STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted on 7/31/19. There was a total of 2 intakes with 2 allegations. One of the allegations was unsubstantiated and the one allegation was substantiated. Past noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity G. The tag F689 constituted Substandard Quality of Care. Non-noncompliance began on 7/18/19. The facility came back in compliance effective 7/23/19.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner (NP) interviews, the facility failed to provide 2 person assistance with bed mobility as specified in a resident's plan of care and electronic Kardex for 1 (Resident #1) of 4 residents reviewed for accidents. The failure to have 2 staff members present to assist Resident #1 with bed mobility resulted in the resident falling	F 689	Past noncompliance: no plan of correction required.	8/19/19

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

Electronically Signed | 08/19/2019

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	345532	A. BUILDING _____ B. WING _____	C 07/31/2019

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F 689	Continued From page 1	F 689		

from her bed and she sustained a subdural hematoma (a collection of blood outside the brain) and a frontal scalp laceration which required treatment at a hospital.

The findings included:

Resident #1 was admitted on 7/20/12 with a diagnosis of Alzheimer's Disease.

Resident #1's quarterly Minimum Data Set dated 7/12/19 indicated severe cognitive impairment and she exhibited no behaviors. She was coded as requiring 2 person assistance with bed mobility and coded for no falls.

Resident #'s 1 current care plan that was last revised on 7/12/19 read she required assistance with the activities of daily living (ADLs) due to dementia. Interventions included 2 person assistance with repositioning and turning in bed.

Resident #1's undated electronic Kardex read she required 2 person assistance with repositioning and turning in bed.

Review of an incident note dated 7/18/19 at 4:00 PM completed by Nurse #1 read Nursing Assistant (NA) #2 came out of Resident #1's room at approximately 3:30 PM and requested assistance. Nurse #1 went to assist Resident #1 because NA #2 reported she had fallen out of the bed. Nurse #1 noted Resident #1 lying on her back on the floor next to the bed. She ensured Resident #1 was alert and had no signs of acute distress. Nurse #1 sent NA #2 to get the Director of Nursing (DON) who was onsite and responded immediately. Resident #1 was assessed for

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	345532	A. BUILDING _____ B. WING _____	C 07/31/2019

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LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

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F 689	Continued From page 2	F 689		

injuries and Emergency Medical Services (EMS) was at approximately 3:35 PM for her to be evaluated as a precautionary measure. Resident #1 was noted with a small laceration to her left forehead with bleeding controlled, and a bandage applied along with an ice pack. Nurse #1 remained with Resident #1 until EMS arrived. The Responsible Party (RP) was notified of the fall at approximately 3:45 PM. The Nurse Practitioner was in the facility and also made aware.

NA #1's written statement dated 7/18/19 read as follows: She and NA #2 had just laid Resident #1 down in bed using a mechanical lift. NA #2 was taking the mechanical lift out of the room and get a brief. NA #1 documented she attempted to remove the lift pad out from under Resident #1 in bed. NA #1 tucked the pad under Resident #1 then turned her towards her and attempted to remove the lift pad. NA #1 documented the lift pad wasn't moving so she turned Resident #1 onto her back to tuck it further under Resident #1 then turned her towards her again in an effort to remove the lift pad. She documented when she did this and pulled the lift pad, Resident #1 rolled over too far. NA #1 documented she braced her knees against the bed frame in an effort to break her fall and yelled for help. She documented her legs gave way and Resident #1 fell to the floor.

In an interview on 7/31/19 at 1:05 PM, NA #1 stated she and NA #2 had laid Resident #1 in bed using the mechanical lift and was preparing to provide her incontinence care. NA #1 stated Resident #1 had just been moved into a new room and all of her personal items had not yet been moved from her old room. NA #1 stated she realized there were no briefs in the new room. NA #1 stated she did not wait for NA #2 to return

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	345532	A. BUILDING _____ B. WING _____	C 07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

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F 689	Continued From page 3	F 689		

before attempting to get the lift pad out from under Resident #1 by rolling her on her side and tucking the lift pad under her. She stated she rolled her over further to get more of the pad under her when Resident #1's legs slid off the bed and she continued to roll. NA #1 stated she tried to catch her using her legs up against the bed frame, but she was unable to hold her weight. NA #1 stated Resident #1 fell onto the floor at the bedside and she called out for help. NA #2 went to get Nurse #1.

NA #2's written statement dated 7/18/19 read as follows: She and NA #1 laid Resident #1 in bed using the mechanical lift. She was removing mechanical lift from the room and get a brief. NA #2 documented apparently NA #1 began removing the lift pad out from under Resident #1. As she was opening the door, she heard Resident #1 fall and NA #1 call out for help. She documented she observed Resident #1 on the floor beside the bed and she apparently hit her head. She then went to get Nurse #1.

In an interview on 7/31/19 at 11:47 AM, NA #2 stated Resident #1 had been moved to a different room at the end of first shift at the request of the RP. NA #2 confirmed there was no change in Resident #1's bed. She stated her personal items were still being transferred to her new room. NA #2 stated she and NA #1 had laid Resident #1 down in the bed using the mechanical lift then realized there were no briefs in the new room. She stated she was removing the mechanical lift out of Resident #1's room and was going to get a brief when she heard NA #1 call for help and heard Resident #1 fall. She stated she was uncertain if the bed was in the low or raised position but thought it was in the normal position

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	345532	A. BUILDING _____ B. WING _____	C 07/31/2019

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LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

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F 689	Continued From page 4	F 689		

because Resident #1 was not in a low bed. NA #2 stated she did not see the actual fall because the privacy curtain was pulled. She stated when she looked behind the curtain, she saw Resident #1 lying on the floor beside her bed with NA #1 on the floor next to her. NA #2 stated she saw blood on the floor and went to get Nurse #1. NA #2 stated NA #1 should not have been attempting to take the lift pad out from under Resident #1 and she should have waited for her to return with a brief.

Nurse #1's written statement dated 7/18/18 read as follows: She was called to the room and noted Resident #1 on the floor with NA #1 beside her. Nurse #1 documented Resident #1 appeared alert and there was no indication of acute distress other than a small laceration to left of her forehead. Nurse # notified the DON, EMS and RP.

In an interview on 7/31/19 at 1:00 PM, Nurse #1 stated she was also the RN Supervisor, but she had worked on a medication cart on first shift on 7/18/19. Nurse #1 recalled Resident #1 was moved from the 200 hall to the 300 hall around the time second shift was coming on at 3:00 PM. She stated NA #2 called her to Resident #1's room where she saw her on the floor beside her bed with NA #1 on the floor next to her. Nurse #1 stated she observed a small laceration to the left side of Resident #1's forehead. She stated she sent NA #2 to get the DON and an ice pack. Nurse #1 stated she completed a neurological assessment and noted no changes in Resident #1's mental status or neurological status. She noted no acute injuries and only observed the laceration. After the complete body assessment , the NP and the RP were notified. Resident #1

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	345532	A. BUILDING _____ B. WING _____	C 07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

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F 689	Continued From page 5 was sent out to the hospital for an evaluation. Review of the local hospital emergency room visit dated 7/18/19 read as follows: Resident #1 sustained a fall with anterior head trauma and a frontal scalp laceration. There were no acute traumatic injuries and per her RP, Resident #1's mental status was at baseline. The laceration measured at approximately 1-2 centimeters. A computerized axial tomography scan (CT Scan) revealed a small subtle trace right subdural frontal hematoma. A CT Scan is a series of x-rays taken at different angles processed by a computer that reveal potential bones, blood vessel and soft tissue injuries. There was no evidence of hemorrhage or no shifting and noted frontal soft tissue swelling to Resident #1's head. She was transferred to a larger hospital for further evaluation. Review of the receiving hospital's Neurology History and Physical dated 7/19/19 read Resident #1's attending Physician requested a neurological evaluation due to a seizure. Family reported Resident was at baseline with dementia and that Resident #1 had a previous history of a seizure approximately 3 to 4 months ago. Family report the CT scan done at that time of her first seizure revealed no acute abnormality. She was not started on any antiepileptic (medication to treat seizures) drugs at that time. Neurosurgical intervention was differed given her examination and the size of the hematoma. The plan was since Resident #1 was not taking any anticoagulation or antiplatelet agents, she would be monitored for increased intracranial pressure or worsening and now prescribed Keppra (antiepileptic drug).	F 689		

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	345532	A. BUILDING _____ B. WING _____	C 07/31/2019

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LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

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F 689	Continued From page 6	F 689		

In an interview on 7/31/19 at 1:25 PM, the NP stated the Physician was out of the country at present, but she was in the facility when the fall happened on 7/18/19. She stated it was an unfortunate accident and the NA #1 made a mistake. She stated the fall could have been avoided if 2 staff were present during bed mobility.

In an interview on 7/31/19 at 2:20 PM, the Nurse Consultant and DON stated NA #1 should have followed the care plan and electronic Kardex and not attempted to remove the lift pad out from under Resident #1 herself. The Administrator, DON and Nurse Consultant each stated it was their expectation that all aides should review with electronic Kardex prior to providing any care to a resident and if the electronic Kardex indicated any resident as 2 person assistance for bed mobility, 2 staff should remain at the bedside while bed mobility was performed. The Nurse Consultant stated the facility implemented a corrective action plan on 07/18/19 to prevent a reoccurrence. She stated their investigation findings revealed Resident #1 sustained a subdural hematoma from the fall on 7/18/19. She was receiving care in bed and rolled off edge resulting in laceration and a bump to her forehead. Resident #1 was sent to the hospital on 7/18/19. On 7/18/19, the involved staff re-enacted the incident with the Administrator and the DON. The involved staff were interviewed, and it was determined that the staff failed to check the electronic Kardex prior to her care. All nurses and aides were re-educated on the importance of checking electronic Kardex prior to initiating care.

Review of the facility's immediate correction action plan dated 7/18/19 read as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 07/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

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F 689	Continued From page 7	F 689		

Corrective action for the involved resident dated 7/18/19 read as follows: Resident #1 was assessed for potential injuries. Next, the Physician and RP were notified and Resident #1 was sent to the hospital for an evaluation.

Corrective action for other potentially affected residents dated 7/18/19 read as follows: Audit of all electronic Kardex's to ensure residents requiring 2 person assistance with bed mobility and positioning was correct. This was completed by the DON with 100% compliance. She stated the electronic Kardex updated automatically based on the care plan which was completed by the MDS Nurse and revised as needed. Beginning 7/18/19, the DON and Unit Managers interviewed and observed aides for the ability to access the electronic Kardex and interviewed to determine if aides were aware of how to access the electronic Kardex prior to initiating resident care each time they worked. Results of the interviews and observations on 7/18/19 was 100% of the aides were aware of how to access the electronic Kardex and aware that it should be accessed prior to care each time assisted a resident with care.

Systemic Changes and Education initiated on 7/18/19 read as follows: On 7/18/19 the DON began education of all full time, part-time and as needed (prn) licensed nurses and aides of the following:
-Utilization of electronic Kardex and following the plan of care
-Bed positioning safety
-The DON would ensure that any of the above identified staff who did not complete in-service training by 7/23/19 would not be allowed to work

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F 689	Continued From page 8 until training completed. -In-service was incorporated into the new employee facility orientation training for all staff Quality Assurance Plan initiated on 7/18/19 read as follows: The DON and Unit Managers would monitor staff using the Bed Positioning Quality Assurance (QA) tool for compliance. This would be done weekly x 2 weeks then monthly x 3 months or until resolved. Reports would be presented to weekly QA committee by Administrator or DON to ensure corrective action was appropriate. Compliance would be monitored, and ongoing auditing program would be reviewed weekly at QA meeting. The weekly QA meeting was attended by the Administrator, DON, MDS Nurse, Therapy Manager, Environmental Manger and the Dietary Manager. The plan alleged compliance on 7/23/19. Review of the facility plan of correction revealed evidence of 100% auditing of residents requiring 2 person assistance for bed mobility, evidence of 100% all staff interviewing and observation of accessing the electronic completed on 7/21/19. The facility provided evidence of 100% staff education on bed mobility and positioning completed on 7/23/19. The facility also provided evidence of a QA audits of observations of bed mobility and positioning completed on 7/22/19 and 7/26/19 on all three shifts and read as ongoing. Resident's deemed alert and oriented revealed no current concerns related to staff providing them with assistance of bed mobility and them feeling unsafe. Observations revealed two staff were assisting residents with bed mobility as specified on the care plans.The facility's date of compliance was validated as 7/23/19.	F 689		

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	345532	A. BUILDING _____ B. WING _____	C 07/31/2019

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LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	**310 COMMERCE DRIVE SANFORD, NC 27332**

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