STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345519	A. BUILDING: ______ B. WING ______	9/5/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	**2315 HIGHWAY 242 NORTH BENSON, NC**

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483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interviews, the facility failed to develop a care plan to address the use of psychotropic medications for 1 of 5 sampled residents (Resident #66) reviewed for unnecessary medications.

The findings included:

Resident #66 was admitted to the facility on 8/7/14 from an acute care hospital. His cumulative diagnoses included anxiety disorder, non-Alzheimer ' s dementia, and a history of urinary tract infection (UTI).

A review of Resident #66 ' s medical record revealed his 8/7/14 admission medication orders included 0.25 mg lorazepam (an antianxiety medication with the brand name of Ativan) given by mouth every 8 hours as needed for anxiety. On 8/14/14, a physician ' s telephone order was received for 0.5 mg haloperidol (an antipsychotic medication with the brand name of Haldol) to be given intramuscularly in a one time only dose. A review of the Physician Progress Notes dated 8/15/14 indicated the resident had experienced an increase in agitation the prior evening (8/14/14) and was subsequently treated with a one time dose of haloperidol.

A review of Resident #66 ' s admission MDS (Minimum Data Set) assessment dated 8/14/14 revealed the resident had severely impaired cognitive skills for daily decision making. He required extensive assistance with bed mobility, transfers, and toileting; supervision with eating; and was totally dependent on staff for locomotion on the unit, dressing, and personal hygiene. The MDS assessment also indicated his medications included insulin injections (on 4 out of the 7 days during the assessment period), an antipsychotic medication (on 1 out of the 7 days), an antibiotic (on 7 out of the 7 days), and an antianxiety medication (on 5 out of the 7 days).

A review of Resident #66 ' s medical record revealed a Care Area Assessment (CAA) Worksheet for

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

The above isolated deficiencies pose no actual harm to the residents

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Psychotropic Drug Use was completed based on the 8/14/14 MDS information. The analysis of findings included in the CAA Worksheet identified the problem/need as " Actual " (versus potential). The nature of the problem/condition was described as follows: " Resident is disoriented and is prescribed Ativan for frequent episodes of restlessness - i.e., getting out of chair without assistance, verbal abuse and combativeness. Resident has been given 1 dose of Haldol for aggressiveness not managed by Ativan. " Further review of the CAA Worksheet revealed Psychotropic Drug Use would be addressed in Resident #66 ' s care plan. The overall objective for care planning this problem was noted as: 1) Avoid complications; and 2) Minimize risks.

A review of Resident #66 ' s care plan (initiated 8/11/14 and last revised on 9/3/14) revealed that the topic of Psychotropic Drug Use was not addressed as a focus area.

Further review of Resident #66 ' s included his August 2014 and September 2014 Medication Administration Record (MAR). According to the August 2014 MAR, the resident received lorazepam for anxiety on 26 occasions between 8/7/14 (admission date) and 8/31/14 with variable levels of effectiveness noted. The resident ' s September 2014 Medication Administration Record (MAR) revealed that he received lorazepam for anxiety on 6 occasions from 9/1/14 through the date of review (9/4/14), with varying results noted.

An interview was conducted with Nurse #2 on 9/5/14 at 10:30 AM. Nurse #2 assumed responsibility for coordinating the development of interdisciplinary care plans for each of the facility ' s residents. Upon inquiry, Nurse #2 stated that she typically created a care plan as soon as a resident receiving a psychotropic medication was admitted to the facility. When asked if she would have expected to specifically address psychotropic medications as a focus area for Resident #66, who received lorazepam on an as needed basis, the nurse stated, " yes. " Nurse #2 indicated she was surprised that she had missed addressing that particular care area in his care plan. The nurse reported that she needed to be more careful to be sure this care area wasn ' t missed for another resident.

An interview was conducted with the facility ' s Administrator on 9/5/14 at 11:30 AM. In regards to the omission of a focus area on psychotropic medications in the care plan for Resident #66, the Administrator stated that her expectation would be, "that it (the focus area) be in there (the care plan)."

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483.30(e) POSTED NURSE STAFFING INFORMATION

The facility must post the following information on a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).

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- Certified nurse aides.

o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews, the facility failed to post daily nurse staffing information for 3 of 7 days from 8/30/14 through 9/5/14.

The findings included:

An observation made on 9/2/14 at 8:50 AM revealed daily nurse staffing information posted across from the Administrator ' s office off of the main lobby was dated 8/29/14 (Friday). An observation made on 9/2/14 at 12:25 PM revealed the posting dated 8/29/14 had been replaced with daily nurse staffing information dated 9/2/14.

An interview was conducted with facility ' s Administrator on 9/3/14 at 3:05 PM. The Administrator indicated the facility ' s receptionist was responsible to post nurse staffing information each day, Monday through Friday. She stated that the manager on duty assumed this responsibility on weekends and holidays. Upon inquiry, the Administrator stated that her expectation would be that the scheduled manager on duty would know how to gather the staffing information and know when and where to post it. The Administrator reported that copies of the daily staff postings were kept by the facility ' s receptionist. A review of the printed postings kept in a designated 3-ring binder revealed these included daily nurse staffing posts from 8/30/14, 8/31/14, and 9/1/14.

An interview was conducted with the receptionist on 9/3/14 at 3:17 PM in the presence of the Administrator. During this interview, the receptionist reported that she herself was responsible to post the staffing information each weekday, Monday through Friday. She stated that either the manager on duty at the facility or the 400 hall nurse was responsible to collect, print, and post the nurse staffing information on the weekends. Upon inquiry, the receptionist reported that on Tuesday, 9/2/14, she herself collected the nurse staffing information from 8/30/14, 8/31/14, and 9/1/14 and printed the postings. After being printed on

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F 356	Continued From Page 3 9/2/14, she put the postings for 8/30/14, 8/31/14, and 9/1/14 directly into the designated binder for retention. Upon further inquiry, the receptionist confirmed that the nurse staffing information from Saturday (8/30/14), Sunday (8/31/14), and Monday (9/1/14) had not been posted over the holiday weekend. A follow-up interview was conducted with the Administrator on 9/3/14 at 3:20 PM. The Administrator reiterated that her expectation was that the daily nurse staffing information would be posted every day, including weekends and holidays.