STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345309	A. BUILDING _____ B. WING _____	C 09/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow their grievance policy for 1 of 1 sampled residents (Resident #1) whose family had concerns. Findings included: According to the facility's grievance policy, revised 06/07, the grievance policy and procedure was "designed to encourage the resolution of grievances at the lowest possible level. It focuses on the mediation and settlement of issues as soon as possible after they arise." In the DATA COLLECTION section it indicated that all grievance forms "will be logged in the computer and monitored by the Quality Assurance Committee to ensure proper follow-up and corrective interventions." Resident #1 was admitted to the facility on 04/29/10. Cumulative diagnoses included hypertension and diabetes mellitus. A Quarterly Minimum Data Set (MDS) assessment of 09/23/11 indicated Resident #1 had a cognition score of 14 out of a possible 15. There were no behaviors indicated. Resident #1's family member had mailed a letter dated 07/13/11 with six concerns to the facility.	F 166	*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.* **F166** **Corrective Action - Affected resident (s)** For Resident # 1 all 6 concerns were written up using the facilities grievance form and documented on the grievance log on 09/29/11. Each concern was given to the department manager in which the grievance was an issue and properly investigated. A meeting was schedule at the convenience of Resident #1's POA to discuss all concerns. This was completed 10/10/11. **Corrective Action - potential resident (s)** All interviewable residents were interviewed to ensure if they had any grievances or concerns they were properly documented and investigated according to the Grievance policy. This was completed 10/17/11. **Systemic Changes to prevent recurrence** An in-service was conducted on 09/30/11, by the facilities Nurse Consultant. Those who attended included all department managers. The in-service included what is considered a grievance, which can make a grievance, how a grievance form is filled out, and procedure for resolving grievances, follow-up and policy reviewed. An in-service was also performed 09/30/11by the Director of Nursing and or Department Manager to staff in all departments. Any in-house staff member who did not receive in-service training by 10/21/11 will not be allowed to work until training has been completed.	10/28/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Peggy W. Bullock RN/LNHA		10/19/11

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 166	Continued From page 1 The first concern indicated Resident #1 had signed a document without first consulting the family. The second concern was short staffing because Resident #1 was not taken to the restroom during feeding time. The third concern indicated Resident #1 was not toileted promptly in the mornings to prevent her from having accidents. This concern also indicated staff were instructing residents to go ahead and "wet her pants" because they were going to change her anyway. The fourth concern indicated Resident #1 was not getting enough exercise. The fifth concern referenced notifying family of any changes in medications. The sixth concern questioned who had authorization to make medication changes without the family's approval. According to the grievance log provided by the facility, there had been one grievance from Resident #1. This grievance was dated 08/16/11 regarding staff treatment and was resolved on 08/18/11. There was no mention of any of the concerns in the 07/13/11 letter nor the concern mentioned in the 09/11/11 letter. According to a progress note of 08/29/11 at 10:30 AM, the Social Worker (SW) indicated that Resident #1's family had come to the facility for a scheduled care plan meeting but the meeting was cancelled. The note indicated the family wanted to meet to discuss concerns at that time. It was noted that Resident #1's family met briefly with the Director of Nurses (DON) and the Administrator. The note indicated a list of concerns was provided. A copy of the listed concerns was attached to the SW's note in Resident #1's record.	F 166	*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 Administrator and or Social Service Director will monitor this issue by discussing any concerns or grievances Monday through Friday during the department manager's morning meeting. The Administrator and or SSD will ensure all concerns are placed in the grievance log and the grievance procedure is followed. This will be done daily times four weeks during the Department Mangers morning meeting, then weekly times three months, in the Quality of Life Meeting, then quarterly for two quarters. Reports will be given to the weekly/monthly Quality of Life- QA committee and corrective action initiated as appropriate.	

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F 166	Continued From page 2 A copy of a letter dated 09/11/11 was provided by the facility. This letter referenced the 07/13/11 letter and concerns within as well as some new concerns. According to the 09/11/11 letter, family had a scheduled appointment at the facility on 08/29/11. Upon arrival at the facility, the family was told the meeting was cancelled. At that time, the family expressed concerns regarding Resident #1 signing documents without presence of family. This letter indicated no response had been received from the facility in regards to any of the concerns expressed by the family. On 09/29/11 at 10:45 AM, the Social Worker (SW) reported that grievances could be expressed verbally or written in letter form. She stated Resident #1's family had been in the facility for a scheduled care plan meeting on 08/29/11 and at that time was given a list of concerns by the family. She added that the meeting had been cancelled that day prior to the family's arrival. The SW stated she did not include these concerns on the facility's grievance log. The SW stated the document the family was concerned about was a grievance form dated 08/16/11. She stated Resident #1 had signed the form attesting to the accuracy of the information that was written concerning care issues she had with Nurse Aide #3 (NA#3). The SW added that there was no reason for the family to be present as it was an internal form and Resident #1 was simply attesting to the accuracy of what she had told staff. The SW stated she should have included all of the family's concerns on the grievance log so that progress could be tracked. She stated the concern about not getting enough exercise had been resolved as therapy had already begun working with Resident #1 prior to	F 166		

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F 166	Continued From page 3	F 166		

the 08/29/11 list. The SW stated she had not relayed this information to the family.

During an interview with the Director of Nurses (DON), on 09/29/11 at 12:15 PM, The DON stated Resident #1 had voiced a concern with one of the nurse aides (NA#3) on 08/16/11. She stated a grievance was completed as well as a 24 hour and 5 day report to the state. The DON added that the concern was that NA#3 verbally abused her and NA#3 had been terminated as a result. She stated the Administrator had provided her with the letter dated 09/11/11 from Resident #1's family. According to the DON, she had determined that NA#3 was the same aide who had told Resident #1 to void in her "pants". She stated she did not do a separate grievance for that concern since it was the same aide even though it was a different issue. The DON stated she had not followed up with the family because a care plan meeting would be scheduled to discuss the concerns but as yet had not been scheduled. She commented she did not know anything about the medication changes other than Ambien had been changed.

An interview was conducted with the Administrator on 09/29/11 at 3:45 PM. She stated the concerns provided by Resident #1's family should have been logged in on the grievance log as 6 separate grievances. She added that she received the 09/11/11 letter on 09/19/11. The Administrator stated she remembered discussing the concerns in stand up meetings prior to 09/19/11 and had asked the SW to telephone the family to set up another meeting. She stated when Resident #1's family came to the facility on 08/29/11 she offered to show the

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F 166	Continued From page 4 grievance form to the family. The Administrator stated she did not remember if the family actually saw the form or not. She stated it was simply an internal form used to complete grievances and was not a legal document. Resident #1 had signed attesting to the accuracy of the information she had provided to the staff.	F 166	*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.*	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	**F225** **Corrective Action - Affected resident (s)** For Resident # 1, a 24 hour and 5 day report was sent on 09/30/11. **Corrective Action - potential resident (s)** The facility was unable to unsubstantiate any inappropriate touching teasing of the resident. All interviewable residents were interviewed to see if they have been touched inappropriately, teased, handled roughly, yelled or spoken to inappropriately. A full skin assessment was preformed on all non-verbal residents for any signs of abuse. This was completed on 10/18/11. **Systemic Changes to prevent recurrence** An in-service was conducted on 09/30/11 by the Administrator and Nurse Consultant. Those who attended included the Director of Nursing and all Department Managers. The in-service included reportable offensives, when and how to report them. 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.	10/28/11

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F 225	Continued From page 5 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow their abuse policy by not reporting an alleged allegation of abuse for 1 of 1 sampled residents (Resident #1). Findings include: According to the facility's Abuse Prohibition policy, last revised on 01/01/07, all reports of resident verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, or misappropriation of resident property shall be promptlly and thoroughly investigated by facility management. In the "REPORTABLE INCIDENTS" section of the policy, it indicated that "Any ALLEGATIONS (regardless of whether the allegations are substantiated) against unlicensed personnel," MUST BE REPORTED to the Health Care Personnel Registry via the 24 hour and 5 day report. "The facility MUST INVESTIGATE ALL REPORTABLE ALLEGATIONS, protect the resident from harm while the investigation is in progress and report the results of their investigation to DHHS within 5 working days of the initial incident report." Unlicensed health care personnel were defined as any worker employed by a nursing facility that worked around/with a	F 225	*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.* **Quality Assurance** The Administrator and or Director of Nursing will monitor this issue by using the Facilities Grievance log. The monitoring will include discussion of any types of complaints or grievances received in the Department Managers morning meeting to ensure that all allegations of abuse are reported by 24 hour and 5 day reports. This will be done daily Monday thru Friday for four weeks, weekly times 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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F 225	Continued From page 6 resident and is not licensed. Examples included certified nursing assistants. Resident #1 was admitted to the facility on 04/29/10. Cumulative diagnoses included hypertension and diabetes mellitus. According to a letter, dated 07/13/11, which was mailed to the facility, a family member reported 2 staff members (Nurse Aide #1 and #2) as "teasing and mishandling another patient in an inappropriate manner. They were touching the patient's breast and laughing about the size of them." The letter further indicated that "Your employees threatened _____ [Resident #1] by stating that if she 'didn't stop being so nosey that somebody was going to kill her.' " According to this letter, Resident #1 had reported to the family member that she was receiving negative comments, shoving and pushing her in the wheelchair. A letter from Resident#1's family, dated 09/11/11, indicated on 08/29/11 a family member had arrived at the facility for a scheduled meeting with administration. Upon arrival into the building, the family member was informed the meeting was cancelled. At that time according to the letter, the family member left a copy of a letter that was written to the facility dated 07/13/11 which included an alleged allegation of abuse. It was noted that a handwritten statement of "Received 9/19/11 at 11:00 AM _____(Administrator's name)" was on the top of the letter. A Quarterly Minimum Data Set (MDS) assessment of 09/23/11 indicated Resident #1 had a cognition score of 14 out of a possible 15.	F 225		

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F 225	Continued From page 7 There were no behaviors indicated. Upon review of the facility's allegations of abuse for the last 3 months, it was noted that there was no mention of the family's concern. During an interview with the Administrator, on 09/29/11 at 3:45 PM, she stated that any type of abuse no matter what the type should be reported. She stated she had received the letter dated 07/13/11 from Resident #1's family. She added that she had given it to the Director of Nurses (DON) for follow-up. The Administrator indicated she had spoken with the DON and instructed her to investigate the allegations included in the letter. She also stated that she had shown the DON the format in which she wanted the reports completed. The Administrator commented that she actually thought the DON had filed the appropriate reports. When questioned if the concern voiced by the family was a reportable concern, she replied that it was and the DON should have completed a 24 hour and a 5 day report. The DON was interviewed on 09/29/11 at 12:15 PM. She stated that she had investigated the concerns in the 07/13/11 letter from Resident #1's family. She added that she determined that the incident was not what the family had reported and therefore she did not implement the facility's abuse policy by filing the appropriate 24 hour and 5 day report. When questioned if she had documentation of her investigation she stated she did not. At approximately 2:00 PM on 09/29/11 she provided a folder that contained handwritten notes with a copy of the 07/13/11 letter concerning the alleged abuse allegation.	F 225		

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F 225	Continued From page 8 According to her notes, the resident who was allegedly abused was not mentioned and the family was unable to provide the name. Her notes of 07/19/11 indicated that another family member had reported to her that Resident #1 had made the statement that "she is so nosey if she don't stop being so nosey somebody is going to kill her" rather than NA#2. Included in this folder were statements from both aides NA#1 and NA#2 indicating they denied abusing anyone. An interview was conducted with the DON, on 09/29/11 at 4:40 PM. She stated that she had received the letter dated 07/13/11 with the concerns from Resident #'1s family member from the Administrator. She indicated she could not remember the exact date that she received it. When questioned as to the reporting of the alleged allegation, she stated she had 24 hours to determine if the allegation actually happened. She stated she had determined that it had not so she did not file any reports.	F 225		