fluted areas.

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

An observation was conducted on 6/28/12 at 8.47 AM of the Common Shower/bathing area #2 on the 111 to 120 hall. Several tiles between the drain and the shower head wall had a build up of blackened matter between the the grout lines between tiles. The base of the wall beside the commode had a buildup of brownish/black matter in the grout between tiles from the floor upward of 1 to 2 inches. Large areas of grout were observed as having had blackened build up between floor tiles. A tile at the end of the base on the entrance wall was missing.

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

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

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

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

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

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

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

Facility ID 923116

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CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTERS FOR MEDICARE & !	MEDICAID SERVICES		- CONCIDUCTUM	(X3) DATE SURVEY
TATEMENT OF DEFICIENCIES	(X1) PROVIDERISHPPLIERICLIA IDENTIFICATION NUMBER	A BUILD	LTIPLE CONSTRUCTION DING	COMPLETED
	34530 9	8 WNG	3	06/28/2012
AME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890 PROVIDER'S PLAN OF CORRE	CTION (X5)
(AT) IS (EACH DESIGIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE ACTION SH	OULD BE COMPLET
hathroom wall above removed and the remunrepaired. An observation of the 6/26/12 at 8:04 AM remails above the sign scrape marks across. An observation of Rep M revealed both classrapes across the obsthroom door has a wide. The bathroom that dripped down that dripped down the dispenser. Under the wall gouges that we emergency pull corobrown in areas and An observation of Rep M revealed the doceans.	der the door handles. The the sink had equipment haining holes were be bathroom in Room 104 on revealed unrepaired holes in link. Both closet doors had so the bottom half boom 106 B on 6/26/12 at 2:41 oset doors had multiple door under the handles. The a gouge that was 5 inches half wall had dried brown matter he wall under the soap he towel dispenser were two	F:	253 This Plan of Correction is the center allegation of compliance. Preparation and or execution of this does not constitute admission or age provider of the truth of the facts alles set forth in the statement of deficient correction is prepared and or execution is required by the provisions of fee. Corrective Action for Residentally Affected. All residents have the potentially Affected. All residents have the potential of the administrator met with a department heads and review inventory list for all residents. From 07/12/12 to 07/18/12 to department heads inventories residents rooms for repairs, the administrator and the middirector conducted a room room review looked at repain inventory review. The definition of the definition of the inventory review. The definition of the inventory to identify the contrance doors to identify the contrance doors in identify the contrance doors is identify the contrance doors.	s plan of correction recement by the reged or conclusions cies. The plan of sited solely because deral and state law. dent dent iial to be 07/09/12 iii wed an its room. the od the On 07/25/12 aintenance eview. The irs mentioned pors in and

Systemic Changes

On 07/19/12 and 07/20/12 the administrator met with full time, part time and prn housekeeping and maintenance staff. Topics included: filling out maintenance request for

soiled emergency pull cords, soiled

the bathroom/room walls where

unrepaired holes might exist.

walls around soap dispensers, cove bases

in need of repair or cleaning, repairs to

not been repaired.

several surrounding holes.

An observation of Room 1108 on 6/26/12 at 2:30

PM revealed the wall behind the soap dispenser

was scraped down to the brown paper and had

An observation of Room 111 on 6/26/12 at 10:21

AM revealed the wall beside the soap dispenser was scraped down to the brown paper and was

unrepaired. The wall above the first bed in the

residents ' room had 2 one-inch holes with

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	AIDING OF THE SECTION				OMB NO.	0938-0391
STATEMENT C	S FOR MEDICARE & DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A BUILDING	CUNSTRUCTION	(X3) DATE SURVI COMPLETED	
		345309	8 WNG		06/28/	2012
	OVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE CAROLINE AVENUE		
LIBERTY (COMMONS NSG AND	REHAB CTR OF HALIFAX CTY	WE	LDON, NC 27890		
(X4) ID PREFIX TAG	/EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRICENCY)	JLD BE	(XS) COMPLETION DATE
	· <u></u>				<u> </u>	-
F 253	Continued From pa		F 253	This Plan of Correction is the center's allegation of compliance.	credible	
	An observation of the bathroom for Room 115 on 6/26/12 at 10:01 AM revealed an area next to the soap dispenser that was scraped down to the brown paper and unrepaired. The cove base was separating from the wall on one side of wall of bathroom. An observation of the bathroom for Room 118 on 6/26/12 at 4:18 PM revealed the wall beside the soap dispenser was scraped down to the brown paper and had not been repaired. An observation of Room 119 on 6/26/12 at 3:40 PM revealed the bathroom wall next to the soap dispenser that was scraped down to the brown paper and unrepaired. An observation of Room 121 on 6/26/12 at 11:04 AM revealed the room door and bathroom door were scraped across the doors below the door handles.			Preparation and or execution of this p does not constitute admission or agree provider of the truth of the facts allege set forth in the statement of deficience correction is prepared and or execute it is required by the provisions of fede	ement by the ed or conclusions es. The plan of d solely because	-27 %
				doors, for soiled emergency proceeded repairs to walls in bath rooms, and broken tiles in the rooms. They also discussed the importance of cleaning under the soap dispensers and the rooms.	rooms and shower : and around utine	
				cleaning of the grout in the sh rooms. A weekly room round conducted by the Maintenance and reported on Thursday dur Morning Department Head m identified concerns and a sche correction/repair submitted to Administrator.	is will be Director ing the eeting, dule for	
During a tour of the facility with the Administrator and Maintenance supervisor on 6/30/12 at 1:15 PM, the areas of scraped and gouged doors, the cove base of the named above mentioned rooms still separated from the walls, the walls were scraped down to the brown paper in the bathrooms and the holes in the resident 's room remained unrepaired. The blackened areas of grout remained on the common shower room floors.			This information has been int into the standard orientation t in the required in-service refr courses for all employees and reviewed by the Quality Assu Process to verify that the chabeen sustained.	raining and esher I will be irance nge has		
	on 6/30/12 at 1:44 bathroom walls the	w with the Maintenance Director PM, the Director stated the at were scraped was a result of soap dispensers. The some of the soap dispensers		· .		

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DEPARTM	IENT OF HEALTH	AND HUMAN SERVICES				OMB NO	938-039
CENTERS	FOR MEDICARE	8 MEDICAID SERVICES		u 110: 5	CONSTRUCTION	(X3) DATE SURVE	
ATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1		, denominant	COMPLETED	
D PLAN OF	CORRECTION	1561111	A BUIL	DING			
		345309	B WIN	G		06/28/	2012
				STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
	MDER OR SUPPLIER			101	CAROLINE AVENUE		
BERTY C	OMMONS NSG AND	REHAB CTR OF HALIFAX CTY			ELDON, NC 27890		
		STATEMENT OF DEFICIENCIES	QI	<u> </u>	PROVIDER'S PLAN OF CORRECT	TION	COMPLETION
(X4) ID PREFIX TAG	(CACH DESIGN	STATEMENT OF DELICIONS INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
	<u> </u>						. (44). [-
•			E	253	This Plan of Correction with center's	credble	
F 253	Continued From p	age 13	,	200	allegation of compliance		
	were replaced cau	ising the scrapes in the walls					
	prior to his hire in	September of 2011.			Preparation and or execution of this p	ouan oj correction ament he die	
	25.7				does not constitute admission or agre provider of the truth of the facts alleg	ed or conclusions	
	During an intervier	w with the Maintenance Director			and the state of the state ment of deficiency	es. The pion of	
	on 6/30/12 at 2:30	PM, the Director reported the				A RUIGIL DECEMBE	
	shower room floor	s were 30 years old and the			it is required by the provisions of fede	eral and state law	— - (7 , ii
	hisckened discolo	rations were in the grout. In the			-		-71
	presence of the A	dministrator, the Maintenance			Quality Assurance	•	
	Director demonstr	rated cleaning the floor vie in			7		_ lag 1
	front of the sink w	ith disinfectant cleaner and a			The Administrator will monit	or this	
	long handled brus	h. The deaning solution			issue using the "Survey QA T	`ool".	1.77
	residue began tur	ning gray in color. The brush			The monitoring will include s	hower	-,
	bristles were a gr	ayish color.			room checks to ensure cleanly	iness and	
					that tiles are in good conditio	n, 5 room	
	During an intervie	w with the Administrator on			and bathroom checks to ensu	re that	
	6/30/12 at 3:33 P	M, the Administrator stated it			bathroom, closet and room de	oors do not	
	was her expectat	ion that maintenance patched,			have scratches, walls are in #	ood repair	
	sanded, and repa	ninted wall damage when the			and clean, and that emergence	y pull cords	
	soap dispensers	were changed and tore into the			are clean. See attached moni	toring tool.	
	wallboard as well	as the towel dispensers. The			This will be done weekly for	three	
	Administrator sta	ted she expected any soap			months or until resolved by	OOL/OA	
	dripped on show	er room walls was washed and			committee. Reports will be	viven to the	
	ensured the soar	was removed from the wall.			weekly Quality of Life-QA	committee	
	The Administrato	or stated she expected the			and corrective action initiate	d as	
	shower room floo	ors and tiles to be clean.		F 274	and corrective action initiate appropriate. The QOL/QA of	committee is	
F 274		COMPREHENSIVE ASSESS		1	appropriate. The QULIQA	ommittee	
SS=D	AFTER SIGNIFI	CANT CHANGE			the main quality assurance c	ed meeting	
	_	e de accesabanativa			They have regularly schedul	cu meemig w the	:
	A facility must co	onduct a comprehensive			weekly which are attended b	y แเร ไมรณ์กล	-
	assessment of a	resident within 14 days after the			Administrator, Director of N	iarsing,	
	, facility determine	es, or should have determined,			other nurse managers, and d	іссагу	1
	that there has be	een a significant change in the			manager.	1.001	/O.A
	resident's physic	al or mental condition. (For			the will also be reviewed in Q	uarterly QOL/	ŲA
	numose of this s	section, a significant change				Medical Direct	101,
	means a major of	decline or improvement in the			Administrator, Director of	Nursing, Socia	1
	resident's status	s that will not normally resolve			Administrator, Director of a	Cavironmenta	F 753
	itself without fur	ther intervention by staff or by			Services, Dietary Manager,	CHAILOUINCING	•
	: implementing st	andard disease-related clinical			Director and Activities Dire	ctor	

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OCNTCO	CODMEDICARES	MEDICAID SERVICES				OND INC I	330-0331
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIERICIA		(X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER	A BUI	LDING			
		345309	B WN	16		08/28/2	2012
NAME OF PR	OVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE		
		EHAB CTR OF HALIFAX CTY			CAROLINE AVENUE		
LIBERTY	COMMONS MAG WHILE	ENAL OTR OF TACIFAC OTT		WE	LDON, NC 27890		
(X4) ID PREFIX TAG	IFACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREF TAC	TIX.	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
			•				
F 2/4	Continued From pag	ne 14	F	274	This Plan of Correction is the center's	credible	
		as an impact on more than			allegation of compliance.		
	one area of the residence requires interdisciplicare plan, or both.)	dent's health status, and nary review or revision of the			Preparation and or execution of this p does not constitute admission or agree provider of the truth of the facts allege set forth in the statement of deficient correction is prepared and or execute it is required by the provisions of fede	ement by the ed or conclusions es. The plan of d solely because	. 1
	by:				F-274 - Comprehensive asses	ssments:	
:	Based on observat	ions, record reviews and staff			significant changes		07/28/12
	interviews the facility failed complete a significant change assessment for 1 (resident #8) of 1 sampled residents, who had unplanned weight loss of -15% in a 90 day period and -12.6% in a 180 day period and developed a Stage 2 pressure ulcer.				Corrective Action for Reside A significant change for reside completed on 07/22/12 by the Corrective Action for Reside	ent # 8 was MDS nurse.	
	Findings include:				Potentially Affected		
	Resident #8 was originally admitted to the facility on 11/23/2004. Diagnoses for resident #8 include Cerebral Vascular Accident, Chronic Kidney Disease, Diabetes Mellitus, and Alzheimer's disease. A review of resident #8's weight history documented by the Dietary Consultant revealed resident #8 had weighed 160.2 pounds on 12/21/11.				All residents who have had a sunplanned weight loss or a prohave the potential to be affect practice. On 07/20/12 the MD reviewed all resident's who have significant weight loss (5 % in	essure ulcer ed by this OS nurse ave had a n 30 days,	
				•	7.5% in 90 days and 10 % in residents with pressure ulcers any resident who should have significant change and did no identified missing assessment	to identify had a h. Any	
		m Data Set (MDS) 2/5/12 indicated the resident I was not on a physician			completed by 07/28/12 by the	MDS nurse.	
	prescribed weight	oss program. The weight listed			Systemic Changes		
	on the MDS was 1 assessment portion resident #8 did_not	40 pounds. The skin n of the MDS indicated have any pressure ulcers at essment nor during the			An in-service was conducted and 07/20/12 by Corporate M the MDS nurse,	on 07/13/12 IDS Nurse for	i i

previous assessment period.

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06/28/2012

DEPARTMENT OF HEALTH AN	D HUMAN SERVICES			OMB NO 09
CENTERS FOR MEDICARE & !	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRU	JICTION (X3) DATE SURVEY COMPLETED
	345309	B MNG		06/28/20
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND RE		STREET ADDRES 101 CAROLIN WELDON, N		
		ll	PROVIDER'S PLAN OF CORRECTIO	N C

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

F 274 Continued From page 15

A review of the Quality of Life minutes dated 2/21/22 indicated resident #8 had developed a Stage 2 pressure ulcer on his left buttock on 2/7/12. The minutes also indicated the wound was acquired in the facility. Measurements were recorded as length 1.2 centimeters (cm.), width 2.0 cm. and 0 cm. depth. The wound tissue was described as granulated tissue.

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

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

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

This Plan of Correction is the center's credible F 274 allegation of compliance.

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

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

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

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DEPARTMEN	IT OF HEALTH AND HUMAN SERVICES			OMB NO. 0938-0391	
	OR MEDICARE & MEDICAID SERVICES	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
STATEMENT OF DE	EFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A BUIL		GOM EZ TES	
		B WING	3	06/28/2012	
	345309		074TF 210 CODE		
1	DER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE		
LIBERTY COM	AMONS NSG AND REHAB CTR OF HALIFAX CTY		WELDON, NC 27890		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	ADOCC DESCRENCED TO THE OFFI	OLD BE	

F 274 Continued From page 16

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

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

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

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

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

F 274

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

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

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

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

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DEPARTMENT OF HEALTH A	ND HUMAN SERVICES		OMB NO 0938-0
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	· <u>· · · · · · · · · · · · · · · </u>

A BUILDING a WNG 06/28/2012 345309

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) 1D COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC (DENTIFYING INFORMATION) TAG DEFICIENCY) TAG

F 274 Continued From page 17

described as epithelial tissue with a length of 0.4 cm and a width of 0 6cm and a depth of 0 01 cm.

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

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

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

This Plan of Correction is the center's credible F 274 allegation of compliance

STREET ADDRESS, CITY, STATE, ZIP CODE

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

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

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

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

F 279

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

					OMB NO	0938-0391
STATEMENT (CENTERS FOR MEDICARE & MEDICAID SERVICE ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE IDENTIFICATION AUI		(X2) MULTIPE A BUILDING	E CONSTRUCTION	(X3) DATE SURV COMPLETEE	EY
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F 279	to develop, review ar comprehensive plan The facility must dev plan for each resider objectives and timela medical, nursing, and needs that are identical assessment. The care plan must to be furnished to althighest practicable psychosocial well-be §483.25; and any sebe required under §483.10, including the under §483.10(b)(4) This REQUIREMEN by: Based on observational family interview plan interventions for loss for 1 of 36 resional family included: Resident #8 was or on 11/23/2004 and	e results of the assessment of revise the resident's of care. elop a comprehensive care at that includes measurable ables to meet a resident's domental and psychosocial fied in the comprehensive describe the services that are tain or maintain the resident's shysical, mental, and sing as required under ervices that would otherwise 483.25 but are not provided exercise of rights under ne right to refuse treatment. This not met as evidenced ons, record reviews and staff is the facility failed to care or pain and a significant weight dents sampled (Resident #8). It is not met as evidenced ons, record reviews and staff is the facility failed to care or pain and a significant weight dents sampled (Resident #8).	F 279	ilus Plan of Correction is the centallegation of compliance. Preparation and or execution of the does not constitute admission or of provider of the truth of the facts of the firth in the statement of deficience rection is prepared and or execution is prepared and or execution is required by the provisions of F279 Comprehensive Care Corrective Action for Reaffected Resident # 8 care plan was 07/22/12 by the MDS nurs pain and significant weight Corrective Action for Repotentially Affected All residents who have haveight loss (5 % in 30 day days and 10 % in 180) and pain medications or are in potential to be affected by On 06/30/12, the administrative reviewed all current residientify residents who recomedications.	this plan of correction agreement by the alleged or conclusions encies. The plan of secured solely because federal and state law re Plans sident supdated on se to include at loss. esident d significant ys, 7.5% in 90 d use as needed pain have the at this practice, trative nurses ats on all facility. On we nurses ent's MAR to	
	Review of the care revealed no probler	plan initiated in August 2011 n or interventions related to				;

pain for this resident.

DEPARTMEN	NT OF HEALTH AND HUMAN SERVICES				PRINTED: 07/16/2012 FORM APPROVED OMB NO 0938-0391
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1a R: O no th h: #	a. A review of the Medication Administration ecords (MAR) for resident #8 revealed in ctober 2011 resident #8 received PRN (as eeded) pain medication 16 times for reasons hat included general pain, leg pain, verbalizing urting and moaning. In November 2011 resident 8 received PRN pain medication 8 times for easons that included generalized pain	F :	279	This Plan of Correction is the centallegation of compliance. Preparation and or execution of the does not constitute admission or exprovider of the truth of the facts a set forth in the statement of deficience or rection is prepared and or executions required by the provisions of On 07/22/12 a computerize generated by the DON and consultant to identify residented weight loss as defined.	his plan of correction agreement by the alleged or conclusions encies. The plan of cotted solely because federal and state law and report was I MDS nurse lents who have
re	evealed in the month of November 2011 signs			these three list were comp	leted the MDS

and symptoms of pain which included drawing legs and arms upward, facial grimacing, and moaning.

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

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

nurse reviewed the care plans by 07/28/12 to ensure that pain and weight loss were appropriately care planned.

Systemic Changes

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

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

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F 279 Continued From page 20 -

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

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

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

Resident #8 was unable to respond to how much time he had spent in pain over the past 5 days, or F 279

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

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

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

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F 279	Continued From		•		allegation of compliance		
	if the pain interru	pted his sleep, or limited his day			**		
	to day activities.	and able to encurer to the nain			Preparation and or execution of this pa	lan of correction	'
	Resident #8 was	not able to answer to the pain sed on the gathered information a			does not constitute admission or agree provider of the truth of the facts allege	acae os ac d or conclusion	s
	intensity and bas	t for pain would be conducted.			wer forth in the statement of defictencie	s The plan of	
	stan assessmen	ment for pain on the MDS			 correction is prepared and or executed 	l salely because	 .
	indicated there	vere no signs and symptoms of			it is required by the provisions of feder	al and state lav	*
	noin or possible	pain observed. The MDS also					
	indicated resider	nt #8 was not on a scheduled			Quality Assurance	•	·=
	nain medication	regime and was not offered or			The Director of Nursing will m	unitar this	
	received any PR	N (as needed) pain medication.			issue using the "Clinical Surve	v OA	
	Resident #8 was	unable to respond to how much			Tool". The monitoring will inc	y yn Slude	
	time he had spe	nt in pain over the past 5 days, or			reviewing 10 residents to ensur	re that	
	if the pain intern	upted his sleep, or limited his day			weight loss and pain are care p	lanned ac	
	to day activities.	Resident #8 was not able to			Weight loss and pain are care p	ill ba	
	answer to the pa	in intensity and based on the			appropriate. The 10 residents v	inal	
	gathered informa	ation a staff assessment for pain			identified during the daily clin	ith waight	
	would be condu-	cted.			meetings based on residents w	nhane	
					loss concerns, pain or new tele	pitone	
	An observation	of the care plan dated 5/11/12			orders for as needed pain medi	This will	
	revealed pain w	as not identified as a problem for			See attached monitoring tool.	inis wiii	
	resident #8. In N	lay 2012 resident #8 received			be done weekly for three mont	ns or uniti	
	PRN pain medic	eation 15 times for reasons that			resolved by QOL/QA committ	.ee. 1.1	
		ng, verbalization of pain, and			Reports will be given to the w	eckiy	
	generalized disc	comfort.			Quality of Life- QA committee	e ano	
		ttion at 2:20 DM			corrective action initiated as a	ppropriate.	
	On 6/26/12 duri	ng an observation at 2:30 PM			The QOLJQA committee is the	e main	
	resident #6 was	in his bed and moaning, groaning			quality assurance committee.		
	and racial grima	cing were evident. An interview			They have regularly scheduled	meeting	
	with Nurse #2 re	evealed resident #8 had moaned			weekly which are attended by	the	•
	or pain in the pa	ist and had physician orders for n. Nurse #2 asked resident #8 if			Administrator, Director of Nu	rsing, other	
	PRN medication	n. Nurse #2 asked resident #6 ii I resident #8 was agitated and			nurse managers, and dietary m	ianager.	,
	ne nao pain and	Ily answer and pointed to his legs;			It will also be reviewed in Qua	arterly QOL/	QA
	unable to verba	lly allower and pointed to the resident			committee attended by the Mo	• •	
	Nurse #2 onere	d pain medication to the resident Nurse #2 and Na #1 attempted	,	•	Administrator, Director of Nu		
	and ne refused.	nuise #2 and resident #8 refused					
	to reposition the	patient and resident #8 refused.	1		Services, Dietary Manager, Er	ivironmental	4

Director and Activities Director

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F 279	Continued From pag	je 22	r	279				i in i
	On 6/27/12 during a	n observation at 12:10 PM						
	resident #8 was lying	g in his bed and awake during						·
		t #8 verbalized he was in pain						
	and pointed to his le	95.						
	On 6/28/12 at 8:35 /	AM an interview was					4	
	conducted with NA	# 3 and she revealed she					٠	
	could usually tell wh	en resident #8 was in pain						3.5
	because he moans.	NA #3 also indicated et you know he was in pain by						
	Kesideur #9 would i	imes he would be able to tell						
	vou. NA#3 also inc	dicated resident #8 did not eat						
	well this morning an	id was moaning and she was						
	on her way to repor	t it to the nurse.						
	On 6/28/12 at 10:00	AM an observation of						
	resident #8 revealed	d he moaned when NA #2 e a protective sheer sleeve						
	attempted to remov	ile skin from his arm. NA #2						
	stopped care and a	sked resident #8 if he was in						
1	pain and he respon	ded yes. NA #2 reported						
	resident #8 ' s pain	to Nurse #2. Nurse #2						
		#8 and gave him pain						
l	medication.							
	On 6/28/12 at 11:30	0 AM resident #8 was						
	observed to be lying	g in his bed quietly without						
1	moaning, groaning	or facial grimacing.						
	On 8/28/12 at 11:4:	5 AM during an interview with				,		
	the Rehab Manage	or it was revealed therapy was						:
	initiated for residen	t #8 because of contractures						1
	and pain. Diatherm	y was used for resident #8 but						1
	was discontinued b	ecause it was not effective to						!
	relieve the pain for	resident #6.						<u> </u>
	.: On 6/28/12 at 3:00	PM during an interview with						
	the DON it was rev	realed a Quality of Life meeting			t			i
1	i							

Facility ID 923116

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES	OMB NO 1938-0					
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F 279	is held weekly and the meeting included paithe Quality of Life text MDS, DON, and the the Quality of Life mi until May 2012 revea not discussed. Here problem was identificate planned to assumet. The DON indictorocess and resident pain and therefore a for this identified prowhy pain had not be On 6/30/12 at 9:45 // family for resident #1 come to visit on mul #8 was moaning and 1b The most recent (CAA) dated 5/11/11 nutritional status was a record review was consultant notes for note dated 9/21/11 for med pass 2.0 60 four times a day to	ne information gathered at the n and nutrition. Members of am included dietary, rehab, Administrator. A review of nutes for September 2011 aled resident #8's pain was expectations would be that if a led it would be discussed and ure the resident's needs are lated she assisted in MDS at #8 had not triggered for care plan had not been done blem. The DON was unsure len care planned. AM an interview with the B revealed that they had atiple occasions and resident domplaining of pain. Care Area Assessment of indicated resident #8's is identified as a concern. Seconducted of the nutritional resident #8. The nutritional resident #8. The nutritional resident #8 due to a concern resident #8 due to a concern in the material indicates and indicates are commendation of mil (milliliters) to be given resident #8 due to a concern	F	270				
	four times a day to resident #8 due to a concern that his food intake had decreased. There had been no weight loss and the supplement was to aid in the prevention of weight loss. The dietary note dated 12/21/11 indicated resident #8 weighed 160.2 pounds with no significant change in 180 days. Interventions for						!	
	wound healing and	supplements remain in place.						

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MEDARTA	MENT OF HEALTH AND HUMAN SERVICES			FORM OMB NO	0938-0391
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F 279	Continued From page 24	F 279	,	,	—
,	A review of NA (Nurse Aide) documentation for December 2011, January, February, March, and April of 2012 revealed resident #8 had an average food intake of 75-100% for most of his meals.				
	A review of the dietary consultant 's noted dated 2/22/12 revealed resident #8 weighed 140 pounds. The Dietary consultant indicated resident #8 had lost -15% of body weight in a 90			<u>-`</u> `,	
	day period. The note also indicated resident #8 had an intake of 25-75% and no interventions would be added to the care plan at that time for weight loss because resident #8 had gained one pound in the past 2 weeks.				:
	On 3/6/12 the dietary note revealed resident #8 had a stage 2 decubitus ulcer and significant weight loss. Interventions were recommended to prevent further weight loss; Promod 30 ml was to be given every day after lunch and a magic cup twice a day between meals. Resident #8 's weight was listed as 136 pounds.				
	A review of the care plan dated 5/11/12 indicated resident #8 was not identified for at risk or actual weight loss on his care plan.				
	During an interview on 6/28/12 at 3:00 PM with the Don it was revealed Dietary recommendations were discussed monthly. Her expectations would be that if a problem was identified it would be discussed and care planned to assure the resident's needs are met. The				
	to assure the resident's needs are met. The DON was unsure why weight loss had not been care planned.	F 280			

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

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DEPARTME	NT OF HEALTH	AND HUMAN SERVICES			OMB NO	0938-0391	
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F 280 Continued From page 25

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

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

This REQUIREMENT is not met as evidenced by:

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

Findings include:

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

During an interview with the MDS Coordinator on

F 280

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

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F280 care plans

07/28/12

Corrective Action for Resident Affected

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

Corrective Action for Resident Potentially Affected

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

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F 280	Continued From pag	ge 26	F	280	This Plan of Correction is the center allegation of compliance.	s credible	
	Director of Nursing (updating the care plus 9:59 AM, the DON supdating the resider reported the care place been reviewed care plans were expended and the resident '7 was 9/22/12 and readment the resident 's more plans bet assessment as applied on	the nurse reported the (DON) was responsible for ans in the facility. with the DON on 6/30/12 at stated she was responsible for nt's care plan. The DON lan for Resident #1 should d and updated on 6/2/12. The pected to be reviewed every admitted to the facility on litted on 4/10/12. Review of strecent full MDS (Minimum lent revealed the assessment 4/24/12. The goal date of the an was documented as 6/7/12.			Preparation and or execution of this does not constitute admission or agree provider of the truth of the facts allegiset forth in the statement of deficience correction is prepared and or execution is required by the provisions of feather than the statement of the facts allegist is required by the provisions of feather than the statement of the facts allegist is required by the provisions of feather than the statement of the facts all the provisions of feather than the facts of the fact	ged or conclusions. The plan of solely because feral and stale left ignificant 7.5% in 90 ave the is practice. report was MDS nurse this who have bove. The wed and	PART TO THE PART T
	During an interview 6/30/12 at 2:12 PM was responsible for facility. During an interview 4:22 PM, the DON reviewed every 90 MDS (Minimum Desired the care place)	w with the MDS Coordinator on the nurse reported the DON or updating the care plans in the w with the DON on 6/28/12 at a stated the care plans were days and re-evaluated with the lata Set) completion. The DON an for Resident #7 should have and updated on 6/7/12.	·		An in-service was conducte 07/20/12 by Corporate MDS the MDS nurse, dietary services an director (the interdisciplina planning team). The in-ser included ensuring that sign loss was appropriately care that all care plans be review Documentation of the care should be maintained by the	S Nurse for vices d activity ry care vice topics ificant weigh related and wed quarterly plan update	

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DEPARTMEN	NT OF HEALTH A	ND HUMAN SERVICES			OMB NO 0938-0391
CENTERS FO	OR MEDICARE &	MEDICAID SERVICES (71) PROVIDER/SUPPLIER/CLIA	(X2) MU	ILTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
STATEMENT OF DI AND PLAN OF COR	ATEMENT OF DEFICIENCIES (71) PROVIDENSUPPLIENCED (DENTIFICATION NUMBER A BUILDING		DING	·	
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	DER OR SUPPLIER	EHAB CTR OF HALIFAX CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890	
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F 280 Continued From page 27

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

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

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

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

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

An interview with the Dietary Manager (DM) on 6/28/12 at 3:15 pm revealed Resident #42 had ! significant weight loss in the last nine months. She notified the Registered Dietitian (RD) in January 2012 of the significant weight loss. She F 280

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

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

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

Quality Assurance

The Director of Nursing will monitor this issue using the "Clinical Survey QA Tool". The monitoring will include ensuring that care plans that have had quarterly MDSs completed in the last week have been updated. 5 will be reviewed if completed in since the last review. See attached monitoring tool. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES			FORM APPROVED OMB NO 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES			(X3) DATE SURVEY
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	8 WNG		08/28/2012
NAME OF PROVIDER OR SUPPLIER		T AUDRESS, CITY, STATE, ZIP CODE CAROLINE AVENUE	
LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CT		LDON, NC 27890	CTION (X5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION	ID L PREFIX N) TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE
would usually call the RD when there was a weight loss. The RD visits the facility monthly The DM indicated she would do nutrition intervention in between the RD visits. Reside #42 never indicated why she did not like her radded salt diet. An interview with the Dietary Manager on 6/3 at 12:09 pm revealed she does the care plan nutrition. She indicated she would also upda care plans for the resident's nutrition status. She indicated she just got busy and did not update Resident #42 care plan for significant weight loss. An interview with the Director of Nursing and Administrator on 6/30/12 at 12.12 pm reveal they had the new daily and weekly quality of meetings now to address weight concerns meetings now to address weight concerns meetings 12 (3) ADL CARE PROVIDED FOR	ent no 10/12 as for ate t t	The QOL/QA committee is quality assurance committee is regularly scheduled meeting which are attended by the Director of Nursing, other managers, and dietary manalt will also be reviewed in Committee attended by the Administrator, Director of Services, Dietary Manager, Director and Activities Director and Activit	is plan of correction freement by the leged or conclusions lenex. The plan of letted solely because lederal and state law. the main letter They have la weekly ladministrator, lurse lager. Quarterly QOL/QA [Medical Director, Nursing, Social Environmental
SS=D DEPENDENT RESIDENTS A resident who is unable to carry out activitic daily living receives the necessary services maintain good nutrition, grooming, and persund oral hygiene.	10		
This REQUIREMENT is not met as eviden by: Based on observations, record review and interviews; the facility failed to provide apply perineal care for 1 (Resident #54) of 1 same residents observed for catheter care; and	I staff ropriate npled '.		: : :

to rinse soap from the resident's skin while providing perineal care and completing a bath for

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DEPARTMEN	T OF HEALTH A	ND HOWAN SERVICES			OMB N	O. 0938-039
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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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F 312 Continued From page 29

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1 (Resident #54) of 1 sampled residents observed for catheter care. Findings include:

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

REGULATORY OR LSC IDENTIFYING INFORMATION)

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

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

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

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

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

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DEFICIENCY)

F 312 ADLS

7/28/12

Corrective Action for Resident Affected

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

Corrective Action for Resident Potentially Affected

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

Systemic Changes

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

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	THE PLANT HOWING OFFICE		OWR NO 0838-03
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NAME OF PROVIDER OR SUPPLIER _____

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SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OF LSC IDENTIFYING INFORMATION)

STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890

PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS REFERENCED TO THE APPROPRIATE

F 312 Continued From page 30

(X4) ID

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

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

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

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

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

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

Quality Assurance

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

Facility ID 923116

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neparti	VENT OF HEALTH A	ND HUMAN SERVICES				FORM AP	PROVED
CENTERS	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDERISUPPLIERICUA IDENTIFICATION NUMBER	(X2) MI		CONSTRUCTION	(A3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER	EHAB CTR OF HALIFAX CTY		101 (T ADDRESS, CITY, STATE, ZIP CODE CAROLINE AVENUE LDON, NC 27890	CYON	(×5)
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F 312	Continued From pag	e 31	 F	312	This Plan of Correction is the center allegation of compliance.		
b. Resident #54 was admitted to the facility on 06/25/10 and readmitted on 03/05/12. Cumulative diagnoses included pyelonephritis, urinary retention and progressive supranuclear palsy (PSP). PSP is a rare brain disorder that causes problems with control of galt and balance,				Preparation and or execution of this does not constitute admission or agg provider of the truth of the facts alloset forth in the statement of deficient correction is prepared and or executions is required by the provisions of fe	reement by the rged or conclusions cies. The plan of ned safely because		
	along with eye move	ement and thinking problems.			This will be done weekly for	three months	

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

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

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

An interview, on 06/28/12 at 11:20 AM, was conducted with NA #1. The observation was reviewed with NA #1, and she confirmed she was This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. They have regularly scheduled meeting weekly which are attended by the Administrator, Director of Nursing, other nurse managers, and dietary manager.

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

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
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F 312		nge 32 eded to be rinsed off before and she had forgotten to do	; F3	allegation of comphance.		
	An interview, on 06 conducted with the The DON stated th	5/29/12 at 3:12 PM was Director of Nursing (DON). e facility had always used soap		Preparation and or execution of does not constitute admission or provider of the truth of the facts set forth in the statement of defic correction is prepared and or exit is required by the provisions of	agreement by the alleged or conclusions vencies. The plan of ecuted solely because	
	staff when giving a the soap off before			F325 Avoiding nutrition unless unavoidable	al status decline	07/28/12
F 325 SS=G	483.25(i) MAINTAI UNLESS UNAVOI	N NUTRITION STATUS DABLE	F3	Corrective Action for Re	esident Affected	
	assessment, the faresident (1) Maintains accestatus, such as bounless the residen	nt's comprehensive active must ensure that a ptable parameters of nutritional dy weight and protein levels, it's clinical condition		For Resident #42, Promot mighty shakes were initia plan was updated on 06/3 42 was reviewed on 07/22 corporate dietician	ted and the care 0/12. Resident # 2/12 by the	,
		this is not possible; and rapeutic diet when there is a		Corrective Action for R Potentially Affected	esidem	
	,			All residents have the pot affected by this practice. weight loss report was ge residents who have had a	A computerized nerated for all significant weight	
	This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to failed to prevent weight loss for 1 (Resident #42) of 2 residents with weight loss.			loss (5 % in 30 days, 7.59 10 % in 180). Any reside significant weight loss an weight was reviewed by 07/20/12 and 07/22/12 ar	ent who has had a d is still losing the dietician on ad interdisciplinary	
	10/11/11 with diag urinary tract infect and anemia. The	admitted to the facility on noses of dementia, stroke, ions, chronic kidney disease Minimum Data Set (MDS) ated Resident#42 required		care planning team on 07 that appropriate intervent implemented and care pla	ions were	
		with meals and was not on a		i	i	

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DEPART	MENT OF HEALTH A	ND HUMAN SERVICES			OMB NO 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA AND PLAN OF CORRECTION (DENTIFICATION FORMULA)		(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 325			F3	25 This Plan of Correction is allegation of compliance.	the cemer's credible
	low cognitive level. dated 12/22/11 indiction and prescricts areas were to be plan problem onset indicated Resident & associated with the The goal was continuous therapeutic diet of nidays. A record review of the reviewed. The weight following: 192 lbs (12/12/11), (2/16/12), 163 lbs (3 lbs (5/8/12) and 155 lbs (5/8/12) and 155 lbs (12/12/11).	ss plan. She was also at a The Care Area Assessment lated Resident #42 triggered source ulcer risk. These two exact planned. The care dated 8/3/11 for nutrition late on 6/27/12 to follow the oxided added salt for the next 90 oxided salt for the next 90 o		Preparation and or execute does not constitute admiss provider of the truth of the set forth in the statement of correction is prepared and it is required by the provise. Systemic Changes An in-service was cound 07/20/12 by Conthe MDS nurse, dictassocial services and a interdisciplinary care in-service topics included weight loss interventinterventions until wor discontinued by Manual control of the service of the servic	of facts alleged or conclusions of deficiencies. The plan of of or executed solely because soons of federal and state time. Inducted on 07/13/12 porate MDS Nurse for ary services manager, ctivity director (the e planning team) The luded appropriate tions and to continue reight loss is stabilized AD.
	conducted. The no physician had calle Resident #42 eating Resident#42 family physician about Re dated 1/27/12 indic only 25% of her me family member was Resident#42 chang was a fax sent to the concern.	he facility nurse notes was te dated 1/26/12 indicated the difference the facility and asked about go the last few days due to member had called the sident #42 appetite. The note ated Resident #42 had eaten had and was drowsy. The se concerned about les and poor appetite. There he physician about this the facility physician orders alled an order for a dietary		review all resident was gain (5 % in 30 days 10 % in 180). This is not limited to percer supplements, snacks notification of MD a Dietician, review of consideration for the significant change is facility wounds included will be presented by This review will als	s, 7.5% in 90 days and review will include but that of meal intake, soffered, labs, and Family, referral to care plan and e completion of a MDS. A review of uding Pressure Ulcers the Wound Care Nurse, o include the care plan for the completion of a

consult.

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	OR MEDICARE & MEDICAID SERVICES	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 325 Continued From page 34

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

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

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

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

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

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

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

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

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> (0.5)COMPLETION

DEPARTMENT	OF HEALTH A	ND HUMAN SERVICES			OMB NO 0938
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F 325 Continued From page 35 and risk for weight decrease. The recommendation was approved by the physician on 2/29/12.

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

REGULATORY OR LSC IDENTIFYING INFORMATION)

+1/9____

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

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

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

. An interview with the RD on 6/28/12 at 4:57 pm revealed Resident #42 had significant loss the I last 180 days and she had recommended a high F 325

TAG

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

DEFICIENCY)

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

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

Quality Assurance

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

Facility ID 923116

PRINTED 07/16/2012 FORM APPROVED

		ID HUMAN SERVICES			OMB NO. 0938-0391
STATEMENT C	S FOR MEDICARE & DE DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (CENTIFICATION NUMBER	(X2) MULTIPLI A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1 4 ± 1 2	345309	B WING		06/28/2012
	OVIDER OR SUPPLIER	EHAB CTR OF HALIFAX CTY	10	ET ADDRESS, CITY, STATE, ZIP CODE 1 CAROLINE AVENUE ELDON, NC 27890	_
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
F 325	When she had visited another decline in we recommended to libe regular diet. When swould provide her wisignificant weight los Quality of Life (QOL) and discuss resident her monthly visits. In nutrition intervention. A record review of the committee minutes was discussed on 13/23/12, 3/30/12, 4/5/10/12, 5/18/12 and 2/29/12 indicated a indication of a multidated 3/15/12 and 3 interventions. The rindicated a weight secommendation for calorie supplement, indicated a facility of 3/6/12 for a liquid pland high calorie supplement. Indicated this recommendation for calorie supplement, indicated this recommendation for calorie supplement. In the weight status we liquid and high calories with the Consultant on 6/29.	ack in February 2012. If in May 2012, she saw bight status and braize Resident #42 diet to a she visits monthly, the DM that list of people with sand dietary consults. The team would meet weekly swith weight loss between the QOL team would do	F 325	This Plan of Correction is the center allegation of compliance. Preparation and or execution of this does not constitute admission or agrowider of the truth of the facts alleset forth in the statement of deficient correction is prepared and or execution is required by the provisions of fermal second done weekly for three month resolved by QOL/QA committee and corrective initiated as appropriate. The committee is the main quality committee. They have regumenting weekly which are a Administrator, Director of Nourse managers, and dietary It will also be reviewed in Committee attended by the Administrator, Director of Services, Dietary Manager, Director and Activities Dire	r plan of correction recement by the rged or conclusions cues. The plan of red solely because deral and state have This will be so or until ittee. Reports Quality of Life- e action : QOL/QA y assurance larly scheduled rended by the lursing, other manager. Quarterly QOL/QA Medical Director, Nursing, Social Environmental

Fecility ID 923116

review weights._There were trials of this meeting which started in March 2012 and officially started

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

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

STATEMENT O	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIERICITA (X2) MILL THE CONTINUE		(X3) DATE SURVI COMPLETED				
AND PLAN OF	CORRECTION	IDER: RIGHTROIT HORIDERS	A BUIL	DING	<u> </u>		
	**************************************	345309	8 WN	3		06/28/	2012
	OVIDER OR SUPPLIER	EHAB CTR OF HALIFAX CTY		101	T ADORESS, CITY, STATE, ZIP CODE CAROLINE AVENUE LDON, NC 27880		
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLO BE	(X5)— COMPLETION DATE :-
F 325	6/11/12. There was meetings where weight	ontinued From page 37 F 325 This Plan of Correction is the center's credible allegation of compliance. Preparation and or execution of this plan of correction. Preparation and or execution of this plan of correction.					
	problems were discu a Quarterly QOL per The Social Worker, I	ssed. Then there would be formed for weights as well. DM, Director of Nursing r and other Administrative	·		does not constitute admission or agre- provider of the truth of the facts alleg set forth in the statement of deficiency correction is prepared and or execute it is required by the provisions of fede	ement by the ed or conclusions es. The plan of d solely because	7
	6/30/12 at 12:12 pm daily QOL meetings concerns more quick	DON and Administrator on revealed they have the new now to address weight kly. They would expect to ention for significant weight			F-371 - Food, Prepare, Store Corrective Action for Reside Affected	ent	07/28/12
F 371 SS=E	have nutrition intervention for significant weight loss immediately.		F	371	No specific resident was ident 2567. On 06/25/12 all unlabe items were discarded. Sanitat were properly stored on 06/28 dietary manager. The nourish refrigerator was replaced on 0 the maintenance director	led stored ion cloths /12 by the ment	
	authorities; and	listribute and serve food			Corrective Action for Resid	ent	
	This REQUIREMEN	IT is not met as evidenced			All residents have the potential affected by this practice. See changes listed below for corresponding to the control of the c	systemic ective action	
	3) An observation of nourishment room is multiple brown/tans the inner walls. The refrigerator had visit other brownish cold splattered debris walls.	on 6/27/12 at 5:50 PM of the evealed a refrigerator with spots of debris on the sides of e bottom shelf of the ble round brown stains and ared debris. Yellowish/tan as noted on each of the		i	Systemic Changes An in-service was conducted by the dietary consultant. Al staff attended: dietary aides a FT, PT and PRN.	l dietary	

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			(X3) DATE SURV	ΕY
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIFR/CLIA IDENTIFICATION NUMBER	A BUILDING	E CONSTRUCTION	COMPLETER	· -
		345309	8 WNG		06/28/	2012
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE		
		THE STATE OF THE S		1 CAROLINE AVENUE		
LIBERTY	COMMONS NSG AND	REHAB CTR OF HALIFAX CTY	W	ELDON, NC 27890	- OTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	QULD BE	COMPLETION DATE
F 371	Continued From p	page 38	F 371	This Plan of Correction is the center allegation of compliance.	e's credible	
	During an observed Housekeeping Diring an observed the Administrator agreed the refrige and free of debris reported the refrigwas last cleaned. Based upon observed the refrigence of the refri	gerator on 6/28/12 at 9:30 AM is remained in the refrigerator. ation with the Administrator and rector on 6/30/12 at 1:30 PM, and Housekeeping Director erator was expected to be clean is. The Housekeeping Director gerator was cleaned weekly and 6/25/12 and should not be dirty. ervations, record reviews and and date opened food and store in a sanitation bucket in the main facility failed to maintain 1 of 1 igerators in clean condition.		Preparation and or execution of the does not constitute admission or age provider of the truth of the facts allowed forth in the statement of deficient is required by the provisions of fe. Any in-house staff who did in-service training by 07/28/allowed to work until training completed. The in-service tricluded the following proplabeling of opened food and storage of sanitation cloths. On 07/19/12 the administration conducted in-service training current housekeeping and in staff to validate the proper proposition.	eged or conclusions cases. The plan of cases. The plan of cases th	
	6/25/12 at 6:20 p (DM) revealed the food color dye understand the sand undated on the exit door. And dressing, pickle unlabeled and understand understand understand understand understand understand unlabeled and understand unlabeled and understand unlabeled and understand unipped critical and whipped critical and whipped critical and unipped c	kitchen tour conducted on om with the Dietary Manager here was vanilla extract and red nlabeled and undated in the dry at 6:23 pm there was prepared a and sweetened tea unlabeled the food preparation table next to the 6:30 pm there was french relish and a chocolate sheet cake undated in the reach-in the chocolate sheet cake was 6:32 pm there was a pitcher of undated prepared pitcher of tea team in the walk-in refrigerator. At was a container of unlabeled and		cleaning the nourishment re Any in-house staff who did in-service training by 07/28 allowed to work until traini completed. This information has been the standard orientation tra the required in-service refr for all employees and will the Quality Assurance Pro that the change has been so	not receive 8/12 will not be ing has been integrated into ining and in esher courses be reviewed by cess to verify	

, freezer. -

, undated chocolate ice cream in the walk-in

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DEPARTM	MENT OF HEALTH A	ID HUMAN SERVICES				CMB NO 0938-0391
CENTERS STATEMENT O	FOR MEDICARE & F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER	(X2) MU A BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345309	в ми			06/28/2012
	OVIDER OR SUPPLIER	CTP OF HALIFAX CTY	STREET ADDRESS, CITY, STATE, 7IP CODE 101 CAROLINE AVENUE			
LIBERTY C	OMMONS NSG AND R	EHAB CTR OF HALIFAX CTY		ME	PROVIDER'S PLAN OF CORREC	TION — (AS)
(X4) ID PREFIX TAG	-DEACH DESIGNATION	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD DC
F 371	Continued-From pag	e 39	F	371	This Plan of Correction is the conter's allegation of compliance.	credible = 100 miles
	1.29 pm-revealed a wrapped with cellop refrigerator. One side exposed to the air. unlabeled and unda refrigerator. A record review of a in-service entitled 'Food Storage Practice and interview with the revealed the staff of the conditional conditions of the staff	de of the cheese was A cup of orange juice was ted in the reach-in In undated food service staff fucted. There was an Cross-Contamination and tices. " It reviewed the proper			Preparation and or execution of this p does not constitute admission or agree provider of the truth of the facts alleg set forth in the statement of deficience correction is prepared and or execute it is required by the provisions of fede. Quality Assurance The Administrator will monit using the "Survey QA Tool", monitoring will include check the nourishment refrigerator is all open foods stored are propand that sanitation cloths are stored. See attached monitor This will be done weekly for months or until resolved by committee. Reports will be gweekly Quality of Life- QA and corrective action initiated appropriate. The QOL/QA of	olan of correction coment by the color conclusions es. The plan of color this issue or this issue The cing to see if s clean, that berly labeled properly ing tool. three QOL/QA given to the committee d as committee is
	6/25/12 at 6:23 pm	itchen tour conducted on with the Dietary Manager anitation cloth with stains was prep table next to the exit			the main quality assurance of They have regularly schedul weekly which are attended b Administrator, Director of N nurse managers, and dietary	ommittee. ed meeting by the lursing, other manager
	1:34 pm revealed the food prep tabl	the main kitchen on 6/28/12 at a sanitation cloth was stored on e next to the stove. Diet Aide #1 on 6/28/12 at 1:35 anitation rag should not have			It will also be reviewed in Committee attended by the Administrator, Director of Services, Dietary Manager, Director and Activities Director	ouarterly QOL/QA Medical Director, Nursing, Social Environmental

been left on the table.

A record review of an undated food service staff

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	CORRECTION DENTIFICATION NUMBER	A BUILDING			
	345309	B WING		06/28/2012	
NAME OF PR	OVIDER OR SUPPLIER	E '	EET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY (COMMONS NSG AND REHAB CTR OF HALIFAX CTY		01 CAROLINE AVENUE VELDON, NC 27890		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETE	on
F 431	in-service was conducted. There was an in-service entitled "Proper Cleaning, Sanitizing and Storage of Service Ware." The in-service mentioned that sanitizing cloths were to be stored in the sanitizing solution. An interview with the DM on 6/28/12 at 1:52 pm revealed dietary staff had been informed that they would need to store sanitation cloths in the sanitation buckets. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 371	this Plan of Correction is the ce allegation of compliance. Preparation and or execution of does not constitute admission or provider of the truth of the facts set forth in the statement of deficorrection is prepared and or exit is required by the provisions of F 431 refrigerator temps	this plan of correction agreement by the alleged or conclusions elegates. The plan of secuted solely because of federal and state law.	/12
	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.		O6/30/12 by maintenance Corrective Action for Re Affected All residents have the pot by this practice. See syste corrective actions.	director. esident Potentially tential to be affected	
	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	•	All medication refrigerate thermometers and daily or refrigerator temperature the charge nurse. Any retemp outside the range of will be reported to the M for appropriate follow up	checks for will be recorded by offrigerators with f 36 to 46 degrees antenance Director	,
	permanently affixed compartments for storage of controlled drugs listed in Schedule II of the		•		

PRINTED: 07/16/2012

EPART	MENT OF HEALTH A	ND HUMAN SERVICES			FORM APPROVE OMB NO 0938-039
ATEMENT C	S FOR MEDICARE & DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345309	B WNG		06/28/2012
ME OF BB	OVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE	
		am that small OTV		CAROLINE AVENUE	
IBERTY (COMMONS NSG AND R	EHAB CTR OF HALIFAX CTY	WE	LDON, NC 27890 PROVIDER'S PLAN OF CORRE	CTION (45)
(X4) ID PREFIX TAG	CAND DECIDEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S POWN OF CONTROL (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE
F 431	Comprehensive Dru Control Act of 1976 abuse, except when package drug distrit quantity stored is m be readily detected. This REQUIREMEN by: Based on observat interviews, the facili	g Abuse Prevention and and other drugs subject to the facility uses single unit oution systems in which the inimal and a missing dose can	F 431	This Plan of Correction is the center allegation of compliance. Preparation and or execution of this does not constitute admission or aggrowider of the truth of the facts alleset forth in the statement of deficient correction is prepared and or execution is required by the provisions of fe. An in-service was conducted and 07/20/12 by Interim DO attended: RNs and LPNs, F1 and the Maintenance Directed Any in-house nurse who did	s plan of correction recement by the reged or conclusions cies. The plan of ited solely because deral and state law I on 07/19/12 N. All nurses T, PT and PRN or.
	medication storage Findings include: Review of an unda "Refrigerator/Freez indicated the temp refrigerator should	ted facility form titled ter Temperature Log " erature range for the stay between > (over) 32 der) 40 degrees," and "notify mostat does not keep temps		service training by 07/27/12 allowed to work until training completed. The in-service of the following: ensuring that logs are maintained for the refrigerator and that temper maintained between 36 and temperature is noted to be at this parameter then mainter notified. Nurses on 11p - the temperature on the temperature on the temperature on the temperature.	ng has been copics included t temperature medication ature should be 46 degrees. If a above or below nance should be
	Director of Nursing temperature of the room registered 3 temperature log for medication room and documented days	OO AM accompanied by the g (DON), an observation of the erefrigerator in the medication 18° F. Review of the or the refrigerator in the revealed for 11 of the 29 of June the temperature was the 29 days documented for the temperature was 34° F.		This information has been the standard orientation tra required in-service refresh employees and will be revi Quality Assurance Process change has been sustained	ining and in the er courses for all lewed by the to verify that the

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

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	T OF HEALTH AND HUMAN SERVICES			OMB NO 0938	-0391
CENTERS FO	OR MEDICARE & MEDICARD DE TOUR DE MEDICARDE LE MEDICARD DE TOUR DE MEDICARD DE TOUR DE MEDICARDO DE MEDICA		TIPLE CONSTRUCTION	(K3) DATE SURVEY COMPLETED	
STATEMENT OF DE AND PLAN OF COR	FIGURE 1 IN COMPEN	A BUILDI		06/28/2012	
NAME OF PROVID	345309 DER OR SUPPLIER		TREET ADDRESS, CITY, STATE, ZIP CO	OE .	-
LIBERTY COM	MONS NSG AND REHĀB CTR OF HALIFAX CTY	10	WELDON, NC 27890 PROVIDER'S PLAN OF	TION SHOULD BE	(X5) PLETION DATE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED 10 DEFICIEN	INE VELLIOU	·
ļ	40	F 4	31 This Plan of Correction is it	w center's credible	

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

> On 06/30/12 at 9.45 AM, accompanied by Nurse #5, the refrigerator temperature was observed and confirmed by the nurse to be 34° F when the refrigerator was opened.

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

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

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

The manufacturer product information for Novolog insulin reads in part: "unopened vials and pens should be stored in a refrigerator at 36-46° F. Do not freeze. Do not use if has been This Flan of Correction is the center's credible allegation of compliance

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

Quality Assurance

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

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

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

SENTERS FOR MEDICARE & MEDICAID SERVICES

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

CENTER	S FOR MEDICARE 8	MEDICAID SERVICES				OMO IN	0 0830-0381
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IULTIPLE C LDING	CONSTRUCTION	(X3) DATE SU COMPLE	
	-	345309	B Wi	16		08/	28/2012
	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE AROLINE AVENUE		
LIBERTY	COMMONS NSG AND I	REHAB CTR OF HALIFAX CTY		WELL	DON, NC 27890		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAC	1X	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
				•			
F 431	Continued From page frozen. "	ge 43	F	431		(X3) DATE SU COMPLE OS/:	i an an in an an an
		•					4 - 4
	The manufacturer p	roduct information for Lantus : "unopened vials should be					
	stored at in a	frigerator at 36-46° F. Lantus					
	should not be allow	ed to freeze."				,	
		roduct information for				•	
		ine reads in part: "unopened should be stored at in a					
		* F. Do not freeze."					
	The manufacturer p	roduct information for					E. J. 44.
		reads in part: "store in 1 36-46° F. Do not Freeze."					
	The manufacturer p	roduct information for Vitamin					
		s in part: "Store at room in 59-86" F. Do not freeze."					
		roduct information for Treistar					
		box read in part: "store perature between 68 and 77					
	° F. Do not freeze."						
	Review of the temp						
		edication room for the month ed documentation for 7 of the					
	30 days of April the	temperature of the					•
		F, for 6 days of month of April					1
		the refrigerator was 34°, and of April the temperature for					
,	the refrigerator was						!
	Review of the temp	erature logs for the					;
	refrigerator in the m	edication room for the month		,			•
		ed documentation that for 14 ay the temperature of the	•				1
		F, and for 6 days of month of		,			ţ

Facility ID 923116

May the temperature for the refrigerator was 34°F

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DEPART	MENT OF HEALTH A	NO HUMAN SERVICES			OMB N	O 0938-0391	
STATEMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER.	(X2) MULTIPI (A BUILDING	- CONSTRUCTION	COMPLETED 06/28/201 ESS. CITY, STATE, ZIP CODE		
		345309	8 WING		06	/28/2012	
	ROVIDER OR SUPPLIER	EHAB CTR OF HALIFAX CTY	10 ⁻	ET ADDRESS, CITY, STATE, ZIP CODE 1 CAROLINE AVENUE ELDON, NC 27890	DDE		
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		O6/28/2012 ORRECTION COMP IN SHOULD BE COMP E APPROPRIATE D.	COMPLETION:: DATE	
r 431	Continued From pag	ne 44	F 431				
	conducted with the I The DON stated she refrigerator tempera of range to store the the June 2012 log a stayed within the pa log. The DON indic where the temperat A phone interview, conducted with the indicated she was t the medication refri When asked if the C checked the refrige Administrator indicated the last monthly vis did not see any info refrigerator temperator						
	conducted with the	on 07/11/12 at 8:55 AM, was Consultant Pharmacist. The				:	

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

Facility ID 923116

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

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

	FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF	D PLAN OF CORRECTION IDENTIFICATION NUMBER		A BUILDING				
		345309	B WN	G		06/28/	2012
	OVIDER OR SUPPLIER	EHAB CTR OF HALIFAX CTY		101	T ADDRESS, CITY, STATE, ZIP CODE CAROLINE AVENUE LDON, NC 27890	•	-
LIBERTY				A&E	PROVIDER'S PLAN OF CORRE	CTION	(45)
(X4) ID PREFIX TAG	AE YOU DESIGIEM	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	DATE
			:	;			
F 431	Continued From pag		F	431	This Flan of Correction is the center allegation of compliance.	's credible	
F 441 SS=D	40° F. She confirmed the temperature for the medication refrigerator needed to be kept between 36 - 46° F. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an		F	441	Preparation and or execution of this does not constitute admission or agr provider of the truth of the facts alle set forth in the statement of deficient correction is prepared and or execution is required by the provisions of fee	eement by the ged or conclusions was. The plan of ted solely because	ì
	Ine facility must est	oram designed to provide a			F 441 Infection Control Inc	ontinent care	07/28/12
	Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.				Corrective Action for Resid		
	Program under whi (1) Investigates, co in the facility; (2) Decides what p should be applied t (3) Maintains a rec actions related to in	tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective infections.			Resident #54 had catheter ca an aide on 07/16/12. The far laundry room was cleaned or laundry staff. Also, see syst Corrective Action for Resi Potentially Affected All residents have the poten affected by this practice. See changes for corrective actio	n in the n 06/28/12 by emic changes. dent tial to be e systemic	
	determines that a prevent the spread isolate the residen	tion Control Program esident needs isolation to of infection, the facility must t			potentially affected. Systemic Changes		
	communicable dis- from direct contact direct contact will (3) The facility mu	st prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. st require staff to wash their			An in-service was conducte and 07/20/12 by Interim DC attended: RNs and LPNs, NPRN.	N, All nurses	: I. i
	hands after each of	firect resident contact for which dicated by accepted					
	(c) Linens Personnel must h	andle, store, process and			·		1

Event ID: 077N11

PRINTED: 07/16/2012 FORM APPROVED

		ID HUMAN SERVICES				OMB NO	0938-0391
CENTERS STATEMENT OF		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN OF C	1	IDENTIFICATION NUMBER	ABUIL	DING			
		3453 09	B WING	3		06/28/	2012
NAME OF PRO	VIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	11 - 12 -	WAR OTO OF HALIENY CTV			CAROLINE AVENUE		
LIBERTY C	HINDRS NSG AND RE	HAB CTR OF HALIFAX CTY		WE	DON, NC 27890		
(X4) ID PREFIX TAG	#FACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	Continued From page transport linens so as infection. This REQUIREMENT by: Based on observation interviews, the facility changed gloves after providing perineal cather 1 (Resident #) of 1 repenneal care, and fair was handled and sto the spread of infection of soiled linens being bed linens; and the firesident clothing and faundry room away ful lint on the grill. Findings included: 1) The facility policy Perineal Care "indimediated in the General Irresident clothing and standards as approving that employees were universal precaution standards as approving the propriate of the grill in the propriate; of the grill in the	is not met as evidenced in, record review and staff relied to ensure staff removing fecal matter while re and completing a bath for sidents observed for illed to ensure soiled linen red in a manner to prevent in during 1 of 1 observations in placed on the resident 's acility failed to maintain I linen in the clean area of the rom 1 of 1 fans with built-up r, dated 10/01/01, titled " cated under the Purpose infection and odor. And, infection Control Guidelines et ic: 1. Observe (standard) is or other infection control red; 2. Wash you hands procedures. Wear gloves in Dispose of disposable ately; and, 9. Dispose of	F	441	This Plan of Correction is the center allegation of compliance. Preparation and or execution of this does not constitute admission or agree provider of the truth of the facts alleset forth in the statement of deficient correction is prepared and or execution in the statement of deficient correction is prepared and or execution in the provisions of feet. Any in-house staff who did in service training by 07/27/12 allowed to work until training completed. The in-service to the following the proper proper providing perineal care to recatheters, proper handling and linen to prevent the spread of Additionally from 07/13/12 registered nurse conducted positionally from 07/13/12 registered nurse conducted positional CNA skills checklist nursing assistants. Annual CNA skills checklist nursing assistants. Annual CNA skills checklist understanding of the policy/Any task not completed by the satisfaction of the observing reeducated until demonstrate technique per policy/proced achieved. Any concerns with DON for appropriate follows.	plan of correction element by the ged or conclusions ries. The plan of the solely because leval and state law to treceive inwill not be g has been opics included redure for sidents with ad storage of finfection. To 07/28/12 a terineal on all active st includes bed foley care skill and procedure, he NA to the Nurse will be ion of proper ure is ill be reported	

; made of Resident #54 receiving perineal care.

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

PRINTED: 07/16/2012 FORM APPROVED

		ND HUMAN SERVICES					0938-0391
CENTERS	S FOR MEDICARE &	MEDICAID SERVICES				(X3) DATE SUR	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l i	ULTIPLE LDING	CONSTRUCTION	COMPLETE	
		345309	B WNG			06/28/2012	
NAME OF PR	OVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		-
LINEBELL	CONTRACTIC NICO AND D	THAR CTR OF HALIFAY CTV		101	CAROLINE AVENUE		
LIBERTY	COMMONS NSG AND R	EHAB CTR OF HALIFAX CTY		WEI	LDON, NC 27890		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	ΊΧ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XŠ) COMPLETION DATE
			•	•			. <u></u> -
F 441	Continued From pag	e 47	۶	441	This Plan of Correction is the center	veredil le	4.9 0
		to be in the midst of bathing			allegation of compliance.		:-
		id obtained a fresh basin of			Preparation and or execution of this	nlan of correction	,
		he perineal area. When she			does not constitute admission or agre	rement by the	
	turned the resident of				provider of the truth of the facts alley	zed or conclusion	·
	observed a moderate	e amount of brown matter at			set forth in the statement of deficienc correction is prepared and or execut	ies. The plan of ad valoby kocznya	
		NA used wipes to remove			t is required by the provisions of fed	eral and state law	
	the brown matter, pla	aced the wipes with the			Training in province 35		
		ne brief under the resident,			The maintenance director was	s in serviced	
	and folded the brief i	inward. The NA proceeded			on 07/20/12 by the administra		
	to wash the rectal ar	ea with soap and water, dried			understanding of the need to		. <u></u>
		the resident onto her back.			clean laundry area including t		<u> </u>
		s on and using the same			cicuit launary area mereung.		
		to clean the rectal area, the			This information has been int	egrated into	
	NA washed and dre	d the resident 's legs and			the standard orientation traini	ng and in the	
	teet. The NA contin	ued with the same gloves on			required in-service refresher	courses for all	
		the resident; to put on the padjust the resident 's			employees and will be review	ed by the	
		nd shirt. With the same			Quality Assurance Process to	verify that	
	gasuostoniy tube an	observed to take the basin of			the change has been sustained		
	water to onen the h	athroom door, to turn on the			ine viiange time even enem		
	faucet: and to rinse	and dry the basin. After			Quality Assurance		
	exiting the bathroom	n, she removed her gloves,			Quanty resources		
	donned new gloves.	placed the soiled brief			The Director of Nursing will	monitor this	
		n matter into a plastic bag,			issue using the "Clinical Surv	ey QA	
	placed the soiled to	wel and wash cloth into a			Tool". The monitoring will i		
	plastic bag, proceed	led to open the resident 's			observations of perineal and		
		he soiled utility door, disposed			and proper handling of linen	to prevent the	
	of the plastic bags, i	returned to the resident's			spread of infection. The Adr	ninistrator	
	room, removed her	gloves, and washed her			will also monitor this issue u		
	† hands.				"Survey QA Tool. The mon		
					include a review of the laund		
	An interview, on 06/	28/12 at 11:20 AM, the			ensure that the fan and area i		
		riewed and an interview was			free from lint. See attached		
Ì		#1. The NA indicated she		•			1
	should have change	ed her gloves and gotten a			tools.		
1	fresh basin of water	to wash the resident's legs		•			
ļ		sident's care. The NA		i			:
	relayed she really h	ad not been feeling well.		:			1

Facility ID 923116

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

OFNITCHC!	OD MEDICADES	MEDICAID SERVICES			OMBING	1 0830-0391
STATEMENT OF STATEMENT OF CO	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M A BUI	ULTIPLE CONSTRUCTION DING	(X3) DATE SUI COMPLET	
		345309	8 WN	6	06/2	8/2012
NAME OF PROVIDER OR SUPPLIER— LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY				STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE WELDON, NC 27890		
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ADDES DEFENDENCED TO THE	IN SHOULD BE E APPROPRIATE	(AS)

F 441 Continued From page 48

An interview, on 06/29/12 at 3:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she would have expected the NA to have removed her gloves and washed her hands after providing perineal care and removing stool. She relayed NA#1 had received training regarding infection control, perineal care, and bathing.

b. On 06/28/12 at 10:50 AM, an observation was made of Resident #54 receiving perineal care and completion of a bed bath. NA #1, with gloves on, was observed to use wipes to remove the brown matter from the resident's rectal area, placed the wipes with the brown matter onto the brief under the resident, and folded the brief inward. She completed the bed bath. The NA was then observed to remove the brief, wrapped up the brief containing the brown matter; and, laid the brief on top the resident's bed linens. She then proceeded to ring out the wash cloth and placed the soiled towel and wash cloth on top of the resident's bed linens. The NA took the basin of water to the bathroom and emptied it. After exiting the bathroom, she removed her gloves, donned new gloves, took the soiled brief containing the brown matter on top of the resident 's bed linens and placed it into a plastic bag. The NA then took the wet wash cloth and towel on top of the resident's bed linens and placed the soiled linen into another plastic bag.

An interview, on 06/28/12 at 11:20 AM, the observation was reviewed and an interview was conducted with NA #1. She indicated she should have placed the soiled brief and soiled linens in plastic bags and not on the resident 's bed

F 441

Fins Pron of Currection is the center's credible allegation of compliance.

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

This will be done weekly for three months or until resolved by QOL/QA committee.

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

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

AND UIDAAN CEDVICES

PRINTED: 07/16/2012

	***	ND HUMAN SERVICES					0938-0391	12	
STATEMENT (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M A BUI		CONSTRUCTION	(X3) DATE SU COMPLET	RVEY		
•	. –	345309	в ми	IG		06/2	8/2012		
	OVIDER OR SUPPLIER	THE OVER OF HALIFAY CTV	I		ADDRESS, CITY, STATE, ZIP CODE AROLINE AVENUE	···	-	<u></u> .	
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF HALIFAX CTY		WEL	DON, NC 27890				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLE CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD 8E	(X5) COMPLETION DATE		
			,	;				-	
F 441			F	441		•			
	linens. The NA relay well.	red she had not been feeling					. <u>.</u>		
•	An interview, on 06/2	0/12 at 2:12 DM an							
	•	ted with the Director of							
	Nursing (DON). The	DON stated she would have							
		ollow the policy for infection							
•	- -	NA#1 had received training ontrol, perineal care, and				,			
	bathing.	miloi, perinear care, and							
								, - -	
								u may	
	2) An observation of							TET V	
		/12 at 1:49 PM revealed a black plastic box blowing on							
		side of the room to the other							
	- ·	f the fan was covered with							
		the fan was also covered							
		sident clothing and a table of							
		kets, and clothes that were ited on the opposite wall							
	facing the blowing far	• •							
	During the observation	n, an interview was							
		irector of Housekeeping and							
		or stated it was hard to keep							
		ause it was the laundry tated the fan had just been					1		
		" and " needed done as					ı		
		be " . The Director stated					:	ĺ	
	he "guessed" the factor over linen.	an should not be blowing						<u> </u>	
	! [!] During an interview w	vith the Administrator on		_					
		he Administrator stated she		;					
	expected the fan in th	e laundry room to be clean		į			!		
	and free of lint						l t	Į	

PRINTED: 08/20/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO: 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION 3 1/3 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED 01 - MAIN BUILDING OF IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 08/17/2012 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 GEROFRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) The statements made on this plan of 8/24/12 correction are not an admission to and do not K 038 SS=D NFPA 101 LIFE SAFETY CODE STANDARD K 038 constitute an agreement with the alleged deficiencies. Exit access is arranged so that exits are readily To remain in compliance with all federal and accessible at all times in accordance with section state regulations the facility has taken or will take the actions set forth in this plan of 7.1. 19.2.1 correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. K 038 SS=D This STANDARD is not met as evidenced by: **Corrective Action** A. Based on observation and staff interview on All staff that was present on 8/24/12 were 08/17/2012 the staff did not know about the instructed on the use and location of the Master Release Switch for the Magnetic Door master release switch at the nurses station. Lock System. The staff not present for the in-42 CFR 483.70 (a) service have been shown where it is located NFPA 101 LIFE SAFETY CODE STANDARD K 072 and how it works. Identification of related safety hazards Means of egress are continuously maintained free potentially affecting Residents of all obstructions or impediments to full instant All Staff have been instructed in the location use in the case of fire or other emergency. No and use of the Magnetic Door Lock System furnishings, decorations, or other objects obstruct (Nurses Station) exits, access to, egress from, or visibility of exits. Systemic Changes 7.1.10 in-service was conducted on 08/24/12 by the Administrator. All Staff, FT, PT, and PRN employed by this facility have completed the in-service. The in-service topics included: Location of the Master Release 1) Switch for the Magnetic Door Lock This STANDARD is not met as evidenced by: System (Nurses Station) A. Based on observation on 08/17/2012 there How and when to utilize the Master items stored in the egress corridors that were not Release Switch for the Magnetic Door Lock System in use. This information has been a. two (2) lifts near room 106 integrated into the standard b. clean and soiled linen stored near room 114 orientation training for all staff and will be reviewed by the Quality 42 CFR 483.70 (a) Assurance Process to verify that the K 147 NFPA 101 LIFE SAFETY CODE STANDARD K 147 change has been sustained

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

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

455

k 038 (continued)

TITLE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that feguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...g 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 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

Facility ID: 923116

(X6) DATE

SS=D

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

B. WING

(X3) DATE SURVEY COMPLETED

345309

A. BUILDING 01 - MAIN BUILDING 01

08/17/2012

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 101 CAROLINE AVENUE

LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY			101 CAROLINE AVENUE			
			WELDON, NC 27890			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	· ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC DATE DEFICIENCY)			
K 147	Continued From page 1	K1	47 K 147 SS=D			
	This STANDARD is not met as evidenced by: A. Based on observation on 08/17/2012 the med. refrigerator was not on the emergency power. 42 CFR 483,70 (a)		Corrective Action The med refrigerator was moved on 8/19/12 in order for it to be plugged into the emergency power receptacle. Identification of related safety hazards potentially affecting Residents This will be monitored by the administrator during daily rounds.			
		-	Systemic Changes The nurses have been in serviced not to rearrange the med room explaining the reason for having the refrigerator plugged into an emergency power receptacle.			
			Quality Assurance The monitoring is to include all nurses (LPN/RN) because they are the only ones who have a key to this room. They all know not to move the refrigerator from its location in case of an emergency power outage.			
		:	·			
CMS-356	17/02-99) Provious Varsions Obsolete Event ID: 0778/21	- ,	Coditive ID: 022116 If continuation shoot Dogo 2 o			

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