DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/18/2011 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WNG 345519 09/30/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH LIBERTY COMMONS NSG & REH JOHN BENSON, NC 27504 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) The statements made on this plan of F 157 483.10(b)(11) NOTIFY OF CHANGES correction are not an admission to and do (INJURY/DECLINE/ROOM, ETC) SS≔J not constitute an agreement with the alleged deficiencies. A facility must immediately inform the resident; consult with the resident's physician; and if To remain in compliance with all federal and known, notify the resident's legal representative state regulations the facility has taken or will or an interested family member when there is an take the actions set forth in this plan of accident involving the resident which results in correction. The plan of correction constitutes injury and has the potential for requiring physician the facility's allegation of compliance such intervention; a significant change in the resident's that all alleged deficiencies cited have been physical, mental, or psychosocial status (i.e., a or will be corrected by the dates indicated. deterioration in health, mental, or psychosocial status in either life threatening conditions or F 157 clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an Corrective Action for Resident Affected: existing form of treatment due to adverse consequences, or to commence a new form of For Resident # 2, discharged to the hospital treatment); or a decision to transfer or discharge the resident from the facility as specified in and deceased §483.12(a). **Corrective Action for Resident Potentially** The facility must also promptly notify the resident Affected: and, if known, the resident's legal representative All resident's have the potential to be or interested family member when there is a affected by the alleged deficient practice. change in room or roommate assignment as All residents are potentially affected specified in §483.15(e)(2); or a change in by this practice. On 9/29/2011, the charge resident rights under Federal or State law or nurses with the supervision of unit manager, regulations as specified in paragraph (b)(1) of MDS nurse and staff development this section. coordinator assessed all current residents for changes in conditions and the attending The facility must record and periodically update physician was notified immediately of any the address and phone number of the resident's identified changes. 92 out of 92 residents legal representative or interested family member. were assessed and 4 were noted to have change in conditions. The attending physicians were contacted by the staff This REQUIREMENT is not met as evidenced nurses and orders were received and

MABORATORY DIRECTOR'S OR PROVIDERSUPPLIER REPRESENTATIVE'S SIGNATURE

Based on record review, staff and physician

interviews, the facility failed to notify the physician

TITLE

implemented. This included a 1. Resident

loose stools and received orders for

who was experiencing nausea, vomiting and

(X6) DATE

10/24/11

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.

PRINTED: 10/18/2011 FORM APPROVED

SAPERANCY CORRECTION A BULDING	1		T SERVICES	, ,			OMB NO	<u>0. 0938-0391</u>	
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN SUMMARY STATEMENT OF DEFICIENCIES PRETAY COMMONS NSG & REH JOHN SUMMARY STATEMENT OF DEFICIENCIES PRETAY REMOVED A CONSECUTIVE ACTION SHOULD BE LOCATED BY FULL REMOVED. NS. 27504 BENSON, NS. 27504 BENSON, NS. 27504 BENSON, NS. 27504 F 157 Continued From page 1 of a change in mental status of Resident #2 after returning from the hospital with diagnoses of a concussion and laceration to the forehead after a fall. This was evident in 1 of 7 residents in the survey sample that had a change in status. Immediate jeopardy began on 7/30/11 when she returned to the facility from the hospital with diagnoses of a concussion and laceration to the forehead after she fall at the facility rome the hospital with diagnoses of a concussion and laceration to the forehead after she fall at the facility rome the hospital with diagnoses of a concussion and laceration to the forehead after she fall at the facility rome the hospital with diagnoses of a concussion and laceration to the forehead after she fall at the facility rome the hospital with diagnoses of a concussion and laceration to the forehead after she fall at the facility rome the hospital with diagnoses of a concussion and laceration to the forehead after she fall at the facility rome the hospital with diagnoses of a concussion and laceration to the forehead after she fall at the facility rome the hospital with diagnoses of a concussion and laceration to the forehead after she fall at the facility. The jeopardy was removed on 9/30/11. The facility remains out of compliance at a scope and severity level 0 (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training. Findings included: Late Effect CVA (cerebral vascular accident) with loft sided Hemiplegia, Chronic Kidney Disease (Stage IV) and Atrial Fibrillation. Review of the quarterly MDS (minimum date sof) assessment dised 6/30/11 revealed Re	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	J			(X3) DATE SU	RVEY	
DIBERTY COMMONS NSG & REH JOHN SUBJUANCY STATEMENT OF DEPOCIONCIES (EACH DISTRIBUTION OF ONLY 1997) F 157 Continued From page 1 of a change in mental status of Resident #2 after returning from the hospital with diagnoses of a concussion and laceration to the forehead after a fall. This was evident in 1 of 7 residents in the survey sample that had a change in status. Immediate Jeopardy began on 7/30/11 when she returned to the facility from the hospital with diagnoses of a concussion and laceration to the forehead after she fell at the facility. The Jeopardy was removed on 9/30/11. The facility remains out of compliance at a scope and severity level 0 (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training. Findings included: Resident #2 was readmitted to the facility on 9/17/11 with cumulative diagnoses which included Late Effect CVA (cerobral vascular accident) with left sided Hemiplegia, Chronic Kidney Disease (Stage IV) and Atrial Fibrillation. Review of the quarterly MDS (minimum data set) assessment dated 0/30/11 revealed Resident #2 was elert to person and time, able to make her needs known and required extensive assistance from the staff for ADLs (activities of daily living). Review of the Nurses' Notes (NN) dated 7/30/11 at 6-65 am revealed the resident was observed on the floor with bleeding from a wound to the forehead. A medical emergency service of 911 was summoned and transferred the resident to the hospital.			345519	B. WI	wingC				
LIBERTY COMMONS NSG & REH JOHN SUMMARY STAVEMENT OF DEFICIENCIES PREFIX PROPERTY PROPERTY	NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		т-	At	09/3	0/2011	
OM-JID PRIEFIX TAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE PRECEDED BY FULL TAGE (LATER) TAGE (LATER) TO BE SUMMARY STATEMENT OF DEFICIENCY MUST DE PRECEDED BY FULL TAGE (LATER) T			JOHN						
F 157 Continued From page 1 of a change in mental status of Resident #2 after returning from the hospital with diagnoses of a concussion and laceration to the forehead after a fail. This was evident in 1 of 7 residents in the survey sample that had a change in status. Immediate jeopardy began on 7/30/11 when she returned to the facility. The jeopardy was removed on 9/30/11. The facility remains out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training. Findings included: Resident #2 was readmitted to the facility on 6/17/11 with cumulative diagnoses which included Late Effect CVA (corebral vascular accident) with left sided Hemiplegia, Chronic Kidney Disease (Stage IV) and Attail Fibrillation. Review of the quarterly MDS (minimum data set) assessment dated 6/30/11 revealed Resident #2 was alert to person and time, able to make her needs known and required extensive assistance from the staff for ADLs (activities of daily living). Review of the Nurses' Notes (NN) dated 7/30/11 at 6-45 am revealed the rasident was observed on the floor with bleeding from a wound to the forehead. A medical emorgency service of 911 was summoned and transferred the resident to the hospital.	<u> </u>				E	BENSON, NC 27504			
of a change in mental status of Resident #2 after returning from the hospital with diagnoses of a concussion and laceration to the forehead after a fall. This was evident in 1 of 7 residents in the survey sample that had a change in status. Immediate jeopardy began on 7/30/11 when she returned to the facility from the hospital with diagnoses of a concussion and laceration to the forehead after she fell at the facility. The jeopardy was removed on 9/30/11. The facility remains out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training. Findings included: Resident #2 was readmitted to the facility on 6/17/11 with cumulative diagnoses which included Late Effect CVA (cerebral vascular accident) with left sided Hemiplegia, Chronic Kidney Disease (Stage IV) and Attail Fibrillation. Review of the quarterly MDS (minimum data set) assessment dated 6/30/11 revealed Resident #2 was salent to person and time, able to make her needs known and required extensive assistance from the staff for ADLs (activities of daily living). Review of the Nurses' Notes (NN) dated 7/30/11 at 6:45 am revealed the resident was observed on the floor with bleeding from a wound to the forehead. A medical emergency service of 911 was summoned and transferred the resident to the hospital.	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETION	
pain.		of a change in mental returning from the hos concussion and lacera fall. This was evident is survey sample that ha Immediate jeopardy be returned to the facility diagnoses of a concus forehead after she fell was removed on 9/30/of compliance at a sco actual harm with potentharm that is not immediate monitoring of systems completion of employer included: Resident #2 was readmed/17/11 with cumulative Late Effect CVA (cerebleft sided Hemiplegia, C(Stage IV) and Atrial Fill Review of the quarterly set) assessment dated #2 was alert to person a needs known and requifrom the staff for ADLs of the Review of the Nurses' I at 6:45 am revealed the on the floor with bleeding forehead. A medical en was summoned and trait the hospital.	status of Resident #2 after pital with diagnoses of a stion to the forehead after a n 1 of 7 residents in the d a change in status. Pegan on 7/30/11 when she from the hospital with sion and laceration to the at the facility. The jeopardy 11. The facility remains out pe and severity level D (no tial for more than minimal liate jeopardy) to ensure put in place and e training. Findings Initted to the facility on e diagnoses which included ral vascular accident) with Chronic Kidney Disease orillation. If MDS (minimum data 6/30/11 revealed Resident and time, able to make her red extensive assistance (activities of daily living). Notes (NN) dated 7/30/11 resident was observed g from a wound to the nergency service of 911 insferred the resident to	F		Intravenous fluids and rocephin. Resident who complained of pa medicated for pain and received urine analysis and culture, 3. Redeveloped rash and received on hydrocortisone, benedryl, prevail heparin, and foley catheter 4. In was experiencing some hallucing received an order to be evaluated physician elder care on 9/30/2010 obtained have been implemented staff nurses. These resident will the acute charting list and will be every shift for 72 hours after treat stopped. If improvement is not in 24 hours the physician will be contented to the physician will be contented to the refollow up instructions/orders. This assessment includes the following of Observing for lact present, clean dry, sterile dressize, depth and bleeding or drain of Observing for swell discoloration; in chart size, site and color. Observing for contented to the precipitating duration, vital stime ended. A whether or not had difficulty bre of Observing and in resident has hear	in, and was a corders for esident who ders for edid, to hold esident with attions and by the litremain or eassessed with the estate of the est	ra o d no i n i f t t t t t f	

1		MEDICAID SERVICES	·			OMB N	O. 0938-0391
AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE SU COMPLE	RVEY
Í			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DING			^
		345519	B. WING	·			C
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET	T ADDRESS, CITY, STATE, ZIP CODE	1 0913	0/2011
LIBERTY	COMMONS NSG & REH .	(OUN	İ		HIGHWAY 242 NORTH		
	——	20414			ISON, NC 27504		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		\neg	PROVIDER'S PLAN OF CORRECT		,
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	.	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	Continued From page	2		_ [△ Ohearving for		
			F 1	57	 Observing for changes. 	personal	ity
	returned to the facility.	1 revealed the resident			Ohearving for a	(4 m m + 42 m m m	
	returned to the facility.				 Observing for all consciousness 	terations	ın
	During a telephone int	erview on 09/30/11 at 7:45			o Observing for inc	n Somflinger	
	am with Nurse #1, who	admitted resident back			○ Observing for file		
	from ER [emergency r	ooml, she stated "I			weakness.	senso	ry
	readmitted the residen	t but I do not remember			o Observing for	aeneraliza	
	how she looked, [regain	rding her mental status) or			weakness.	generanze	, u
	any other bruises than	what I documented in my			o Observing for	speed	.h
	notes, she looked tired	." Nurse #1 stated			disorder.	opece	'11
j	Resident #2 was sleep	ing the whole time when			 Observing for ga 	ait, postur	'e
	sne returned from the	nospital. Her face had a			or balance disor	rder.	Ĭ
	large bump on her fore	head, stitches with no			 Observing for stiff 	f neck.	-
	aressing on it. The nui	rse stated "I thought it was			 Observing for 		er l
	odd that she was sent					onse t	
	they gave her a dose o	y. I know in the hospital f Tylenol #3, and I am not	ļ		painful stimuli).	_	_
	sure if that had anythin	to do with her hoing			Observing for	abdomina	ıi İ
ĺ	sleepy." She continued	"I only work every other			spasm or pain.		
}	weekend, so I really did	not know this resident's			 Observing for blee 	eding fron	n
İ	normal behavior or aler	tness." Continued			ears, nose, throa	at.	
1	interview with Nurse #1	indicated Resident #2 did			o Observing for	unequa	1
	not follow commands u	pon return from the			pupils.		
	hospital as she did prio	r to the fall. Nurse #1			 Observing for dy 	/spnea o	r
	indicated that, after her	return from the ER, the			variations in re	spirations	;
	resident would respond	by smiling. This nurse			(irregular).		1
ļ	indicated she did not fe	el it was necessary to			○ Observing for flu	ushing o	·
İ	just returned from the h	ecause the resident had			cyanosis.		İ
	expected the resident to	ospital, so Nurse #1	1		 Observing for pain Observing for a 		
]	and and testinetif (f	, ne med.	1			abduction,	<u> </u>
	During an interview with	NA #5 on 9/30/11 at 3:15			adduction, shor Improper posi		
	pm, who worked Saturd	av (7/30/11). Sundav	1		improper posi extremities.	ition of	
17	(7/31/11) and Monday (8/1/11) during the day			o Taking vital signs	a hu 4k-	
1:	shift and cared for Resid	dent #2, she stated "she			o running vital signs	s ny tue	ĺ
10	(Resident #2) was very	different when she came]	ļ
	pack from the ER, she s	tayed in the bed and					
8	slept more. Her appetite	was poor. The					1

PRINTED: 10/18/2011 FORM APPROVED

STATEMENT	OF DEFICIENCIES	WEDIOAID SERVICES				OMB N	O. 0938-039
AND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345519	B. WIN	IG		1	C
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>				09/3	30/2011
	COMMONS NSG & REH	JOHN		STF 2	REET ADDRESS, CITY, STATE, ZIP CODE 2316 HIGHWAY 242 NORTH		
			_	E	BENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD 8E	(X5) COMPLETION DATE
	her to eat. She did not lunch, and I told the nit Saturday and Sunday Monday"). NA #5 indic decreased eating or nit meals was unusual. Review of NN dated 7, completed by Nurse #2, no signs and symptom shortness of breath. Repain at 7:00 PM, an as Tylenol #3, was admin She was resting in becunlabored. Vital signs documented as blood pulse (P) 97, respiration saturation 92%. During an interview on Nurse #2, who worked stated "she (Resident and sleepy. She ate abothe NA informed me she even with a lot of encounted fed her. She was moar because she had pain it meds, but was unable to actually was. She did signer head hurt. It was obsomething different aboresponded, I just thougher head. I told the once about her behavior during a stranger in the second in the proposition of the propo	to assist her and encourage to eat Sunday breakfast or urses." (Nurse #1 on and Nurse # 5 on cated on interview that the eeding assistance with ### ### ### ### ### ### ### ### ### #	F	157	systemic Changes On 9/29/2011 and staff nurses were in-service development coordinator, unit nurse consultant and the admeto contact the physician document significant changes staff nurses have received to (see Attachment A). The excontent is as follows: Credible Allegation In-service • After all resident falls changes in physician function, the charge monitor the following for 72 hours: • Observe for la present, clear dry, sterile dry, sterile dry, sterile dry size, depth and bleeding or dresize, see and color. • Observe for chart size, see and color. • Observe for chart time precipitating duration, vital time ended. whether or rehad difficulty in observe and	9/30/2011, ced by manager, ninistrator and how 24 out of this education act in-ser es, injuries a nurse g every so accrations n and appressing. Not amountainage, if presente, amo convulsion and appressite, amo convuls	staff the how to f 30 ation vice or ntal will shift ; if pply lote t of and ent, unt ns; an, ors, und lart ent
8	checks and documented any difference (in her vit	d them. I did not notice als signs]." She indicated			resident has h pain.		

PRINTED: 10/18/2011 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WNG 345519 09/30/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH LIBERTY COMMONS NSG & REH JOHN BENSON, NC 27504 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) o Observe for personality Continued From page 4 changes. F 157 even though she had a poor appetite, needed o Observe for alterations in encouragement from her family to eat. consciousness. complained of discomfort that she was unable to Observe for incontinence. describe and slept a lot during the shift.) "I did Observe for sensory not think it was necessary to call the doctor." weakness. Observe for generalized During an interview with NA #3 on 09/30/11 at weakness. 3:10 pm; who worked with Resident #2 on o Observe for speech Saturday and Sunday; 3:00pm-11:00 pm shift. NA disorder. #3 stated "the resident did not eat and I tried to o Observe for gait, posture or encourage her to eat. She slept a lot and she was balance disorder. more sedated than usual. Before she went to the Observe for stiff neck. hospital she was usually out of bed in her o Observe for proper reflexes wheelchair and ate her meals in the dinning (response to painful room. I told the Nurse (Nurse # 6), that she was stimuli). sleeping more and not as hungry or eating like o Take vital signs and include she usually did." temperature. During an interview with NA #4 on 09/30/11 at o Observe 3:12 pm who also worked on Saturday and for abdominal Sunday from 3:00 pm-11:00 pm NA #4 stated spasm or pain. o Observe for bleeding from "The resident was very sleepy and did not respond to me like she did before she fell. Usually ears, nose, throat. she would smile at me and assisted me when it o Observe for unequal pupils. was time to change her clothes. That weekend o Observe for dyspnea or she did not assist with any of her care. I told the

was to be expected."

Nurse (Nurse #6) and she told me she had a

head injury and was taking pain medication, it

completed by Nurse #3 revealed Resident #2 was

easily aroused but did not follow commands; she

was sleepy. She moaned and groaned when she

was moved or was encouraged taking fluids or waking up. She did not answer the nurse's questions because she was too sedated. Nurse #3 gave the resident pain medications per PRN

Review of NN dated 7/31/11 at 2:32 am

abduction.

variations in respirations

(irregular).

cyanosis. o Observe for pain.

improper

extremities.

o Observe

o Observe for flushing

for

adduction, shortening or

position

PRINTED: 10/18/2011 FORM APPROVED OMB NO. 0938-0391

1		MEDICAID SEKVICES				OMB NO	<u>0. 0</u> 938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY
		345519	B. WIN	≀G		i	С
NAME OF P	ROVIDER OR SUPPLIER		1	, 		09/3	0/2011
	COMMONS NSG & REH	ЛОНИ		2	REET ADDRESS, CITY, STATE, ZIP CODE 315 HIGHWAY 242 NORTH BENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE PRIATE	(X5) COMPLETION DATE
	(when necessary) ord crying out. The nurse resident. Her vital sign (temperature) 98.7, P. Review of NN dated 7 completed by Nurse # bed resting quietly. N/noted. She was easily did not follow comman sedated. She was not much as before the paradministered. Resident nurse's hands when as strength in upper extre arms back when "we wigns. No apparent dis fall. Will con't (continue were T 97.4, R 16, P 1 During an interview with 9:32 am she indicated most of the shift. Pain administered. She state would not respond, and out of "norm" that was her she usually slept the neuro checks, I think the hours, from what I was usually coherent at time commands and expressiontinued "this was the when she required medory out at times and market in the correct of the shift was the when she required medory out at times and market in the correct of the shift was the when she required medory out at times and market in the correct of the shift was the when she required medory out at times and market in the correct of the shift was the when she required medory out at times and market in the correct of the shift was the when she required medory out at times and market in the correct of the shift was the when she required medory out at times and market in the correct of	er due to moaning and continued to monitor the is at 6:00 am were: T 109, R 16 BP 124/70. //31/11 at 5:00 am 3 revealed Resident #2 in ND (no acute distress) aroused but drowsy, and ds because she was too moaning and crying out as in medication was t #2 would not squeeze the sked but she had some mitties as evident by pulling were trying to get her vital tress noted from previous e) to monitor." Vital signs 08, BP 139/84. In Nurse #3 on 9/30/11 at she (Resident #2) slept medication was ed "she (Resident #2) I was not sure how far for her, anytime I cared for e whole time. I did the ey were done every 2 told by the NAs she was as and was able to follow is her needs." Nurse #3 in first time I cared for her lication. She did moan and de facial grimacing; it that she was in pain. The	F.	ĺ	physician on call, call the call within 30 minu contacting the primary p for further instructions. The call phone number is 1-3214. This assessment should documented in the nursing the nurse will note any conchanges noted by other family Additionally, neurological assessments should completed any time there physician order, when causes an impact to the when there is an un-witness or any other time the	is calling cian, if if in should ithin 15 in of an es that a outlined in ephone in at each shysician hange of bove 24 a week. In a character of the error of hysician in error of	

for

neurological checks. -

	TO TOTAL BIOTAL G	WEDIONID SERVICES	· · · · · · · · · · · · · · · · · · ·			OMB N	√O. 0938-0391
STATEMENT AND PLAN C	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION	(X3) DATE S COMPL	ETED
		345519	B. Wil	√G		09	C /30/2011
NAMEOFP	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	
LIBERTY	COMMONS NSG & REH .	они		2	315 HIGHWAY 242 NORTH		
0/ 0/ 10	0.000.000		<u></u>		BENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Review of NN dated 7 completed by Nurse # was resting in bed and speech was somewhat comments. Pt (patient when asked but when nurse's hand; Residen nurse's hand. Pt. ate a meal. Her vital signs 1 Review of NN dated 7/completed by Nurse # checks continued and respond to verbal stimulattempted to verbally rund the province of the continued and respond to verbal stimulattempted to verbally rund the province of the continued and respond to verbal stimulattempted to verbally rund the province of the continued and respond to verbal stimulattempted to verbally rund the province of the continued and respond to verbal stimulattempted to verbally rund the province of the continued the neuro chaigns were okay, I did rund the neuro chaigns were okay.	/31/11 at 10:34 am 1 revealed that Resident #2 I appeared disoriented. Her t clear with rambling I will hold the nurse's hand asked to squeeze the t #2 would "pet" the pproximately 25% of am 28/68, 92, 18, 98.3. 31/11 at 2:35 pm I revealed the neuro she (Resident #2) would all by opening her eyes and espond. She continued to ". She did not eat her ff's encouragement. Proview with Nurse #1 wealed Resident #2 was her family member kept and get her to drink and eat. thought it was because a lot from the fall. I did not to notify the doctor. I ecks like ordered. Her vital not realize her pulse was fin from the hospital. " (who worked on 7/31/11 am and 08/01/11 from an 9/30/11 at 9:32 am inue to do the neuro aing. I was told in report by the #6) that it was no the #3 concluded the	I.	157	stuporous or comato Pupil response: Is resident's pupil equal reactive to light. document the response in each ey either brisk, sluggish reactive, pinpoint, d or fixed. Motor functions: Docu the hand grasp as equal, the right gr than left, left greater right, if the resider unable to participate hand grasp is ab Also document wh the resident is able move all extremities unable to move extremities then docu which extremities they able to move. Com this for the right arm arm, right leg and left	the the was seen and Also pupil ye as all and pupil ye as all and illated are than or if sent. ether to to left all ment y are plete, left leg,	
1993	revealed "I did not cont checks on Sunday ever the reporting nurse (Nu	inue to do the neuro ing. I was told in report by se #6) that it was no			which extremities the able to move. Com this for the right arm	y are plete , left	
		my documentation was		-	arm, right leg and left checking all that appl the resident is unabl	y. If	

		MEDICAID SEKVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		345519	8. WI	1G_	_	09/	C 30/2011
NAME OF PI	ROVIDER OR SUPPLIER	-		STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 007	00/2011
LIBERTY	COMMONS NSG & REH .	JOHN			2315 HIGHWAY 242 NORTH		
					BENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Sunday at night, I usu was sleeping. All her y did not realize her puls with the NAs and they like she usually did. I a baseline was. She had her to be groggy from the doctor, but told the condition." During an interview at Nurse #5 who cared for am -3:00 pm, she state acting herself; I told the Nursing) and thought a speak to the doctor. She was lethargic and not rewant to drink or eat and and lunch. She (Nurse put more information in her change in condition going to contact the dottnat morning." Review of the NN dated Nurse #4 revealed the loxygen and tried to succontacted the doctor and evaluation. During a telephone interes was unresponsive and wheeled and the doctor and evaluation.	ally only saw her when she rital signs seemed normal; I see rate was fast. I spoke said she was not acting am not sure what her if a head injury, I expected head injury. I did not notify noncoming nurse of her 7:07 am 09/30/11 with per resident on 08/01/11 7:00 and "the resident was not a DON (Director of the (the DON) was going to the revealed the resident eally herself, she did not direfused her breakfast #5) stated "I should have a my nursing note about any nursing note about any it thought the DON was gotor after I spoke to her d 8/1/11 completed by resident was found at 7:00 and making rounds to be eazing. The nurse applied tion the resident. She did sent her to the ER for riview with Nurse #4 on the did 3:00 pm -11:00pm on the #2 to ER) she stated the this resident." She	F	•	follow commands they are absent extremities indicate t well. Pain response: Docum the resident has appropriate pain response or no response. Vital Signs: Docum blood pressure, respirations temperature Observations: Docum any addit observations such seizure, head vomiting or paralysi Sign you name in t indicated on the form Complete an incident, accide risk management report facility policy. Notify resident's responsible If a new order is received physician then the order be documented by the num received the order of telephone order sheet. The order should be transcrift medication administration or treatment administration as appropriate depending	any hat as nent if s an conse, pain pain ument pulse, and ument itional as lache, is he box m. dent or rt per party. by the should se who n the hen the bed to record on the non- orders	
-	•	• • •	1		type. This transcription sho	ould be	

		MEDIOVID OFIVAICES				- OMR V	O. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE S COMPLE	
			8. WIN	IG.			С
		345519		· · · · ·		09/	30/2011
NAMEOFP	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NSG & REH.	лног		2	2315 HIGHWAY 242 NORTH		
				E	BENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X6) COMPLETION DATE
F 157	alert, she was talking According to the NAs did before she fell. Nu medication pass at ab hear Resident #2 whe She went and got O2, She stated "I was cordinner that evening by that she could have as she called the doctor at the hospital. Resident #2 was sent evaluation of unresportal unresponsiveness date complaint: unresponsivaltered mental status, confirming focal lingular	incoherently like a mumble, she was not acting like she rse #4 indicated during her out 7:00 pm, she could ezing from her room door, and put it on the resident, accrned that she was fed ther family. My thought was spirated." She continued and the resident was sent to the ER on 8/1/11 for asiveness. Records for treatment of ed 08/02/11 read: Chief	receiving the order. nurse is to complete a c every night where ever reviewed for new order orders (within the last are identified the night s is to verify that the c transcribed appropriate medication/treatment r implemented appropriat problem or concern is then the night shift nu notify the Director of Nu morning by either phon placed in the Director of box at the nursing station • Any concerns identified			r. The a chart chevery chair rders. If ast 24 ho pht shift number order riately to the record priately. the is identificately the order or record for the cord fo	11-7 neck rt is new urs) urse was the or lf a fied nust that note og's this or
	3:45 pm revealed her estaff was that when a refrom the hospital; the rehead to toe assessment if necessary start neurofacility policy for 48 hounurse or staff are to not call nurse, DON or mystoncerns about the resorders. The neuro check Sunday evening. The factorial resorders are staff and the resorders are staff and the resorders. The neuro check Sunday evening. The factorial resorders are staff and the resorders are staff and the resorders.	inistrator on 09/29/11 at expectation of the nursing esident was readmitted urse would complete a at of the resident and also ochecks to be done per ers. Most importantly, the ify the physician, the onelf if they have any idents status and /or ks were stopped on acility policy is that the for 48 hours and changes		;	An in service on 9-30-2011 provided to the Nursing Assista Staff Development Coordinator Consultant, Nurse manager and Coordinator to report any changer resident to the nurse on the unidentified (see attachment B). development coordinator will er any nursing assistant who does complete the in-service training 9/30/2011 will not be allowed to	has been ants by the control of the staff as soon a control of the staff as the sta	9 S

		MEDICAID SERVICES				OMB N	O. 0938-039
STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
							С
<u> </u>		345519	B. WIN			ļ	30/2011
	ROVIDER OR SUPPLIER COMMONS NSG & REH	Ј ОНИ		2	REET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH		
	1		,	LE	BENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 157	supervisor." During an interview wi 09/30/11 at 6:10 am re understanding that the of any changes becau DON that Resident #2 admitting nurse to be a mentation when she red indication of that asset and she would have expected the doctor of the mental status changes behavior.	ith Administrator on evealed it was her ephysician was not notified se she was told by the was assessed by the at her baseline for eturned from the hospital. Exords, there was no essment or documentation expected the staff to have the change in Resident #2's or changes in her	ľ.	157	completed this training. This incorporated into the new er orientation. This information has been in standard orientation training required in-service refresher employees and will be review Quality Assurance Process to change has been sustained. Quality Assurance A quality assurance	s in-service integrated in and in the courses fo wed by the to verify tha	was cility to the ar all the
	(DON) on 09/29/11 at a was made aware durin meeting (administrative resident had a head inj hospital and got stitche facility on the same day actually the nurse who the hospital who is resident, transcribe the to the appropriate place the physician the resident facility. That nurse is all sure she informs the or concerns about the resthe resident returned for the on-call nurse can of contact the physician if indicated it was ultimate responsibility to make scondition were reflected.	as and was returned to the y." The DON stated "It is admitted the resident from consible to assess the orders from the hospital es in the chart and notify ent had returned to the so responsible to make a-call nurse if she had any ident's condition or orders om the hospital with, so arify these things and necessary. She further ely the DON's ure changes in resident		, 	completed five times a weel by the Administrator or Dire and then will continue we months and then monthly u the Quality Assurance Commof_the_MD_notification audit_the director of nursing to the of Life- QA committee and contitated as appropriate. The committee consists of the Nursing, Administrator, State Coordinator, Dietary Mar Nurse, Minimal Data Assessand Support Nurse and Head Management and meets ween This monitor will include revier residents who went to the emor hospital charts to ensure the physician was notified of any condition when they were first	ector of Nu eekly for intil resolve nittee. Re will-be-give e weekly Qu corrective a e Quality of ne Director ff Develope nager, We ssments N alth Informa ekly ewing all nergency ro nat the changes in	rsing three ed by ports en-by uality ction f Life r of ment ound lurse ation

PRINTED: 10/18/2011 FORM APPROVED

	····	T OENTIOLO				OMB N	<u>O.</u> 0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE St COMPLE	URVEY TED
		345519	B. WIN	ខេ		09/	C 30/2011
	ROVIDER OR SUPPLIER COMMONS NSG & REH	JOHN		2	REET ADDRESS, CITY, STATE, ZIP CODE 315 HIGHWAY 242 NORTH BENSON, NC 27504		0072013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPIRECT (CROSS-REFERENCE)	OULD BE	(X5) COMPLETION DATE
F 157	of any changes or new contact the physician changes. The nurses physician if they feel the resident's condition reviewed the chart after the hospital on Monda assessment of the resident, but the staff of She continued "the assessment of the staff of She continued "the assessment of the resident, but the staff of She continued "the assessment of the resident was from the hospital. Accordinately acting different to the hospital. The nurdoctor or the on-call nuror concern. No one toleron.	w needs of the resident and to inform him of any were also to notify the here were any changes in n. She stated "as I er the resident was sent to by, there was no ident when she returned there was a change in did not notify the doctor." assessment should have ne nurses) had a picture of like when she returned ording to the NN she was ently from before she went reses should have called the larse if they had a question did me they had a concern mental status changes until	E	157	by staff, if the physician restaff notified the medical d call if needed. This review on 100 % of residents who emergency room or hospital attachment C).	irector and will be con go to the	RN on
	09/29/11, UM #2 indica a unit manager was to reviewed the charts whadmission, re-admission sure all the orders were (referring to resident #2 critical care meeting on after the DON had revies tated "the DON usual to make sure everything referrals, treatments and they reviewed the charts and they reviewed the charts and they reviewed the charts and they reviewed the charts and they reviewed the charts and they reviewed the charts and they reviewed the charts and they realized the reviewed the charts and they reviewed the charts and they realized the reviewed the charts and they reviewed the charts and they reviewed the charts and they reviewed the charts and they reviewed the charts and they reviewed they re	tenever there was an on or new orders to make the clarified. The chart of the chart of the was reviewed during the worden was the chart first. She was in place; like orders, of physician notifications of the chart of the critical care of the orders of the orders of the orders of the orders of the orders of the orders of the head		e provincia de la companya de la com			

PRINTED: 10/18/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 345519 09/30/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH LIBERTY COMMONS NSG & REH JOHN BENSON, NC 27504 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 157 Continued From page 11 F 157 TAR (Treatment Administration Record), there was no assessment of the resident's change in status from the nurses and the doctor was never notified." Interview with the Physician on 09/30/11 at 11:45 am revealed he was unaware Resident #2 had a fall or was returned back to the facility. He stated "the staff should have contacted me if there was a change in the resident's condition (example: change in vital signs, pain, sleepiness, lethargy, poor appetite, difficult to arouse, anything that was different from her baseline behavior). They (the nurses) received discharge orders/instructions from the hospital and they stated to contact the physician immediately if there was a change. She was diagnosed with a concussion; I would have expected them to call me." The Administrator was notified of the Immediate Jeopardy on 9/29/11 at 12:45 pm. The facility presented a credible allegation of compliance on 9/30/11 at 3:41 pm which included: "Resident # 2 was discharged to the hospital on 8/1/2011. On 7/30/2011, she sustained a fall and

and was sent to _

was treated at the emergency room. She returned to the facility on 7/30/2011 with orders for the staff nurses to complete neurological checks per facility protocol for 48 hours and a diagnosis of concussion. On 8/1/2011 at 8:30 PM, she was noted to have respiratory distress

_(name of hospital)

PRINTED: 10/18/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С B. WING 345519 09/30/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH LIBERTY COMMONS NSG & REH JOHN BENSON, NC 27504 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 157 Continued From page 12 F 157 where she was admitted and later died from aspiration pneumonia. On 8/11/2011 in-service training was completed by the Director of Nursing and staff development. All staff nurses attended this in-service. The exact in-service included: "In-service 8-9-11 Neurochecks are done as ordered. If you have a resident with a head injury there must be done using the flow sheet that is attached. Any changes in neuro status, the MD, must be notified. Checks are q 15 mins x1 hour, q30 mins x 1 hour q hour x 4 hours, q4 hour x 24 hours. When orders are received, the nurse transcribing should initial and date on the MAR. If received at the end of month, it should be transcribed on new month MARS's as well. Weekly charting and vital signs is to be done on every resident. Documentation is to be done on any change in condition, medication, or education. This is to be done prior to leaving your shift. Any change of condition, or medication that is reported, should be written on 24 hour acute charting sheet as well. Third checks should be completed on all orders. Falls witnessed and unwitnessed, neuro checks must be done. Any change in mental status must be followed up with Physician and RP Notified. Family R/P must be notified on all incidents. Medication changes or change in condition When notifying the residents RP, you are to only use the facility phone. Cell Phone use during work hours is prohibited. (Please refer to policy). Nurses are to do walking rounds with your report sheet and if there is an incident or if it is reported

to the oncoming nurse, it must be placed on the 24 hour report sheet. Documentation must be

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345519	B. WNG			С	
	ROVIDER OR SUPPLIER		231	T ADDRESS, CITY, STATE, ZIP CO 5 HIGHWAY 242 NORTH NSON, NC 27504		30/2011	
(X4) ID PREFIX TAG	_ (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	done in the residents All residents are poter practice. On 9/29/201 the supervision of unit staff development coor current residents for content the attending physicia of any identified change were assessed and 4 in conditions. The attending the staff received and implement Resident who was expand loose stools and rephenergan, immodium intravenous fluids and who complained of paintravenous fluids and rehydrocortisone, bened heparin, and foley cathexperiencing some half an order to be evaluated on 9/30/2011. Order of implemented by the staff in the physician staff nurse assigned to instructions/orders. The following: Observing for laceration	chart. " Intially affected by this Intially affected by this Intially affected by this Intially affected by this Intially affected by this Intially affected by this Intially affected by this Intially affected by this Intially affected by the Intially affected by the Intially affected by the Intially affected by the Intially affected by the Intially affected by the Intially affected by the Intially affected by the Intially affected by the Interior and Intially affected Intially affected by the Intially affected by the Interior affected by the Interior affected by the Interior affected by the Interior affected by the Interior affected by the Interior affected by the Interior affected by the Interior affected by the Interior affected by the Interior affected by the Interior affected by the Interior affected by the Interior affected by the Interior affected by the Interior affected by the Interior affected and Intialnage. Intially affected by the Interior affec	F 157				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
·		345519	B. WING_		C 09/30/2011		
	ROVIDER OR SUPPLIER COMMONS NSG & REI		s	TREET ADDRESS, CITY, STATE, ZIP CO 2316 HIGHWAY 242 NORTH BENSON, NC 27504		-0.2011	
(X4) ID _PREFIX TAG	EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	COMPL DAT	
	precipitating factors, ended. Also chart widifficulty breathing. Observing and inquiror pain. Observing for persor Observing for alterat Observing for sensor Observing for sensor Observing for general Observing for gait, pour observing for proper stimuli). Observing for abdomn Observing for bleedir Observing for unequal Observing for dyspnerespirations (irregular Observing for flushing Observing for abducting for position of each of the observing for pain. Observing for abducting observing for abducting for position of each of the observing for abducting for position of each observing for abducting for position of each observing for abducting for position of each observing for abducting observing for point of each observing for abducting observing for point observing for abducting observ	duration, vital signs and time nether or not resident had re if resident has headache nality changes. ions in consciousness. inence. Ty weakness. alized weakness. alized weakness. a disorder. csture or balance disorder. ck. reflexes (response to painful inal spasm or pain. all pupils. ea or variations in cy.). g or cyanosis. ion, adduction, shortening or extremities. ithe nursing assistant staff development ager, the nurse consultant	F 15				
i i i i i i i i i i i i i i i i i i i	and the administrator obysician and how to changes. 24 out of 30 his education. The exollows: Credible Allegation Infer all resident falls,	how to contact the document significant I staff nurses have received eact in-service content is as			TANAN AND AND AND AND AND AND AND AND AND		

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		345519	B. WING	3		C 09/30/2011		
	ROVIDER OR SUPPLIER COMMONS NSG & RE			STREET ADDRESS, CITY, STATE, ZIP CO 2315 HIGHWAY 242 NORTH BENSON, NC 27504	DDE	09/30/2011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE		
	Observe for laceratic apply dry, sterile dreamount of bleeding Observe for swelling chart size, site, amo Observe for convuls precipitating factors ended. Also chart will difficulty breathing. Observe and inquire pain. Observe for personation observe for alteration Observe for alteration Observe for sensory Observe for sensory Observe for speech Observe for speech Observe for stiff neco Observe for proper restimuli). Take vital signs and Observe for bleeding Observe for unequal Observe for lushing Observe for gain. Observe for flushing Observe for flushing Observe for pain. Observe for abduction improper position of other standards of the proper position of the proper grant of the promptly (within 15 means assessment that of the proper position of the promptly (within 15 means assessment that of the proper position of the promptly (within 15 means assessment that of the proper position of the promptly (within 15 means assessment that of the proper position of the promptly (within 15 means assessment that other proper position of the promptly (within 15 means assessment that of the proper proper proper proper proper promptly (within 15 means assessment that of the proper pro	g every shift for 72 hours: ions; if present, clean and essing. Note size, depth and or drainage. g and discoloration; if present, ount and color. ions; chart time began, duration, vital signs and time hether or not resident had e if resident has headache or ality changes. ons in consciousness. ence. weakness. disorder. sture or balance disorder. k. efflexes (response to painful include temperature. nal spasm or pain. g from ears, nose, throat. pupils. or variations in respirations or cyanosis. in, adduction, shortening or extremities. with the resident while the	F 1	57				

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUIL		CONSTRUCTION	(X3) DATE : COMPL	
		345519	B. WIN	G			C
	ROVIDER OR SUPPLIER	ЈОНИ	L	2315	T ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 242 NORTH ISON, NC 27504	09	/30/2011
(X4) ID	SUMMARY ST/	TEMENT OF DEFICIENCIES	ĮD.		PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREEIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
	physician should be calcondition as outlined a days a week. This proto to time or day of the was a week. This proto to time or day of the was a week. This proto to time or day of the was a week. This proto to time or day of the was a minutes of contacting further instructions. The number is 1-919-820-32. This assessment shound the number is 1-919-820-32. The nurse will note any noted by other staff or Additionally, neurologic completed any time the when a fall causes an inthere is an un-witnesse nurses deems necessed document using the for Neurological checks shour times 4 hours and of 48 hours. A neurological checks shour times 4 hours and of 48 hours. A neurological checks shour times 4 hours and of 48 hours. A neurological checks shour times 4 hours and of 48 hours. A neurological checks shour times 4 hours and of 48 hours. A neurological checks shour times 4 hours and of 48 hours. Date and time the asset Level of Consciousness drowsy, stuporous or conceptive to light. Also diresponse in each eye a non-reactive, pinpoint, of Motor functions: Documenther equal, the right grithan right, if the resident is a whether the resident is a weekling than and grasp is abserved.	e physicians are in the ach nurses station. The alled for any change of above 24 hours a day and 7 ocess does not change due eek. ach the attending physician i, call the RN on call within ng the primary physician for e RN on call phone in the interest of the accumented in the interest of the head, when it is an physician order, in the interest of the head, when it is an physician order, in pact to the head, when it is an physician order, in pact to the head, when it is an physician order, in pact to the head, when it is an physician order, in pact to the head, when it is an every shift for a total gical assessments. It is resident alert, or a total gical assessments is ssment was completed every then every shift for a total gical assessments. It is resident alert, or atomatose resident's pupil equal and ocument the pupil is either brisk, sluggish, dilated or fixed. In the hand grasp as reater than left, left greater it is unable to participate int. Also document	F	157			

PRINTED: 10/18/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345519	B. WING		09	C //30/2011
	ROVIDER OR SUPPLIER COMMONS NSG & RE	н Јони	2315	T ADDRESS, CITY, STATE, ZIP CO HIGHWAY 242 NORTH ISON, NC 27504	•	
(X4) ID PREFIX – TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X6) COMPLETION DATE
F 157	Continued From pa	ge 17	F 157			
	move. Complete the right leg and left leg the resident is unable they are absent any well. Pain response: Documers and ten observations: Documers and ten observations such a vomiting or paralysis Sign you name in the Complete an incider management report Notify resident's results a new order is recthe order should be	ent blood pressure, pulse, nperature ument any additional is seizure, headache, s e box indicated on the form. nt, accident or risk per facility policy.				
	medication administ administration record on the type of order. non-medication/trea initiated based on or should be completed the order. The 11-7 check every night will for new orders. If ne hours) are identified verify that the order to the medication/tree implemented appropicancern is identified must notify the Direct order.	tment orders should be der type. This transcription d by the staff nurse receiving nurse is to complete a chart here every chart is reviewed lew orders (within the last 24 the night shift nurse is to was transcribed appropriately				

FORM APPROVED

PRINTED: 10/18/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPHER/CHA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С B. WING 345519 09/30/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH LIBERTY COMMONS NSG & REH JOHN **BENSON, NC 27504** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ΙD ___(X5) COMPLETION (EACH DEFICIENCY MUST-BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 157 Continued From page 18 F 157 Nursing's box at the nursing station. Any concerns identified by this audit will be corrected or addressed by the Director of Nursing and will be reviewed weekly at the Quality Assurance Committee Meeting describe in this document. The staff development coordinator will ensure that any staff nurse who does not complete the in-service training by 9/30/2011 will not be allowed to work until the training is completed. This in-service was incorporated into the new

employee facility orientation. An in service on 9-30-2011 has been provided to the Nursing Assistants by the Staff Development Coordinator, Nurse Consultant, Nurse manager and MDS Coordinator to report any changes to the resident to the nurse on the unit as soon as identified. The staff development coordinator will ensure that any nursing assistant who does not complete the in-service training by 9/30/2011 will not be allowed to work until the training is completed. 32 out of 69 have completed this training. This in-service was incorporated into the new employee facility orientation. A quality assurance monitor will be completed five times a week for two weeks by the Administrator or Director of Nursing and then will continue weekly for three months and then monthly until resolved by the Quality Assurance Committee. Reports of the MD notification audit will be given by the director of nursing to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Dietary Manager, Wound Nurse,

Minimal Data Assessments Nurse and Support

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/18/2011 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WNG 345519 09/30/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH LIBERTY COMMONS NSG & REH JOHN BENSON, NC 27504 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 157 Continued From page 19 F 157 Nurse and Health Information Management and meets weekly. This monitor will include reviewing all residents who went to the emergency room or hospital charts to ensure that the physician was notified of any changes in condition when they were first documented by staff, if the physician responded and if the staff notified the medical director and RN on call if needed. This review will be completed on 100 % of residents who go to the emergency room or hospital. Completion Date: 9/30/2011 Validation of the credible allegation of compliance was done on 09/30/11 from 3:58 pm to 5:15 pm. Validation of the credible allegation of compliance was done on 09/30/11 from 3:58 pm to 5:15 pm. Interviews with nurses and nursing assistants and licensed nursing staff confirmed they had received training on 09/30/11 on nursing assessment, use of the new neuro check policyfor assessment and when/ whom to notify for acute changes in resident condition. Documentation of training, auditing and new F 309 protocols was reviewed. Corrective Action for Resident Affected: Immediate Jeopardy was removed on 09/30/2011 at 6:39 pm. For Resident # 2 who was discharged to 483.25 PROVIDE CARE/SERVICES FOR F 309

and plan of care.

HIGHEST WELL BEING

Each resident must receive and the facility must

provide the necessary care and services to attain

accordance with the comprehensive assessment

or maintain the highest practicable physical, mental, and psychosocial well-being, in

Affected:

F 309

the hospital and deceased.

Corrective Action for Resident Potentially

be affected by the alleged deficient practice.

All resident's have the potential to

	CENTERS FOR WEDICARE & I				···	OMB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
			B. WA				С	
11115050		345519		·		09/3	30/2011	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
LIBERTY	COMMONS NSG & REH	JOHN		1	2315 HIGHWAY 242 NORTH			
240.15	0.11.11.15.1.0-			L t	BENSON, NC 27504			
(X4) ID PREFIX	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y-MUST BE PRECEDED BY FULL	ID PREF	ıx-	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLE)		(X5) COMPLETION	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRODEFICIENCY)		DATE	
F 309		F	309	All residents are potentially at practice. On 9/29/2011, the cwith the supervision of unit mourse and staff development.	harge nurs anager, Mi	ses DS		
		is not met as evidenced			assessed all current residents	for chang	es in	
	by:	ew, staff and physician	İ		conditions and the attending	hysician v	vas	
	interviews, the facility			notified immediately of any ide	entified			
	mental status and noti			changes. 92 out of 92 reside assessed and 4 were noted to	nts were	nao		
	resident (Resident #2)	when Resident #2			in conditions. The attending p	hvsicians	119c	
	exhibited sleepy, letha	argic and inappropriate			were contacted by the staff no			
	fall which resulted in a	ing from the hospital post			orders were received and imp	lemented.		
		to the forehead. This was			This included a 1. resident wh			
ļ		ents in the survey sample			experiencing nausea, vomiting	g and loose	e	
	that had a change in s	tatus.			stools and received orders for immodium, clear liquid diet, in	travenous	n,	
	Immediate jeopardy be	egan on 7/30/11 when she			fluids and rocephin 2. Reside	ent who		
,	returned to the facility	from the hospital with		ĺ	complained of pain, and was i	nedicated	for	
		sion and laceration to the	1		pain, and received orders for			
	torenead after she fell	ell at the facility. The jeopardy			analysis and culture, 3. Reside			
1	of compliance at a sco	The facility remains out pe and severity level D (no			developed rash and received hydrocortisone, benedryl, prev		\id	
	actual harm with poten	tial for more than minimal			heparin, and foley catheter 4.	resident v	who	
ĺ	harm that is not immed	liate jeopardy) to ensure			was experiencing some halluc			
	monitoring of systems	put in place and			received an order to be evalua-	ited by		
İ	completion of employe	e training. Findings		ı	physician elder care on 9/30/2	011. Order	r	
	included:				obtained have been implemen	ted by the		
	Pavious of the Cooling	Policy for Navan Charles			staff nurses. These resident	will remain	on	
	nursing dated 10/01/01	Policy for Neuro Checks for revealed the purpose of			the acute charting list and will	be assess	ed	
	the policy is to assess	the patient's condition and		- 1	every shift for 72 hours after tr	eatment ha	as	
	stability and to provide	pertinent information to the			stopped. If improvement is no			
	physician. Observation	s should note the			24 hours the physician will be staff nurse assigned to the res	contact by	ine	
	presence or absence o				follow up instructions/orders.	iu c ni IVI Thie		
		ific conditions were not			assessment includes the follow	niua. Euro		
	identified in the policy.				accoontain moldade (16 folloy	mig.		
	Resident #2 was readm	nitted to the facility on						

OLITICAL.	TO F OR WEDIOARE &	MEDIOVID OFFICES	,		~	OMB	NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	lultip Lding	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345519	8. WI	∤G			C
NAME OF PI	ROVIDER OR SUPPLIER			1		08	/30/2011
	TO TIDE! OF OUT I EIE!				EET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NSG & REH	JOHN		1	315 HIGHWAY 242 NORTH		
				В	ENSON, NC 27504		
(X4) ID		ATEMENT OF DEFICIENCIES	αı	ı	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PRÉFIX TAG	REGULATORY OR	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR		COMPLETION DATE
			IAC	.	DEFICIENCY)	OPRIATE	2.112
F 309	Continued From no se	- 04		-	o Observing for laceration	ns: if	
1 309	1 pag.		F	309	present, clean and		İ
	6/17/11 with cumulati	ve diagnoses which included			dry, sterile dressing.		}]
	Late Effect CVA (cere	ebral vascular accident) with		ĺ	size, depth and amou		
	left sided Hemiplegia,	Chronic Kidney Disease			bleeding or drainage.	ant Or	
	(Stage IV) and Atrial I	ribriliation.			o Observing for swelling	ı and	
	Davidson of the	1 1150/ 1		Ì	discoloration; if pre		
		rly MDS (minimum data			chart size, site, an	ount	1
		d 6/30/11 revealed Resident			and color.	lount	
	#2 was alert to persor	n and time, able to make her		İ	 Observing for convuls 	lone	
	from the stoff for ADL	uired extensive assistance	:		_	•	
	HOW THE STAIL TO ADE	s (activities of daily living).		1		egan, ctors,	
	Review of the Nurses	Notes (NN) dated 7/30/11			precipitating facturation, vital signs		
		ne resident was observed			time ended. Also		1
		d on her left side in front of	1	l			[
		of bright red blood was			whether or not res		
		nd to the forehead. This		ļ	had difficulty breathin		
		pressure and ice was		İ	o Observing and inqui		
		eding. A 3 centimeter (cm)			resident has headacl	ne or	
		to the forehead. Resident			pain.	114	1
		emperature at 98.7 degrees	` .		o Observing for person	nality	
		at 54 beats per minute,			changes.		1
-		aths per minute and blood		!			
	pressure reading of 96	6/40. A medical emergency			 Observing for alteration 	ns in	-
	service of 911 was sur	mmoned and transferred			consciousness.		
1	the resident to the hos				o Observing for incontine		
ľ		•	ĺ			nsory	
	An interview on 9/29/1	1 at 6:30 am with nurse #7	ļ		weakness.		
1	who responded to Res	sident #2 on 7/30/11			 Observing for general 	alized	i i
	indicated he heard the	nursing assistant (NA) call			weakness.	_	
		the nurses' station and				oeech	
	saw Resident #2 on th				disorder.]]
	facing down, and he sa	aw red blood on the floor.			 ○ Observing for gait, po 	sture	
1	He applied pressure a	nd ice to her forehead. He			or balance disorder.		
	stated she was moanir	ng and "I explained to her			 Observing for stiff neck 		
		r head." The NA (nursing				roper	
		the resident and another			reflexes (response	to	
		reep her still. He stated "I			painful stimuli).		
'	was surprised that she	fell because she never			 Observing for abdo 	minal	
					spasm or pain.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345519	B. WING_		C 09/30/2011			
	ROVIDER OR SUPPLIER COMMONS NSG & REH	JOHN	s	TREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504	00/00/2011			
(X4) ID PREFIX- TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION			
F 309	tried to get up or move continued "the whee against the wall to the brakes were locked. fell. When she was ly lying towards her left from her previous street Review of the NN data completed by Nurse returned to the facility Review of the Hospita Orders/Instructions re	re out of her wheelchair." He Ichair was sitting upright e nurses' station and the I do not understand how she ring on the floor she was side, which is her weak side oke." ted 7/30/11 at 12:05 pm #1 revealed the resident	Observing for bleeding from ears, nose, throat. Observing for unequal pupils. Observing for dyspnea or variations in respirations (irregular). Observing for flushing or cyanosis. Observing for pain. Observing for abduction, adduction, shortening or improper position of extremities. Taking vital signs by the nursing assistant					
		f1 revealed the resident was t, no active bleeding with		Systemic Changes On 9/29/2011 and 9 staff nurses were in-servic development coordinator, unit nurse consultant and the admi	ed by staff manager, the			
	am with Nurse #1, where from ER [emergency readmitted the reside how she looked, [regalany other bruises that notes, she looked tire Resident #2 was slee she returned from the large bump on her for dressing on it. She in short synopsis narration orders/instructions from the get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital, no one cannot get a report [referent the hospital]	nt but I do not remember arding her mental status] or n what I documented in my d." Nurse #1 stated ping the whole time when hospital. Her face had a ehead, stitches with no dicated she reviewed the	to contact the physician and how to document significant changes. 24 out of 30 staff nurses have received this education (see attachment A). The exact in-service content is as follows: Credible Allegation In-service • After all resident falls, injuries or changes in physical or mental function, the charge nurse will monitor the following every shift for 72 hours: • Observe for lacerations; if present, clean and apply dry, sterile dressing. Note size, depth and amount of bleeding or drainage.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		346519	B. WING			C 30/2011
	DER OR SUPPLIER	Ј ОНИ		STREET ADDRESS, CITY, STATE, ZIP CODE 2316 HIGHWAY 242 NORTH BENSON, NC 27504	•	00/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST-BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE
bai col we that her do: any ind sig sta the eve res Col Res fror Nul ER Nul boo she indi con just exp	ncussion, how to close very generic directly generic directly generic directly. I know in see of Tylenol #3, are sything to do with he dicated the nursing and after the united to do the neuron every 15 minutes for the rest of my uno check sheet." So any other weekend, idents normal behavious of the hospital as store #1 indicated the street of the resident would returned from the hospital as store #1 indicated the street of the resident would returned from the intention of the returned from the returned from the returned from the returned from the sected the resident would return the physician in the returned from the	cated what to look for with a ean the laceration, they betions. I thought it was odd k so soon after sustaining a the hospital they gave her a ad I am not sure if that had r being sleepy." Nurse #1 assistant (NA) got her vital hit manager came in "I checks." "I think I did so for the first hour then he next 2 hours then every shift. I documented on the he continued "I only work so I really did not know this evice or alertness." ith Nurse #1 indicated llow commands upon return he did prior to the fall. It is after her return from the interest resident when hospital. This nurse eeel it was necessary to because the resident had hospital, so Nurse #1 to be tired. Ith NA #5 on 9/30/11 at 3:15 day (7/30/11), Sunday (8/1/11) during the day ident #2, she stated "she y different when she came stayed in the bed and	F 30	discoloration; chart size, site and color. Observe for co chart time precipitating duration, vital time ended. A whether or no had difficulty bre Observe and i resident has he pain. Observe for alter consciousness. Observe for incont Observe for gr weakness. Observe for gr weakness. Observe for gr weakness. Observe for gr odisorder. Observe for stiff ne Observe for prope (response to stimuli). Take vital signs an temperature.	if present, e, amount envulsions; began, factors, signs and also chart t resident eathing. nquire if adache or ersonality rations in inence. sensory eneralized speech costure or ck. r reflexes painful d include bdominal ing from	

OCIVICIA.	O I OR WEDIOARE &	MEDICAID SERVICES				<u>OMR N</u>	<i>J.</i> 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		345519	B. WIN	IG		1	C 30/2011
NAME OF PE	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	-1	
LIBERTY	COMMONS NSG & REH	иноц		2	315 HIGHWAY 242 NORTH BENSON, NC 27504		
	01011110110			,			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	L ID	,	PROVIDER'S PLAN OF CORRECT		(X5)
TAG		SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				COMPLETION DATE
F 309	Continued From page	24	F	309			
	lunch, and I told the n		· '				
		and Nurse # 5 on Monday			 Observe for dyspne 	ea or	1
	"). NA #5 indicated on				variations in respir		
					(irregular).		
İ		eeding assistance with			o Observe for flushing	g or	
	meals was unusual.				cyanosis.	.g 01	
	Date Charles to	//00 / / / · · · · · · · · · · · · · · ·			∘ Observe for pain.		
	Review of NN dated 7					.atlan	
		2 revealed Resident #2 had				iction,	
	no signs and symptom				adduction, shorteni	~	
		esident #2 complained of			improper position	of	[
	pain at 7:00 PM, an as needed pain medication,				extremities.		
		istered and was effective.		•	Have someone stay with	the	
İ		d with respirations even and			resident while the nurse is o		
- 1		ecks continued. No falls			the attending physiciar		
		ital signs at 6:00 PM were			necessary. The physician s		
		pressure (BP) 138/73,			be called promptly (withi	n 15	
		ons (R) 19, and oxygen			minutes) after completion	of an	
	saturation 92%.		assessment that determines that a				
					change of condition has occi	urred.	
	During an interview on	9/30/11 at 2:55 PM with					
		7/30/11 (3-11 PM) she			The phone numbers for	or the	
		#2) appeared to be tired]		physicians are in the rol		1
		oout 50% of her dinner, but	1		located at each nurses		
	the NA informed me st				The physician should be ca		
		uragement, and her family		•	any change of conditi		. 1
		ning about 8:30 pm, I think	}				· 1
	because she had pain	in her head. She took her			outlined above 24 hours a c		ŀ
	meds, but was unable	to describe where the pain			7 days a week. This proces		l
		shake her head to indicate			not change due to time or	aay of	
	her head hurt. It was o				the week.	_	Ì
		out the way she acted and		•	If you are unable to rea		
		ht it was from the bump on			attending physician o		
					physician on call, on c	all RN	
	her head. I told the oncoming nurse (Nurse # 3) about her behavior during report. I did the neuro checks and documented them, I did not notice				within 30 minutes of con	tacting	
					the primary physician for		
		itals signs]." She indicated			instructions. The RN on call		
					number is 1-919-820-3214.	PHOTIC	f
1	even mough she had a	poor appetite, needed		1	114111001 10 1-010*020*0214,	Ì	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCT A. BUILDING	TION	(X3) DATE SUI COMPLET	
		345519	B. WING		1	C 0/2011
	ROVIDER OR SUPPLIER	ЈОНИ	STREET ADDRESS, 2315 HIGHWAY 2 BENSON, NC 2		1 09/3	0/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES O'Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PF PREFIX (EAC	ROVIDER'S PLAN OF CORRECT OF CORRECTIVE ACTION SHO B-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	encouragement from complained of discor describe and slept a not think it was necesured and think it was necesured and think it was necesured and should also the courage her to eat more sedated than undeschair and ate hospital she was usus wheelchair and ate hospital she was usus wheelchair and ate hospital she was usus wheelchair and ate hospital she was usus wheelchair and ate hospital she was usus wheelchair and ate hospital she was usus wheelchair and ate hospital she was usus wheelchair and ate hospital she was and interview was 3:12 pm who also wo Sunday from 3:00 pm "The resident was verespond to me like she would smile at move to change hospital she was time to change hospital she was to be expected." Review of NN dated 7 completed by Nurse #easily aroused but did was sleepy. She moail	with NA #3 on 09/30/11 at did seary to call the doctor. " with NA #3 on 09/30/11 at did with Resident #2 on y; 3:00pm-11:00 pm shift. NA ent did not eat and I tried to a She slept a lot and she was sual. Before she went to the ally out of bed in her er meals in the dinning to (Nurse # 6), that she was be as hungry or eating like with NA #4 on 09/30/11 at riced on Saturday and the she had a sisted me when it er clothes. That weekend in any of her care. I told the she told me she had a aking pain medication, it with 11 at 2:32 am are as a sisted me when she couraged taking fluids or	The n chan famil Additi asse comp phys caus when or a deem shou for Neuro comp hours total asses follow	assessment sumented in the nursurse will note any orges noted by other light of the second of the se	concerns or her staff or her staff or heurological uld be there is an en a fall the head, tnessed fall the nurses The nurse g the form checks. should be r times 4 shift for a eurological les the les the was-lisness: Is drowsy, natose ls the equal and it. Also e pupil ch eye as gish, non-it, dilated	•

		L CENTROLO	1		V - 111 - 11	T CIVID IN	<u>U. 0936-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
			B. WN	IG			C
		345519		,		09/	30/2011
NAME OF PE	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NSG & REH .	IOHN		:	2315 HIGHWAY 242 NORTH		
					BENSON, NC 27504		
(X4) ID		ATEMENT OF DEFICIENCIES	ÌD		PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX		/ MUST-BE PRECEDED BY-FULL	PREF		(EACH CORRECTIVE ACTION SHOU		COMPLETION DATE
IAO	***************************************	SO DELTH THO IN ONIATION	TAG	•	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	UATE .
							1
F 309	Continued From page	26	F	309			
	#3 gave the resident r	pain medications per PRN					
		er due to moaning and			unable to participate	or if	
		continued to monitor the			hand grasp is ab		
	resident. Her vital sigr				Also document wh		
	(temperature) 98.7, P				the resident is able	to to	
					move all extremities	. if]
	Review of NN dated 7				unable to move	all	
		3 revealed Resident #2 in			extremities then docu	ment	
	bed resting quietly. NA				which extremities the	y are	
	noted. She was easily	aroused but drowsy, and			able to move. Com	plete	
		nds because she was too			this for the right arm	, left	
		moaning and crying out as			arm, right leg and lef		
	much as before the pa				checking all that appl		
		nt #2 would not squeeze the			the resident is unab		
		sked but she had some			follow commands	or if	
		emities as evident by pulling			they are absent	any	
		were trying to get her vital			extremities indicate th		1
		stress noted from previous e) to monitor." Vital signs			well.		1
İ	were T 97.4, R 16, P 1				o Pain response: Docum	ent if	
	WOIG 1 37.4, IC 10, F 1	100, DF 103/04.			the resident has	an	
]	During an interview wit	th Nurse #3 on 9/30/11 at			appropriate pain respo	onse,	
		she (Resident #2) slept			inappropriate	pain	
	most of the shift. Pain				response or no	pain	
		ted "she (Resident #2)			response.	-]
		d I was not sure how far			o Vital Signs: Docu	ment	
		for her, anytime I cared for	1		blood pressure, p	ulse,	
		ne whole time. I did the			respirations	and	
		ney were done every 2			temperature		<u> </u>
		told by the NAs she was			o Observations: Docu	ment	
		es and was able to follow			any addit	ional	
		s her needs." Nurse #3			observations such	as] [
		e first time I cared for her	1		seizure, heada	ache,	ļ l
		dication. She did moan and			vomiting or paralysis		
1	•	ade facial grimacing; it			o Sign you name in the	box	
) that she was in pain. The			indicated on the form.		
		arouse, I thought it was					
	from medication."				1		1

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDIN		С
		345519	B. WING _		09/30/2011
	COMMONS NSG & REH	JOHN		REET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504	
(X4) ID		TEMENT OF DEFICIENCIES	(I)	PROVIDER'S PLAN OF CORRECTI	
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
F 309	was resting in bed and speech was somewhat comments. Pt (patient when asked but when nurse's hand; Resider nurse's hand. Pt. ate at meal. Her vital signs 1. Review of NN dated 7. completed by Nurse # checks continued and respond to verbal stim attempted to verbally in the speech was somewhat the speech was speech was somewhat the speech was	/31/11 at 10:34 am 1 revealed that Resident #2 d appeared disoriented. Her at clear with rambling) will hold the nurse's hand asked to squeeze the at #2 would "pet" the approximately 25% of am 28/68, 92, 18, 98.3. /31/11 at 2:35 pm 1 revealed the neuro she (Resident #2) would uli by opening her eyes and espond. She continued to ". She did not eat her affs encouragement.	F 309	facility policy. Notify resident's responsib If a new order is received physician then the order be documented by the nureceived the order telephone order sheet. Order should be transce medication administration or treatment administration as appropriate depending type of order. Other medication/treatment should be initiated based type. This transcription stompleted by the staf	ort per le party. d by the r should urse who on the Then the ribed to n record n record g on the er non- orders on order hould be f nurse he 11-7 urt check
		vealed Resident #2 was		reviewed for new orders.	If new
	trying to wake her up a Nurse #1 stated "I jus she had been through think it was necessary continued the neuro of signs were okay, I did elevated since her retu. During an interview with 3:30 pm (who was famindicated Resident #2 feed herself meals in the fall).	necks like ordered. Her vital not realize her pulse was arn from the hospital. " th NA #6 on 09/30/11 at alliar with Resident #2) was able to independently the dining room (before the		orders (within the last 2 are identified the night shis to verify that the or transcribed appropriately medication/treatment reimplemented appropriate problem or concern is it then the night shift nurnotify the Director of Nursmorning by either phone placed in the Director of Novat the nursing station.	ift nurse der was to the cord or ly. If a dentified se must sing that or note
		3 (who worked on 7/31/11 am and 08/01/11 from			

AN SERVICES PRINTED: 10/18/2011
FORM APPROVED

1D SERVICES OMB NO. 0938-0391

CENTER	S FUR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPI ILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345519	B. WN	1G		09/30/2011	
NAME OF P	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NSG & REH	JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504				
(X4) ID	1	ATEMENT OF DEFICIENCIES	1		PROVIDER'S PLAN OF CORRE		
PREFIX TAG		Y MUST-BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE DATE	
F 309	11:00 pm to 7:00 am) revealed "I did not co checks on Sunday ev the reporting nurse (Nonger necessary." No interview by stating "I from the resident's reasonable and interview by stating "I from the resident's reasonable and interview by stating "I from the resident's reasonable and interview at the NAs and they like she usually did. I shaseline was. She had her to be groggy from the doctor, but told the condition." During an interview at Nurse #5 who cared from -3:00 pm, she statiacting herself; I told the Nursing) and thought speak to the doctor. Swas lethargic and not want to drink or eat an and lunch. She (Nurse put more information in her change in condition going to contact the dethat morning." Review of the NN date Nurse #4 revealed the pm while the nurse was unresponsive and who oxygen and tried to su	on 9/30/11 at 9:32 am ontinue to do the neuro ening. I was told in report by lurse #6) that it was no urse #3 concluded the All my documentation was actions on Saturday and rally only saw her when she vital signs seemed normal; I se rate was fast. I spoke a said she was not acting am not sure what her d a head injury. I did not notify the oncoming nurse of her at 7:07 am 09/30/11 with or resident on 08/01/11 7:00 red "the resident was not	F	309	Any concerns ident audit will be addressed by the Nursing and will weekly at the Qual Committee Meeting this document. The staff development will ensure that any st does not complete the training by 9/30/2011 allowed to work until to completed. This in-seincorporated into the facility orientation. An in service on 9-30-been provided to the Assistants by the Staff Coordinator, Nurse Condinator, Nurse Condinator, Nurse Condinator to report to the resident to the unit as soon as identified development coordinated that any nursing assist not complete the in-seincomplete	corrected or Director of be reviewed ity Assurance g describe in It coordinator taff nurse who e in-service will not be the training is ervice was new employee -2011 has Nursing ff Development onsultant, MDS any changes nurse on the fied. The staff ator will ensure stant who does ervice training be allowed to is completed. If this training This in-service of the new intation. egrated into the and in the courses for all ed by the	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

PRINTED: 10/18/2011

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO). 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SUR COMPLET	
		345519	B. WIN	G		1	C 0/2011
NAME OF PE	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NSG & REH	ЈОНИ		23	816 HIGHWAY 242 NORTH ENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIENG	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	9/30/11 at 5:20 pm (w 8/1/11 and sent Residershe was not familiar indicated Resident #2 when she initially saw alert, she was talking According to the NAs did before she fell. Numedication pass at abhear Resident #2 whe She went and got O2. She stated "I was cordinner that evening by that she could have a she called the doctor the hospital.	terview with Nurse #4 on worked 3:00 pm -11:00pm on Jent #2 to ER) she stated with this resident. " She is seemed to be doing ok, wher at 4:00 pm, she was incoherently like a mumble, she was not acting like she was not acting like she was not acting like she was fed during her wout 7:00 pm, she could be reciping from her room door, and put it on the resident, incerned that she was fed of her family. My thought was spirated. " She continued and the resident was sent to be seted neuro Check sheets for	t.	309	Quality Assurance A quality assurance completed five times a we by the Administrator or D then will continue weekly and then monthly until Quality Assurance Commithe this audit will be given nursing to the weekly Quality committee and corrective appropriate. The Quality consists of the Direct Administrator, Staff Coordinator, Dietary M Nurse, Minimal Data Assurand Support Nurse and H Management and meets w This monitor will in the charts (nursing notes, rassessment forms, physicial	eek for two prector of for three resolved litee. Re by the dir uality of L action initi of Life con tor of N Devel danager, sessments dealth Info reckly. clude revien	o weeks Nursing months by the ports of rector of ife- QA ated as mmittee Nursing, lopment Wound Nurse ormation ewing
	Resident #2 was sent to the ER on 8/1/11 for evaluation of unresponsiveness. Review of the Hospital Records for treatment of unresponsiveness dated 08/02/11 read: Chief complaint: unresponsiveness. "Admitted for altered mental status. The patient sustained a fall last Saturday (07/30/11), after which she was assessed, underwent a CT scan, which turned out to be negative. She was sent back to the facility awake, alert and oriented; however today (Monday) she was found to be unresponsive, where she is tachycardic. She was found to be in moderate respiratory distress, she underwent an x-ray confirming focal lingular infiltrates and a urinalysis showing evidence of a urinary tract			necessary documents to implementation of physic observation of 10 resider experienced an acute ep review. If 10 residents he experienced an acute ep review then any residents criteria will be reviewed. check to ensure that the appropriately assessed a changes in conditions. Tidentifying changes of co the physician and RN on properly implementing ar physician orders and conneurological assessment		verify an orders) and its who have sode since the last ve not sode since the last who meet this The review will staff nurses and responded to his will include aditions, contacting call if needed, d transcribing pletion of	

PRINTED: 10/18/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С B. WNG 345519 09/30/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH LIBERTY COMMONS NSG & REH JOHN BENSON, NC 27504 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ___(X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL) **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 309 Continued From page 30 F 309 infection. " Review of Consultation for Mental Status Changes completed on 8/2/11 read: "she fell off the wheelchair and suffered a laceration on the forehead. Discharged but not doing well. She was poorly responding, she barely opened her eyes on verbal commands. She was brought into the hospital for history of mental status changes. Resident #2 expired on 8/6/11 in the hospital. Interview with the DON (director of Nursing) on 09/29/11 at 3:30 pm, She stated "we (the administrative staff) are unable to locate the neuro check sheet used for this resident, this chart has been reviewed by a lot of people, we are checking to make sure it was not left with one of the consultants who reviewed the chart. " Interview with the Administrator on 09/29/11 at-3:45 pm revealed her expectation of the nursing staff was that when a resident was readmitted from the hospital; the nurse would complete a head to toe assessment of the resident and also

if necessary start neuro checks to be done per facility policy for 48 hours. Most importantly, the nurse or staff are to notify the physician, the on call nurse, DON or myself if they have any concerns about the residents status and /or orders. The neuro checks were stopped on Sunday evening. The facility policy is that the neuro checks are done for 48 hours and changes were to be reported to the doctor and the supervisor. We did an inservice about that issue, so the staff is aware of the facility policy for neuro checks and to document the resident condition

ON WILDIOMIL &	MEDICAID SERVICES			OMB N	O. 0938-0391
DEFICIENCIES DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i i		(X3) DATE SU COMPLE	JRVEY
	345519	B. WING)	00%	C
IDER OR SUPPLIER		<u> </u>			30/2011
	ЮНИ	ļ	STREET ADDRESS, CITY, STATE, ZIP CO 2315 HIGHWAY 242 NORTH BENSON, NC 27504	ODE .	
SUMMARY STA	TEMENT OF DEFICIENCIES	l in	PROVIDER'S PLAN OF	CORRECTION	(X5)
			(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	COMPLÉTION DATE
		F3	09		
e/30/11 at 6:10 am renderstanding that the had say changes becau ON that Resident #2 dmitting nurse to be a sentation when she re	evealed it was her e physician was not notified se she was told by the was assessed by the at her baseline for eturned from the hospital.				The state of the s
dication of that asses nd she would have ex otified the doctor of th	ssment or documentation xpected the staff to have ne change in Resident #2's				
ON) on 09/29/11 at a seas made aware during eating (administrative sident had a head inj	9:04 am the DON stated "i g the Monday morning e staff meeting) that the jury and went to the				THE PARTY OF THE P
cility on the same date sident's care (Reside ring the critical care anagers. In this meet aff) reviewed the chanit Manager) #1, who cility on 7/30/11 and ecks, "pt eval, use gair alarm and fall mait manager did an as a DON stated "It is a mitted the resident freponsible to assess the state of the computation."	y. "The DON indicated the ent #2) was discussed meeting with the unit ting we (administrative ent, and noticed the UM to was on-call, came to the wrote orders for neuro peri chair until pt eval, add to ", and I assumed the sessment of the resident. Eactually the nurse who from the hospital who is the resident, transcribe the lit to the appropriate places				
TO IT I THE TOTAL STATE OF THE	SUMMARY STA- (EACH DEFICIENCY REGULATORY OR L Ontinued From page early in their nurse's uring an interview with any changes because ON that Resident #2 direction of that assess that the direction of that assess that the direction of that assess that the direction of the entation when she redication of that assess that the doctor of the entation when she redication of that assess that the doctor of the entation when she redication of that assess that the doctor of the entation when she redication of that assess that the doctor of the entation when she redicated the doctor of the entation when she redicated the doctor of the entation when she redicated the doctor of the entation of that assess that is made aware during the made aware during the critical care anagers. In this meeting the critical care anagers. In this meeting the critical care anagers. In this meeting the critical care anagers. In this meeting the critical care anagers. In this meeting the critical care anagers. In this meeting the critical care anagers. In this meeting the critical care anagers. In this meeting the critical care anagers. In this meeting the critical care anagers. In this meeting the critical care anagers. In this meeting the critical care anagers. In this meeting the critical care anagers and fall mass the consistency of the critical care anagers. In this meeting the critical care anagers and the critical care anagers. In this meeting the critical care anagers are the critical care anagers. In this meeting the critical care anagers are the critical care anagers. In this meeting the critical care anagers and the critical care anagers are the critical care anagers.	MMONS NSG & REH JOHN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY-MUST BE PRECEDED BY FULL- REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 31 early in their nurse's notes " uring an interview with Administrator on 2/30/11 at 6:10 am revealed it was her nderstanding that the physician was not notified any changes because she was told by the ON that Resident #2 was assessed by the dmitting nurse to be at her baseline for entation when she returned from the hospital. Iter reviewing the records, there was no dication of that assessment or documentation and she would have expected the staff to have obtified the doctor of the change in Resident #2's ental status changes or changes in her	DEFICIENCIES DRRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MU 345519 DIDER OR SUPPLIER MMONS NSG & REH JOHN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY-MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Ontinued From page 31 early in their nurse's notes " uring an interview with Administrator on 1/30/11 at 6:10 am revealed it was her inderstanding that the physician was not notified any changes because she was told by the ON that Resident #2 was assessed by the direction of that assessment or documentation at dishe would have expected the staff to have elified the doctor of the change in Resident #2's ental status changes or changes in her shavior. Uring an interview with the director of nursing ON) on 09/29/11 at 9:04 am the DON stated "I as made aware during the Monday morning setting (administrative staff meeting) that the sident had a head injury and went to the spital and got stitches and was returned to the spital and got stitches and w	DEFICIENCIES (X1) PROVIDERSUPPLIER (CLA) 348519 STREET ADDRESS, CITY, STATE, ZIP CC 2316 HIGHWAY 243 NORTH BENSON, NC 27504 BENDAMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Ontinued From page 31 early in their nurse's notes " uring an interview with Administrator on y30/11 at 6:10 am revealed it was her addrestanding that the physician was not notified any changes because she was told by the ON that Resident #2 was assessed by the imitting nurse to be at her baseline for entation when she returned from the hospital. ter reviewing the records, there was no dictation of that assessment or documentation do she would have expected the staff to have infiled the doctor of the change in Resident #2's entat status changes or changes in her ihavior. Juring an interview with the director of nursing ON) no 9/29/11 at 9:04 am the DON stated "I as made aware during the Monday morning betting (administrative staff meeting) that the sident had a head injury and went to the signification of that and got stitches and was returned to the sident's care (Resident #2) was discussed inging the critical care meeting with the unit an agers. In this meeting we (administrative afting the critical care meeting with the unit an agers. In this meeting we (administrative firing the critical care meeting with the unit an agers. In this meeting we (administrative in the resident the int manager did an assessment of the resident, e DON stated "I the statual by the unit an agers. In this meeting we (administrative in the resident the content of the propriate places the chart and notify the physician the resident the feets from the hospital who is ponsible to assess the resident, tensorible the effects from the hospital to the appropriate places the chart and notify the physician the resident.	DEPICIENCIES (X1) PROVIDERSUPPLIER (ALL DILLIUM) 345519 STREET ADDRESS, CITY, STATE, 2P CODE 2316 HIGHWAY 242 NORTH BERSON, NC 27504 SUMMARY STATEMENT OF DEFICIENCIES EACH DEPICIENCH STATE, 2P CODE 2316 HIGHWAY 242 NORTH BERSON, NC 27504 SUMMARY STATEMENT OF DEFICIENCIES EACH DEPICIENCH STATE, 2P CODE 2316 HIGHWAY 242 NORTH BERSON, NC 27504 D PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES EACH DEPICIENCY OF LEG DEPICIENCIES EACH DEPICIENCY OF LEG DEPICIENCIES ON THE DEPICE OF THE CODE OF T

PRINTED: 10/18/2011 FORM APPROVED

CENTER	(S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-039 ²	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
							С	
		345519	B. WIN	1G ⁻	-	09/	30/2011	
NAME OF PR	ROVIDER OR SUPPLIER		•	s	TREET ADDRESS, CITY, STATE, ZIP CODE		***************************************	
LIBERTY	· COMMONS NSG & REH ·	IOHN			2315 HIGHWAY 242 NORTH			
LIDLINIT		JOHN			BENSON, NC 27504			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORE	ECTION	(X5)	
PREFIX— TAG		Y-MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF		COMPLETION DATE	
		,	170	•	DEFICIENCY)	THOTRIALE		
F 309	Continued From page	32	F	30	e			
	responsible to make s	sure she informs the on-call					1	
	nurse if she had any	concerns about the						
	resident's condition or	r orders the resident						
		pital with, so the on-call						
	,	e things and contact the						
		/. She further indicated it						
		N's responsibility to make						
	sure changes in resid	ent condition were reflected						
		sure the orders were clear						
	needs of the resident	e of any changes or new and contact the physician to						
		and contact the physician to nges. The nurses were also	·					
		if they feel there were any						
		nt's condition. She stated						
		art after the resident was						
		Monday, there was no						
•		ident when she returned						
	from the hospital and	there was a change in						
	resident, but the staff	did not notify the doctor. "						
	She continued "the as	ssessment should have	İ					
		ne nurses) had a picture of						
		like when she returned	-					
-		ording to the NN she was			1			
		ently from before she went						
		irses should have called the			`			
I		urse if they had a question						
		ld me they had a concern mental status changes until						
	after she went to the h							
İ	atter sile werk to the h	ioapitai.						
	During an interview wi	th UM #2 at 8:48 am on						
		ated her responsibilities as	1					
	a unit manager was to							
ļ	reviewed the charts wi				**************************************			
		on or new orders to make	1					
	sure all the orders wer							
	(referring to resident #	2) was reviewed during the	E					

PRINTED: 10/18/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 345519 09/30/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH LIBERTY COMMONS NSG & REH JOHN BENSON, NC 27504 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION DATE PREFIX -(EACH DEFICIENCY-MUST BE PRECEDED BY FULL-PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 309 Continued From page 33 F 309 critical care meeting on Monday (8/1/11) morning after the DON had reviewed the chart first. She stated "the DON usually looks through the charts to make sure everything was in place; like orders, referrals, treatments and physician notifications. As they reviewed the chart in the critical care meeting they realized the neuro checks were not completed properly and the orders for the head laceration were not clear or transcribed to the TAR (Treatment Administration Record), there was no assessment of the resident's change in status from the nurses and the doctor was never notified. " Interview with the Physician on 09/30/11 at 11:45 am revealed he was unaware Resident #2 had a fall or was returned back to the facility. He stated "the staff should have contacted me if there was a change in the resident's condition (example: change in vital signs, pain, sleepiness, lethargy. poor appetite, difficult to arouse, anything that was different from her baseline behavior). They (the nurses) received discharge orders/instructions from the hospital and they stated to contact the physician immediately if there was a change. She was diagnosed with a concussion; I would have expected them to call me. " The Administrator was notified of the Immediate Jeopardy on 9/29/11 at 12:45 pm. The facility presented a credible allegation of

included:

compliance on 9/30/11 at 3:41 pm which

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION	(X3) DATE SU COMPLET	
		345519	B. WING			1	С
		349919			**************************************	09/3	30/2011
	ROVIDER OR SUPPLIER COMMONS NSG & REH	JOHN		231	ET ADDRESS, CITY, STATE, ZIP CODE 15 HIGHWAY 242 NORTH ENSON, NC 27504		
(X4) ID	SHMMARYST	ATEMENT OF DEFICIENCIES	1 10		PROVIDER'S PLAN OF CORRECTI	ON	1 7/5
PREFIX	ſ	/ MUST BE-PRECEDED BY FULL	ID PREFIX		(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	.	CROSS-REFERENCED TO THE APPRO		DATE
<u> </u>					DEFICIENCY)		
F 309	Resident # 2 was disc 8/1/2011. On 7/30/20 was treated at the em	charged to the hospital on 111, she sustained a fall and	F3	09			Triple of the control
		complete neurological					
		tocol and a diagnosis of					
		011 at 8:30 PM, she was					
		ory distress and was sent to					
		ospital] where she was					
	admitted and later die	d from aspiration		1			
	pneumonia.			-			
		ce training was completed					
		sing and staff development.					
		ed this in-service. The					
	exact in-service includ	led:					l
	"In-service 8-9-11						
		e as ordered. If you have a		İ			
		njury there must be done					
	using the flow sheet the			1			
	changes in neuro state						
		1 15 mins x1 hour, q30 mins urs, q4 hour x 24 hours.	İ	-			1
		urs, q4 nour x 24 nours. Ived, the nurse transcribing					
		on the MAR. If received at]
[ould be transcribed on new					
	month MARS's as wel			•			
	Weekly charting and v	ital sings is to be done on		İ			
	every resident.						
		e done on any change in]
		education. This is to be					
		our shift. Any change of	1				
		on that is reported, should	1			1	
		acute charting sheet as					
	well.	-					
		e completed on all orders.	1]
		witnessed, neuro checks		-			
		ange in mental status must					
		ysician and RP Notified.					

		AND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 10/18/20 RM APPROVI IO: 0938-03
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPLE	
		345519	B. WING		09/	30/2011
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
LIBERTY	COMMONS NSG & RE	NHOL !		2315 HIGHWAY 242 NORTH BENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETE DATE
F 309	Medication changes When notifying the use the facility phon work hours is prohit Nurses are to do wa sheet and if there is to the oncoming nur 24 hour report sheet done in the resident All residents are poi practice. On 9/29/2 the supervision of u staff development of current residents for the attending physic of any identified cha were assessed and in conditions. The a	notified on all incidents. or change in condition residents RP, you are to only e. Cell Phone use during bited. (Please refer to policy). alking rounds with your report an incident or if it is reported ree, it must be placed on the t. Documentation must be	F 3	09		
	resident who was exand loose stools an phenergan, immodifintravenous fluids a complained of pain urine analysis and odeveloped rash and hydrocortisone, ben heparin, and foley of experiencing some an order to be evaluated on 9/30/2011. Orde implemented by the will remain on the a	rented. This included a 1. Experiencing nausea, vomiting of received orders for the formum, clear liquid diet, and received orders for a culture, 3. Resident who have dereved orders for the formulation of the formulation				

has stopped. If improvement is not noted within

PRINTED: 10/18/2011 FORM APPROVED

STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPL	ETED	
		345519	B. WNG	•	C 09/30/2011		
	OVIDER OR SUPPLIER	JOHN	2315	T ADDRESS, CITY, STATE, ZIP CODE 5 HIGHWAY 242 NORTH NSON, NC 27504	CODE		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETI DATE	
F 309	nurse assigned to the instructions/orders. the following: Observing for laceral apply dry, sterile dres amount of bleeding of Observing for swellin present, chart size, so Observing for convul precipitating factors, ended. Also chart will difficulty breathing. Observing and inquir or pain. Observing for person Observing for incontition of Observing for sensor Observing for generations of the property of the pro	an will be contact by the staff or resident for follow up. This assessment includes sions; if present, clean and sing. Note size, depth and or drainage. Ig and discoloration; if ite, amount and color. sions; chart time began, duration, vital signs and time tether or not resident had the if resident has headache sality changes. It is in consciousness. In ence. It is weakness. It is weakness. It is disorder.	F 309				
	Observing for stiff ne Observing for proper stimuli). Observing for abdom	reflexes (response to painful inal spasm or pain. ng from ears, nose, throat. al pupils. a or variations in			·		
	Observing for pain.	ion, adduction, shortening or extremities.					

On 9/29/2011 and 9/30/2011, all staff nurses

PRINTED: 10/18/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			1			()
		345519	B. WIN	3 <u></u>		09/30	0/2011
NAME OF PE	OVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NSG & REH	JOHN			15 HIGHWAY 242 NORTH :NSON, NC 27504		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		
F 309	and the administrator	taff development ager, the nurse consultant	F:	309			
	changes. 24 out of 3	0 staff nurses have received xact in-service content is as					
	After all resident falls physical or mental full monitor the following Observe for laceratio	, injuries or changes in nction, the charge nurse will every shift for 72 hours: ns; if present, clean and ssing. Note size, depth and					
	amount of bleeding o Observe for swelling chart size, site, amou	r drainage. and discoloration; if present, int and color.					
	precipitating factors, ended. Also chart wh difficulty breathing. Observe and inquire	ons; chart time began, duration, vital signs and time ether or not resident had if resident has headache or					
	pain. Observe for personal Observe for alteration Observe for incontine	ns in consciousness.					
	Observe for sensory Observe for generalia Observe for speech of Observe for gait, pos	zed weakness.					:
	Observe for stiff neck Observe for proper re stimuli).	t. eflexes (response to painful	The state of the s				
	Take vital signs and in Observe for abdoming Observe for bleeding Observe for unequal	al spasm or pain. from ears, nose, throat.					
	Observe for dyspnea (irregular).	or variations in respirations					

Event ID: MQX611

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345519	B. WING_		C 09/30/2011		
	OVIDER OR SUPPLIER	ЈОНИ	STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CO		(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	improper position of et Have someone stay vinurse is calling the att necessary. The physic promptly (within 15 man assessment that do condition has occurred the physicians are in the each nurses station. To called for any change above 24 hours a day process does not character the physician on called for any change above 24 hours a day process does not character the week. If you are unable to refor the physician on caminutes of contacting further instructions. The number is 1-919-820-1. This assessment should not a second the physician on the physician on the physician on caminutes of contacting further instructions. The number is 1-919-820-1. This assessment should not a second the physician of	or cyanosis. In, adduction, shortening or extremities. In, with the resident while the ending physician, if ician should be called inutes) after completion of etermines that a change of condition as outlined and 7 days a week. This hage due to time or day of ach the attending physician ill, on call RN within 30 the primary physician for the RN on call phone 3214. Ild be documented in the series an physician order, impact to the head, when the fall or any other time the fary. The nurse should arm for neurological checks, thould be completed every did then every shift for a total orgical assessments.	F 309				

PRINTED: 10/18/2011 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u>O. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			17.20	ILUII			С
		345519	8. WA	NG_		Į.	30/2011
NAME OF PR	ROVIDER OR SUPPLIER					1 0010	30/2011
				51	REET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH		
LIBERTY	COMMONS NSG & REH	JOHN		ļ	BENSON, NC 27504		
0(0.15	CHRIMADY OT	ATEURIE OF PERIOR NOISO	1	٠	·		ı
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST-BE-PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	-	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
F 309	Continued From page	39	F	309	9		a-treese
	Pupil response: Is the	e resident's pupil equal and					
	reactive to light. Also	document the pupil					
	response in each eye	as either brisk, sluggish,	1				
	non-reactive, pinpoint	, dilated or fixed.					
	Motor functions: Doc	ument the hand grasp as					
ļ		greater than left, left greater					
-		ent is unable to participate)				
[or if hand grasp is abs		ĺ				
	whether the resident i						
		to move all extremities then					
		mities they are able to	-				
		for the right arm, left arm,					
		checking all that apply. If					1
		to follow commands or if					
	they are absent any e. well.	xtremities indicate that as					
	Pain response: Document	ment if the resident has an					
		onse, inappropriate pain					
İ	response or no pain re						
	Vital Signs: Documen	it blood pressure, pulse,					
ļ	respirations and temp		-				
	Observations: Docum						
j	observations such as	seizure, headache,					
ŀ	vomiting or paralysis		1				
	Sign you name in the	box indicated on the form.	-				1
	Complete an incident,		1				[
	management report pe						
	Notify resident's respo						
		ved by the physician then	-				ŀ
		ocumented by the nurse				!	
		r on the telephone order					
		should be transcribed to					THE PERSON NAMED IN COLUMN 1
		tion record or treatment					
		as appropriate depending				ļ	
	on the type of order. (
	non-medication/treatm				-		
		er type. This transcription					
ĺ	should be completed b	y the staff nurse receiving			•		

ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345519	B. WN	G		09	C /30/2011
	OVIDER OR SUPPLIER	н Јони		2316	T ADDRESS, CITY, STATE, ZIP CODE 5 HIGHWAY 242 NORTH NSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES IGY-MUST-BE-PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFU TAG	×	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETI DATE
The state of the s	check every night w for new orders. If no hours) are identified verify that the order to the medication/tre implemented appropression or notify the Direct by either phone or not Nursing's box at the Any concerns identification or address and will be reviewed Assurance Committed document.	nurse is to complete a chart where every chart is reviewed ew orders (within the last 24 If the night shift nurse is to was transcribed appropriately eatment record or oriately. If a problem or If then the night shift nurse ctor of Nursing that morning note placed in the Director of nursing station. Ified by this audit will be sed by the Director of Nursing If weekly at the Quality weekly at the Quality ee Meeting describe in this	F	309			
7	that any staff nurse v in-service training by allowed to work until This in-service was i employee facility orie An in service on 9-30	who does not complete the y 9/30/2011 will not be the training is completed, ncorporated into the new entation. 0-2011 has been provided to					
	Coordinator, Nurse Cand MDS Coordinate the resident to the nudentified. The staff densure that any nurse complete the in-servinot be allowed to wo completed. 32 out of This in-service was incompleted and the service was incompleted and the service was incompleted and the service was incompleted and the service was incompleted and the service was incompleted and the service was incompleted and the service was incompleted and the service was incompleted.	monitor will be completed		TO COMPLETE AND AND AND AND AND AND AND AND AND AND			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	72	345519	8. WN	G		C 09/30/2011		
	ROVIDER OR SUPPLIER COMMONS NSG & REH	1 ЈОНИ	23		ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 242 NORTH SON, NC 27504			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES GY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	monthly until resolved Committee. Report given by the director Quality of Life- QA caction initiated as ap Life committee cons. Nursing, Administrated Coordinator, Dietary Minimal Data Assess Nurse and Health Interview Minimal Data Assess Nurse and Health Interview Minimal Data Assess Nurse and Health Interview Will include (nursing notes, neurophysician orders, and verify implementation observation of 10 resexperienced an acute review. If 10 resident acute episode since residents who meet to the review will cheel nurses appropriately changes in condition identifying changes of physician and RN on implementing and trained completion of the credit was done on 09/30/1 Interviews with nurse licensed nursing staff received training on 0	three months and then ed by the Quality Assurance ts of the this audit will be of nursing to the weekly committee and corrective propriate. The Quality of ists of the Director of for, Staff Development Manager, Wound Nurse, sments Nurse and Support formation Management and ude reviewing the charts plogical assessment forms, d necessary documents to n of physician orders) and esidents who have e episode since the last has have not experienced an the last review then any this criteria will be reviewed. Acto ensure that the staff assessed and responded to s. This will include of conditions, contacting the call if needed, properly unscribing physician orders surological assessment as training outlined above. 10/2011 lible allegation of compliance 1 from 3:58 pm to 5:15 pm.	F	309				

TATEMENT	(S FOR MEDICARE 8 OF DEFICIENCIES	MEDICAID SERVICES	······································		OMB i	RM APPRO NO. 0938-0
ND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE : COMPL	SURVEY
		345519	B. WNG		С	
IAME OF PR	ROVIDER OR SUPPLIER			TOTET ADDRESS AS	09/30/2011	
LIBERTY	COMMONS NSG & REH	JOHN	j	TREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	PPECTION	1
TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETI DATE
F 309	Continued From pag		F 309			
	acute changes in res Documentation of tra protocols was review	ining, auditing and new				
	Immediate Jeopardy at 6:39 pm.	was removed on 09/30/2011				
		·			NAME OF	*****
		· ·				
		100			***	
1			99.5			
ĺ		1	. [ļ	