

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

PRINTED: 03/31/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345309</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/03/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CAROLINE AVENUE WELDON, NC 27890</b>		
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E 000	Initial Comments	E 000			
F 655 SS=D	<p>Baseline Care Plan CFR(s): 483.21(a)(1)-(3)</p> <p>§483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-</p> <p>(i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-</p> <p>(A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p>	F 655		3/31/22	

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

TITLE

(X6) DATE

Electronically Signed

03/26/2022

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

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F 655	<p>Continued From page 1</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <ul style="list-style-type: none"> <li>(i) The initial goals of the resident.</li> <li>(ii) A summary of the resident's medications and dietary instructions.</li> <li>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</li> <li>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.</li> </ul> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews the facility failed to develop a baseline care plan within 48 hours of admission and failed to develop a resident centered baseline care plan to address wound care on admission and readmission for 1 of 13 residents reviewed for baseline care plans (Resident #184).</p> <p>The findings included:</p> <p>1.a. Resident #184 was admitted on 2/10/22 with diagnoses that included a Stage 2 pressure ulcer to the sacrum and an unstageable pressure ulcer to the left buttock.</p> <p>Review of Resident #184 ' s physician orders dated 2/10/22 revealed an order for calcium alginate to the sacrum and left buttock wounds one time per day.</p> <p>Review of Resident #184 ' s base line care plan dated 2/14/22 revealed there was no baseline care plan developed within 48 hours of admission on 2/10/22 and that it failed to address pressure</p>	F 655	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</p> <p>F-655 Baseline Care Plan</p> <p>Corrective action for affected residents: Resident #184: Resident's care plan was revised to include a focus and related interventions for an Unstageable pressure ulcer to left buttock. Care plan was also revised to include the focus and related interventions for a shear wound to the right buttock. These updates were completed on 03/01/22 by the Quality</p>		

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F 655	<p>Continued From page 2 ulcers.</p> <p>b. Resident #184 ' s Minimum Data Set indicated a discharge assessment was completed on 2/14/22 and a reentry was completed on 2/22/22.</p> <p>Review of Resident #184 ' s medical record revealed resident was readmitted on 2/22/22 with an unstageable pressure ulcer to the left buttock and shear wound to right buttock.</p> <p>Review of Resident #184 ' s physician orders dated 2/22/22 revealed orders for collagenase ointment to buttock wound and zinc oxide to shear wound every shift.</p> <p>Review of Resident #184 ' s base line care plan dated 2/23/22 revealed there was no baseline care plan developed to address pressure ulcers.</p> <p>An interview on 3/3/22 at 1:44 PM with MDS nurse revealed that wounds should be included in the baseline care plan which is developed 48 hours after admission. She further stated the baseline care plans generated the information to the Kardex which informed the staff how to care for the resident.</p> <p>An interview at 2:16 PM on 3/3/22 with the Administrator revealed that the baseline care plans should be developed within 48 hours, should be person centered and include areas such as wounds that are significant to each resident ' s care.</p>	F 655	<p>Assurance Nurse Consultant. The care plan was revised again on 03/22/22 by the Regional Minimum Data Set Consultant in order to resolve the shear wound to right buttock which has now healed.</p> <p>Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents have the potential to be impacted by the alleged deficient practice. A 100% audit of all current residents who have been admitted to the facility within the last 30 days was completed in order to determine if the baseline care plan requirement was met for each of them. Audit was completed by Unit Manager and MDS Coordinator on 03/25/22.</p> <p>The results of this audit were:</p> <p>2 of 12 residents were identified as having not had the baseline care plan requirement met. 10 of 12 residents were identified as having had the baseline care plan requirement met.</p> <p>All residents who were identified as not having had the Baseline Care Plan requirement met will have their care plan revised and updated in order to include all information necessary to provide quality and individualized care for them. This will be completed by Unit Manager and MDS Coordinator no later than 03/29/22.</p> <p>Systemic Changes</p>		

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F 655	Continued From page 3	F 655	<p>On 03/23/22, the Regional Minimum Data Set Nurse Consultant provided education to the Minimum Data Set Coordinator and any member of the Interdisciplinary Team who participates in the care planning process including care planning meetings. This education reviewed CMS requirements for ensuring that the Baseline Care Plan requirement be met for all newly admitted residents.</p> <p><b>Baseline Care Plan Requirement:</b> The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must:</p> <ol style="list-style-type: none"> <li>1. Be developed within 48 hours of a resident's admission.</li> <li>2. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: <ul style="list-style-type: none"> <li>¿ Initial goals based on admission orders.</li> <li>¿ Physician orders.</li> <li>¿ Dietary orders.</li> <li>¿ Therapy services.</li> <li>¿ Social services</li> <li>¿ PASARR recommendation, if applicable.</li> </ul> </li> </ol> <p>Within 48 hours of admission to the facility, the facility must develop and implement a Baseline Care Plan for the resident that includes the instructions</p>		

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F 655	Continued From page 4	F 655	<p>needed to provide effective and person-centered care of the resident that meets professional standards of care (42 CFR 483.21(a)). In many cases, interventions to meet the resident's needs will already have been implemented to address priority issues prior to completion of the final care plan. At this time, many of the resident's problems in the 20 care areas will have been identified, causes will have been considered, and a baseline care plan initiated. However, a final CAA(s) review and associated documentation are still required no later than the 14th calendar day of admission (admission date plus 13 calendar days).</p> <p>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing, Administrator or designee will review 5 random residents who have been admitted to the facility during the past 30 days in order to determine if the Baseline Care Plan was completed during the required timeframe. This audit will be completed using the Quality Assurance audit tool entitled Baseline Care Plan Completion Audit. This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as</p>		

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F 655	Continued From page 5	F 655	appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Management, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 03/31/22		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		3/31/22	

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F 657	<p>Continued From page 6</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and staff interview, the facility failed to revise the comprehensive care plan based on current interventions including physical and occupational therapy recommendations for 1 of 13 residents (Resident # 7) reviewed for care plans.</p> <p>The findings included:</p> <p>Resident #7 was admitted to the facility on 9/25/20 with diagnoses that included history of stroke with hemiparesis.</p> <p>A review of Resident #7 ' s quarterly Minimum Data Set (MDS) assessment dated 11/26/21 revealed that resident required extensive assistance with bed mobility, transfers, eating and toileting.</p> <p>Review of the Care Planning Process policy dated 12/2021 indicated that care plans are to include information from a variety of documentation sources, are to include pertinent areas of care, assign relevant items to the Kardex for nursing assistant (NA) communication and are updated with changes by the MDS and Nurse Management Team.</p> <p>Review of Resident #7 ' s physical therapy discharge summary dated 1/23/22 indicated resident was discharged from skilled therapy services on a functional maintenance program which included daily ambulation with a front</p>	F 657	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</p> <p>F657 Care Plan Timing and Revision</p> <p>Corrective Action for Affected Residents Corrective Action for Resident #7: The care plan for resident #7 was revised in order to accurately reflect that they are on a functional maintenance program and to include that they use plastic utensils, plastic cup with lid and straw, plastic utensils should be stored on their bedside table and that they require food to be cut and sliced. This was completed by the Unit Manager on 03/25/22.</p> <p>Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be impacted by the alleged deficient practice. A100% audit was conducted on all current</p>		

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F 657	<p>Continued From page 7</p> <p>wheeled walker and cueing with a goal of 50 feet at a time.</p> <p>Review of Resident #7 ' s occupational therapy functional therapy maintenance program for feeding dated 2/19/22 indicated staff were to set up each meal by cutting and slicing items and placing drink in plastic cup with lid and straw and utilize plastic utensils. Plastic utensils were to be kept in resident ' s room on bedside table. The goal of this plan was that resident would continue to self-feed with set up assistance.</p> <p>Review of Resident #7 ' s care plan dated 2/25/22 indicated resident had an ADL (Activities of Daily Living) self-care problem related to cerebrovascular accident (stroke) with hemiparesis. Interventions included in part, able to feed herself independently with set up, limited assist with eating as needed, set up and supervision for meals. Ambulation was not included in the care plan.</p> <p>On 3/3/22 at 8:30 AM Nursing Assistant (NA)#1 was observed standing beside Resident #7 ' s bed feeding her using standard silverware, not plastic.</p> <p>Interview on 3/3/22 at 8:30 AM with NA#1 revealed she was not aware of self-feeding interventions for Resident #7. She further stated, "I think she is walked sometimes but I am not sure who does it."</p> <p>Interview with the Social Worker (SW) on 3/3/22 at 9:08 AM indicated that care plan meetings are not held unless there is a grievance and there was no way to know what was discussed or revisions to be made to the care plan.</p>	F 657	<p>residents who are on a Restorative Nursing Program, Functional Maintenance Program and/or those who use assistive devices for eating in order to determine if their care plan reflects these services.</p> <p>Audit Results: A total of 4 residents are currently on a Restorative Nursing or Functional Maintenance Program (including any special instructions for related care). 2 of 4 residents were identified as having a care plan that reflects the restorative or functional maintenance program, including any special instructions for related care that they are currently on. 2 of 4 residents who are currently on a restorative nursing or functional maintenance program, including any special instructions for related care did not have these items reflected on their care plan.</p> <p>A total of 3 residents were identified as using an assistive device for eating. 0 of 3 residents who use assistive devices were identified as having these devices reflected on the care plan. 3 of 3 residents who use assistive devices were identified as not having these devices on the care plan.</p> <p>Audit was completed by the Unit Manager on 03/25/22. All care plans that were identified as not accurately reflecting restorative and functional maintenance programs, as well as assistive devices used for eating were updated in order to accurately reflect</p>		

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F 657	<p>Continued From page 8</p> <p>Interview on 3/3/22 at 9:15 AM with Occupational Therapy Assistant revealed Resident #7 received occupational therapy services for strengthening and improving fine motor skills. Resident #7 was able to feed herself with interventions in place upon discharge from occupational therapy.</p> <p>Interview with Nurse #1 on 3/3/22at 10:30 AM indicated she assisted with some administrative duties and updated the MDS nurse about the residents as needed. Nurse #1 indicated that interventions from the functional maintenance program should be added to the care plan to generate information to the Kardex for the NA ' s.</p> <p>Interview via phone at 1:44 PM on 3/3/22 with MDS nurse revealed she completed MDS and care plans remotely for the facility. She indicated she reviewed nurse notes, physician orders and medications to develop and revise the care plan. She further stated she did not attend care plan meetings for the residents. She indicated that she called the facility or sent an e mail if she needed further information or clarification. She stated that Resident #7 ' s care plan should have been revised to include the functional maintenance program interventions from physical and occupational therapy.</p> <p>Interview at 2:16 PM on 3/3/22 with the administrator revealed that she expected care plans were revised to include current interventions including physical and occupational therapy recommendations. The administrator indicated that care plans were to be up to date, individualized and contain goals that were appropriate for each resident</p>	F 657	<p>these items. This was completed by the Unit Manager on 03/25/22.</p> <p><b>Systemic Changes</b> On 03/23/22, the Minimum Data Set Nurse Consultant in-serviced the facility Minimum Data Set Nurse on the importance of maintaining up to date care plans that are reflective of the resident's current status and needs. Emphasis was placed on ensuring that care plans are individualized for each resident's specific needs. This includes ensuring that any specialized programs such as Restorative Nursing or Functional Maintenance Programs that the resident is on, including any special instructions for care provided is included on the care plan. The care plan should also include any special assistive devices that they use in order to complete their Activities of Daily Living. Frontline staff who provide direct care to residents rely on the care plan in order to provide safe and effective care. Therefore, it is critical that in addition to the routine quarterly assessment and care plan reviews and updates that are completed, that care plans also be updated and revised as a resident's condition changes. Care plan updates and revisions is an on-going process.</p> <p>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or designee will audit up to 5 current residents in order to</p>		

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F 657	Continued From page 9	F 657	validate whether or not the care plan accurately reflects whether the resident is currently on a restorative nursing or functional maintenance program, including any special instructions for providing care, and will review care plans to ensure that any assistive devices that are used for eating are also included. This will be done on weekly basis x 4 weeks then monthly x 2 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 03/31/22		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		3/31/22	

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F 812	<p>Continued From page 10</p> <p>facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews the facility failed to date potential hazardous food items stored for use in 1 of 1 walk-in cooler and 1 of 1 reach-in cooler. This practice had the potential to affect food served to residents.</p> <p>The findings included:</p> <p>1. a. Initial observation of the kitchen walk-in cooler on 02/28/2022 at 11:24 AM revealed the following foods were unlabeled and undated:</p> <p style="padding-left: 40px;">1 opened container of thickened liquid 1 opened package of cheese</p> <p>b. Initial observation of the kitchen reach-in refrigerator on 02/28/2022 at 11:26 AM revealed the following food was unlabeled and undated:</p> <p style="padding-left: 40px;">1 bag of opened shredded cheese</p> <p>c. Observation of the kitchen reach-in refrigerator on 03/03/2022 at 11:32 AM revealed the following food was unlabeled and undated:</p> <p style="padding-left: 40px;">1 opened container of pimiento cheese</p> <p>An interview with the Dietary Manager (DM) on 02/28/2022 at 11:26 AM revealed that all opened</p>	F 812	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</p> <p>F812</p> <p>1. For dietary services, a corrective action was obtained on 2/28/2022.</p> <p>During the initial walk through of the kitchen, it was noted dietary services had failed to date and label an opened container of thickened liquid and one opened package of cheese in the walk-in cooler. It was also noted that 1 bag of opened shredded cheese and 1 container of pimiento cheese in the kitchen reach-in refrigerator were unlabeled and undated. The Dietary Service Director stated that</p>		

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F 812	<p>Continued From page 11</p> <p>food in the kitchen walk-in refrigerator, the reach-in refrigerator should be labeled and dated at the time it was opened. She further revealed that any unlabeled and undated food should be discarded. The DM stated staff who opened a container was responsible for labeling and dating that container at the time it was opened. She further stated she was responsible for checking the units for proper storage of opened food.</p> <p>An interview with the Administrator on 03/03/2022 at 11:48 AM revealed it was her expectation that kitchen staff make sure all food was labeled and dated upon opening the packaging. She also stated if food was not labeled and dated it should be discarded.</p>	F 812	<p>any unlabeled and undated food should be discarded: an opened package of cheese, an opened container of thickened liquid, an opened bag of shredded cheese, and 1 container of pimento cheese were discarded.</p> <p>2. Corrective action for residents with the potential to be affected by the alleged deficient practice.</p> <p>All residents have the potential to be affected by the alleged deficient practice. On 02/28/22, the Dietary Service Director completed a kitchen walk through to ensure all food items were within their dates and dated properly and discarded if not.</p> <p>3. Systemic changes</p> <p>In-service education was provided to all full time, part time, and as needed staff. Topics included:</p> <ul style="list-style-type: none"> <li>¿ Storage and dating policies and regulations.</li> <li>¿ Use by dates</li> <li>¿ Shift inspections to observe all food are within their dates and tossed if out of date.</li> </ul> <p>This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained.</p>	

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

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F 812	Continued From page 12	F 812	<p>4. Quality Assurance monitoring procedure.</p> <p>The Dietary Service Director or designee will monitor procedures for proper food storage weekly x 2 weeks then monthly x 3 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that all food is labeled, dated, and within proper dates. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager.</p>		