STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 08/26/2019 through 08/29/2019 . The facility was found to be in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # CTVW11.	E 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires	F 645		9/26/19

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

Electronically Signed | 09/17/2019

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F 645	Continued From page 1 specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to apply for a level II PASRR	F 645	Specific deficiency for Resident #41 was resolved on 8/28/19 by the facility Social	

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F 645	Continued From page 2 screening for one of two residents reviewed for PASRR II screenings (Resident#41). Findings included: A review of the medical record revealed Resident #41 was admitted 3/25/2019 with diagnoses including Post Traumatic Stress Syndrome (PTSD). The Admission Minimum Data Set (MDS) dated 4/1/2019 noted Resident #41 to be cognitively intact and needed only limited assistance for all care with the help of one person. The MDS noted Resident #41 had a PASRR I number but no screening for a PASRR level II. On 8/28/2019 at 10:10 AM the Social Worker was interviewed and stated she did not know anything about the PASRR II screening. In an interview on 8/28/2019 at 10:30 AM, the MDS Nurse stated Resident #41 came from the hospital. The MDS Nurse indicated she thought the hospital would have applied for a level II PASRR screening for Resident #41. The MDS Nurse stated she was not aware she should have initiated the application to screen Resident #41. The facility Administrator was interviewed 8/28/2019 at 11:45 AM. In the interview, the Administrator stated she did not think the facility should be responsible for the application for the level II PASRR screening because the hospital obtained the PASRR I number which should have triggered for the PASRR level II. The Administrator stated she did not know if the hospital used the mental health diagnosis when they obtained the PASRR I number.	F 645	Services Director who submitted a new request for review via NCMUST. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of current residents who have had a new mental illness diagnosis assigned or have been admitted with will be completed in order to validate that the State Mental Health Authority was notified and a new resident review request was sent through the NCMUST. Any resident who is identified as not having had a new request for PASRR review sent to State Mental Health Authority via NCMUST will have this completed immediately. This audit will be completed by the facility Social Services Director and completed by 9/20/19. All residents who were identified as having been assigned a new diagnoses of severe mental illness or intellectual disability/mental retardation and DID NOT have evidence of having been referred to state mental health authority for new PASARR screening via NCMUST had new request for PASARR level review sent via NCMUST. This will be completed by the Social Services director and completed by 9/26/19 All residents who receive a diagnosis of a Serious Mental Illness or Intellectual Disabilities/Mental Retardation have the potential to be impacted. On 09/17/2019, the Regional Minimum Data Set Consultant completed an	

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F 645	Continued From page 3 In an interview on 8/28/2019 at 1:30 PM, the Administrator stated her expectation was any resident who needs to be screened for a PASRR level II will have that application completed appropriately.	F 645	in-service training for the facility Social Services Director, Director of Nursing, Nurse Managers and Minimum Data Set Coordinators that included the importance of thoroughly reviewing each resident□s medical record in order to identify whether or not the resident has a diagnosis of a severe mental illness or intellectual disability/mental retardation. It is very important that the medical record is thoroughly reviewed upon resident admission to facility, as well as afterwards in order to promptly identify the addition of mental illness and/or intellectual disability diagnoses. The education also included the importance of ensuring that the state mental health authority is notified in order to request a new review of PASRR level via NCMUST of all residents who have newly received these diagnoses either upon admission or while an already established resident. This information has been integrated into the standard orientation training for new Social Services Directors, Directors of Nursing, Nurse Managers and Minimum Data Set Coordinators. On 09/16/19, the Director of Nursing and or Social Services Director will begin auditing residents who have a diagnoses of a severe mental illness and/or intellectual disabilities/mental retardation to ensure that state mental health authority is notified via NCMUST system anytime that they are newly diagnosed with above diagnoses, using the quality assurance survey tool to ensure that the	

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F 645	Continued From page 4	F 645	plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. 5 residents will be reviewed to determine appropriate screening has been completed. This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The Administrator is responsible for implementing the acceptable plan of correction.	
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.	F 657		9/26/19

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F 657	Continued From page 5 (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 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to have the required staff present for a care plan meeting for one of three residents reviewed (Resident #41) and the facility failed to conduct a care plan meeting for one of three residents reviewed for care plan meetings (Resident #33). Findings included: 1.A review of the medical record revealed Resident #41 was admitted with diagnoses that included Diabetes and Post Traumatic Stress Syndrome (PTSD). The Admission Minimum Data Set (MDS) dated 4/1/2019 noted Resident #41 to be cognitively intact and needed limited assistance for all care with the assistance of one person. Resident #41 was interviewed on 8/26/2019 and stated she did not recall being invited to her care plan meeting. A review of Assessments revealed Resident #41 had a care plan meeting on 7/9/2019. The assessment revealed Resident #41 was present	F 657	A care plan meeting will be conducted for Resident #41 by 9/26/19. This meeting will be attended by the following: (Minimum Data Set Nurse, Activity Director, Social Services Director and Dietary Manager) with resident in attendance. A care plan meeting will be conducted for Resident #33 by 9/26/19. This meeting will be attended by the following: (Minimum Data Set Nurse, Activity Director, Social Services Director and Dietary Manager) with resident in attendance. All residents have the potential to be affected by the alleged deficient practice. A 100% audit was conducted on all current residents to determine whether or not they, their representative and physician have received invitations to their care planning conference during the past	

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F 657	Continued From page 6 at the meeting along with the Social Worker and the MDS nurse. There was no documentation of anyone else present in the meeting. In an interview on 8/28/2019 at 10:17 AM, the Social Worker stated she did not know who should be at the care plan meeting. On 8/28/2019 at 11:30 AM, the MDS Nurse was interviewed and stated the care plan meetings were usually held in residents' rooms. The MDS Nurse indicated she did not remember if a Dietary representative was in the room for Resident #41's care plan meeting. The MDS Nurse stated she typically documented notes from the care plan meeting in the assessment but did not see any notes from that 7/9/2019 meeting. An interview with the facility Administrator was conducted 8/28/2019 at 1:30 PM. The Administrator stated the physician was informed of the meeting, the dietary manager was involved in care planning, and the Nursing Assistant gave input. The Administrator stated her expectation was the meeting would involve all who should be present. 2. Record review revealed Resident #33 was admitted 10/20/08 with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right side. Review of the most recent MDS (minimum data set) dated 6/27/19 showed resident was cognitively intact. He needed extensive assistance with bed mobility, transfers and toilet use. In an interview with resident #33 on 8/27/19 at 1:57 PM, he stated he had never been invited to a	F 657	90 days. A 100% audit of all current residents was completed to determine if a care plan had been held during the past 90 days to include all IDT members (Minimum Date Set Nurses, Activities Director, Dietary Manager and Social Services) to include involvement from the physician, resident and C.N.A. This audit was completed by Minimum Data Set Nurses and will be completed by 9/26/19. All residents who were noted to NOT have been invited to his/her care planning conference; representative or physician noted to NOT have been invited or who did not have evidence of CNA involvement in care planning process/conference will be scheduled a new care planning meeting. A new invitation will be extended to the resident, as well as invitation mailed to resident representative and physician, and CNA will be included in care planning process/meeting. Each of these meetings will be scheduled and invitations extended/mailed no later than 09/26/19. This will be completed by the facility Social Services Director. On 09/17/19, the Minimum Data Set Nurse Consultant in-serviced the facility Interdisciplinary Team including: Minimum Data Set Nurses, Activities Director, Dietary Manager and Social Services Director on the importance as well as requirement to invite and involve	

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F 657	Continued From page 7 care plan meeting. A record review of Resident #33's chart on 8/27/19 revealed no evidence of a care plan meeting charted after December 2018. An interview was conducted with the Social Worker on 8/27/19 at 3:40 PM. She stated that Care Plan Assessments should be in the resident's chart and they were done every 90 days. She stated she was sure she did one in June. In an interview with the Staff Development Coordinator on 8/27/19 at 4:35, she stated a care plan meeting was done in March and June, but it was not documented in the chart. In an interview with the Social Worker on 8/27/19 at 4:40, she stated a care plan meeting was done in March and June, but it was not documented in the chart.	F 657	residents, physicians and their representatives in care planning conferences. Each resident should have a care planning conference on a quarterly basis. The facility interdisciplinary team should be included in these care planning meetings. The facility should extend invitations to both the resident, physician and their representative, and encourage their involvement, as they are the best resources for coordinating an individualized care plan. The resident□s CNA must also be included in the care planning process. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators and Social Services Directors. The Director of Nursing or Minimum Data Set Nurse or designee will review 5 current residents to ensure that the resident as well as their representative, physician and the Interdisciplinary Team is present and participate in their care planning conference during the past quarter. This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Minimum Data Set Coordinator, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the	

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F 657	Continued From page 8	F 657	Administrator. The Administrator is responsible for implementing the acceptable plan of correction.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews, the facility failed to provide ongoing activities during a 7 week period from 07/01/2019 through 08/26/2019 to 1 of 3 residents reviewed for activities (Resident #11). Findings: Review of the medical record of resident #11 indicated she was admitted to the facility on 05/01/2018. The resident's current diagnoses included End Stage Renal Disease and Depression. Review of the most recent comprehensive significant change Minimum Data Set (MDS) dated 02/19/2019 indicated the resident had no	F 679	On 9/2/19 Resident #11 was delivered an Activity Calendar for September to include Bingo on Tuesdays. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of residents was completed to ensure all residents had an activity calendar in room on 9/2/19 by the Activity Director. On 9/2/19 the Activity Director was educated by the Administrator to ensure an ongoing program is in effect to support residents in their choice of activities to include both facility-sponsored group and individual activities and independent activities designed to meet the interests of	9/26/19

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F 679	Continued From page 9 cognitive impairment. The resident also indicated it was somewhat important to do things with groups of people. The MDS also indicated the resident used a walker and a wheelchair to get around. Review of a quarterly activity review dated 05/24/2019 indicated the resident wanted to be invited to out of room activities. 08/27/19 01:35 PM Resident #11 stated the facility had been without an activity person for a few months, and during that time, she didn't receive an activity calendar, and they didn't continue weekly bingo games. She stated bingo games were scheduled several days a week when the activity director was still in the facility, and the only day available to her were Tuesdays, as she was out for appointments on Mondays, Wednesdays and Fridays. She further stated during couple of months period, no staff came to her and told her about any upcoming activities. The resident also stated she was told there was a bingo game this morning after it took place. She stated she was told it was announced over the intercom, but she did not hear it, and no one came and told her about it. She expressed disappointment in missing it. In an interview with the facility administrator on 08/28/2019 at 3:45 PM, the administrator stated the facility was without an activity for about the last 7 weeks. She stated during that period, volunteers came to the facility on random occasions and conducted bingo games. She stated church services continued as scheduled during the time period and also stated no activity calendars were available to residents during that time.	F 679	and support the physical, mental and psychosocial well-being of each resident, encouraging both independence and interaction in the community. The Activity Director will schedule group activities, independent activities and in room visits on or before 9/26/19. The Activity Director will keep a resident attendance record of facility designed activities on or before 9/26/19. The Administrator and/or designee will interview 5 residents to ensure they receive a monthly activity calendar and are able to hear announcements and participates in activities of their preference in which meets their interests and needs. This will be completed weekly for 4 weeks, then monthly for a minimum of 3 consecutive months or then until resolved by the Quality Assurance committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attending by the Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator. The Administrator is responsible for implementing the acceptable plan of correction.	

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F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to date an open vial of insulin in one of two medication carts reviewed for expired medication (400 hall cart). Findings included: On 8/28/2019 at 4:00 PM, the 400-hall cart was inspected for expired medications. A vial of insulin was found to be open and with no date. Lot #	F 761	On 8/28/19 the open vial of insulin LOT # 8FD468 on the 400 hall cart with an expiration date of 6/30/2021 was discarded. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all medication carts and medication storage areas to ensure all required medications are dated and not	9/26/19

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F 761	Continued From page 11 8FD468 and expiration date of 30 06 2021. The Nurse stated she would get a new vial and the vials are to be dated when they are opened. Interview with the Director of Nursing on 8/28/2019 at 4:20 PM, who stated her expectation was any vial that was opened would be dated when it was opened.	F 761	expired. The audit was completed by confirming each medication present on the medication cart and medication storage was dated by the facility and was not expired. Results of this audit revealed no other medications not dated or expired. The audit was completed by the Director of Nursing and was completed on 8/28/19. On 8/29/19 the Pharmacy Consultant completed medication cart and storage room audits to ensure all requited medications were dated and not expired. On 8/28/19 all licensed nurses and medication aides began being educated by the Staff Development Coordinator on dating and removing medication from the mediation carts and returned to pharmacy as appropriate. The education has been integrated in the standard orientation training for all licensed nurses and medication aides. The Director of Nursing and/or Designee will review 2 medication carts to ensure all required medications are dated and within date. This will be completed weekly for 4 weeks, then monthly for 2 months for a minimum of 3 months and then until resolved by the Quality Assurance committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Minimum Data Set Coordinator, Unit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 12	F 761	Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator. The Administrator is responsible for implementing the acceptable plan of correction.	