STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345309	A. BUILDING _____ B. WING _____	C 01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY	101 CAROLINE AVENUE WELDON, NC 27890

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E 000	Initial Comments An unannounced Recertification survey was conducted on 1/14/19 through 1/16/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #K3U611.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey on 1/16/19. Event ID #K3U611.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		2/5/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/01/2019

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F 657	Continued From page 1 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update a care plan for 1 of 1 residents with a nephrostomy (an artificial opening created between the kidney and the skin which allows the urinary diversion directly from the upper part of the urinary system.) (Resident #27) The findings included: Resident #27 was originally admitted to the facility on 5/30/14 with diagnoses including Hydronephrosis (a condition characterized by excess fluid in a kidney due to backup of urine) with renal calculous obstruction and Chronic Kidney Disease Stage 3 moderate. According to the most recent Minimum Data Set (MDS) dated 11/20/18, Resident #27's cognition was intact. She required extensive assistance in most areas of activities of daily living. Resident #27 was coded in Section H, of the MDS, (Bowel/Bladder) for indwelling catheter (including nephrostomy tube). The resident's bladder continence was coded as not rated because she had a urinary ostomy or no urinary output for the entire seven days. Review of Resident #27's medical record revealed she had a nephrostomy in place since 11/26/18. Review of Resident #27's Care Plan which was updated on 1/8/19 revealed the resident's nephrostomy was not care planned.	F 657	F657 Care Plan Timing and Revision The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to update/revise the care plan for Resident #27 to reflect nephrostomy tubes that were placed on 11/26/18. The care plan for Resident #27 was updated and revised by the Director of Nursing on 1/16/19 to reflect that the resident has left and right nephrostomy tubes due to urinary retention and obstructive uropathy. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 1/31/19, the Regional Minimum Data Set Nurse Consultant conducted an audit on all current residents who have any type of urinary device/catheter or ostomy in order to validate that their care plan accurately reflects the presence, use and care of such device. An Order Listing Report from Point Click Care was run in order to identify all residents who currently have any of the following devices: ostomy of any type, indwelling foley catheter or suprapubic catheter. The results of this audit were: " 1 resident identified with colostomy. Care Plan does indeed reflect presence	

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F 657	Continued From page 2 During an interview on 1/16/19 at 2:49 PM the Director of Nursing revealed nephrostomy was supposed to be care planned. She stated she just noticed nephrostomy was not on the care plan. During an interview on 1/16/19 at 4:29 PM the Administrator revealed care plans should be updated when there were any changes in diagnoses or changes in condition of residents.	F 657	and care for colostomy. " 1 resident identified with nephrostomy. Care Plan does reflect presence and care for nephrostomy tubes. " 0 residents identified with indwelling foley catheter or suprapubic catheter. On 1/31/19, the Regional Minimum Data Set Nurse Consultant in-serviced the Nurse Managers on the importance of maintaining up to date care plans that are reflective of specific devices and/or care that is required for promoting bladder and bowel emptying. The education also emphasized the importance of ensuring that resident care plans should be updated/revised on an on-going basis as the resident□s needs change. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or designee will audit 5 random (current) residents in order to validate whether or not the resident□s needs related to bladder and bowel emptying and related care are accurately reflected on his/her care plan. This will be done on weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS	

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F 657	Continued From page 3	F 657	Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 2/5/19	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) 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: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or	F 732		2/5/19

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F 732	Continued From page 4 written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. 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 observation, record review and staff interviews, the facility failed to post accurate staffing data by including staff providing care for residents on the assisted living hall with staff providing care for residents on the skilled nursing halls and failed to post accurate census by including residents from the assisted living hall with residents on the skilled nursing hall for 3 out of 3 days during the survey conducted 1/14/2019 to 1/16/2019. The findings included: During the initial tour of the facility on 1/14/2019 at 9:30 AM, the "Report for Nursing Staff Directly Responsible for Resident Care" staff posting form dated 1/14/2019 indicated 1 Registered Nurse (RN) for a total of 8 hours, 2 Licensed Practical Nurses (LPNs) for a total of 16 hours, and 5 nursing assistants (NAs) for a total of 37.5 hours staffed the skilled nursing unit on the 7:00 AM to 3:00 PM shift. The form indicated the resident census was 48 which did not correspond to the number of residents on the resident roster for the skilled nursing unit which was 42. Review of the posting forms revealed the 1/15/2019 posting listed 4 nurses and 6 NA and a	F 732	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F732 Posted Nurse Staffing Information Corrective Action: 1. On 1/16/19 the staff posting forms were corrected to reflect the census of only skilled patients. Systemic Changes: 1. On 1/16/19 DON was inserviced on how to properly fill the staff posting forms excluding the assisted living residents. 2. All staff that will have the duty of filling out staff posting forms will be inserviced by 2/5/19. Monitoring: Administrator or DON will monitor the completion and accuracy of staff posting	

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F 732	Continued From page 5 census of 47 on the 7:00 AM to 3:00 PM shift. The 1/16/2019 posting listed 3 nurses and 5 NA and a census of 47 on the 7:00 AM to 3:00 PM shift. An interview was conducted on 1/16/2019 at with the Medication Aide (MA) who stated she filled out the staff posting forms. The MA stated she put the total census on the posting form for all residents in the building which included the skilled nursing residents and the assisted living residents. The MA stated the staff and staff hours were for all the residents in the building, both the skilled and assisted living residents. The MA stated she had not been instructed to exclude the assisted living residents from the census. On 1/16/2019 at 11:25 AM, an interview was conducted with the Administrator who stated she did not realized the staff posting included both the skilled and assisted living residents. The Administrator stated she expected the form to be filled out to include only the skilled residents, and the staff hours should reflect care only for the skilled residents.	F 732	forms 5 times a week for 4 weeks then weekly for 4 weeks and then monthly for 3 months. This QA tool will be monitored by the Administrator. To ensure compliance this reports will be presented to the weekly QA Committee by Administrator or designee to assure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Therapy, HIM, and Dietary Manager. Date of Compliance: _2/5/19_	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		2/5/19

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F 812	Continued From page 6 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean two of two plate warmers and 4 of 4 sheet pans. Then findings included: During the initial kitchen tour on 1/14/19 at 9:30 AM the plate warmer was observed with dark brown dried food particles inside both wells. During a second observation on 1/16/19 at 9:38 AM the plate warmer was observed with dark brown dried food particles inside both wells. The right well a hairnet and 4 dried dark fruit rinds were observed inside. A third observation on 1/16/19 at 11:26 AM the plate warmer was observed to be in the same condition. A review of the Daily Deep Cleaning schedule dated Jan. 1-31, 2019 page 3, reads as "Clean Plate Rack" there were no signatures to indicate the plate warmer had been cleaned. During the kitchen observation on 1/16/19 at 9:14 AM 2 sheet pans of prepared chicken were observed on the prep table ready for noon meal. The sheet pans had dark black charred food build	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. Corrective action On 1/16/19 the Dietary Services Director took the Sheet Pans out of service. New Sheet pans were ordered 1/28/19. On 1/16/19 dietary staff was instructed to thoroughly clean the plate warmer. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. All dietary staff was in-serviced on 1/29/19 regarding proper cleaning and sanitizing of service ware and equipment and	

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F 812	Continued From page 7 up under the rim and bottom of each pan. One half size sheet pan with yeast rolls was observed with a dark black charred food build up under the rim and bottom of pan. In an interview with the Certified Dietary Manger on 1/16/19 at 2:48 PM she indicated they had several cleaning schedules and that she would order new sheet pans. In an interview with the Administrator on 1/16/19 at 3:13 PM stated she would expect the kitchen staff to clean the plate warmer daily and she would order new sheet pans for the kitchen.	F 812	completing duties as assigned on daily and weekly cleaning schedules. Cleaning schedules were modified on 1/29/19 to include daily cleaning of plate warmers 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff by the Dietary Services Director. Topics included: " Proper cleaning and sanitizing of service ware and equipment. " Completing duties as assigned on daily and weekly cleaning schedules. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Services Director or designee will monitor completion of cleaning assignments daily. Using Dietary Audit Tool: Monitoring Dietary Cleaning, the Dietary Services Director will audit cleaning schedules, cleaning of pots and pans and cleaning of the plate warmer 5 times weekly x 4 weeks then weekly x 2 months and then monthly for 3 additional months. Reports will be presented to the weekly Quality Assurance committee. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the	

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F 812	Continued From page 8	F 812	Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Services Director. Date of Compliance: 2/5/19	