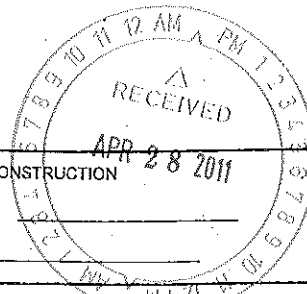


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345520	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2011
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NAME OF PROVIDER OR SUPPLIER LIBERTYWOOD NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360
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(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
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F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to keep the head of the bed elevated at 45 degrees as care planned for 1 of 2 sampled residents (Resident #98) with feeding tubes.</p> <p>The findings included: Resident #98 was admitted to the facility on 11/15/10. Cumulative diagnoses included status post stroke and percutaneous endoscopic gastrostomy (PEG) tube.</p> <p>The quarterly minimum data set dated 2/16/11 revealed that the resident had no memory problems or cognitive impairment, needed extensive assistance for bed mobility and had a feeding tube.</p> <p>The care plan, dated 11/16/10 and updated 2/23/11, identified the feeding tube as a problem. Interventions included keeping the head of bed elevated at a 45 degree angle at all times except during incontinent care and personal care for aspiration precautions and due to the resident becoming short of breath when lying flat. The care plan indicated that the resident received bolus feedings 4 times a day.</p>	F 282	<ul style="list-style-type: none"> The head of the bed for resident #98 was elevated to 45 degrees, he was pulled up in the bed, his PEG tube was verified for placement, and residual checked. All licensed nurses were in-serviced by the Staff Development Coordinator on checking by PEG tube placement prior to utilizing it and to check residual. All licensed nurses and certified nursing assistants were in-serviced by the Staff Development Coordinator on keeping the head of the bed elevated to 45 degrees for resident #98 except while staff providing personal and/or incontinent care and then the tube feeding must be turned to HOLD. The licensed nurse will turn the feeding back on after certified nursing assistant notifies them; and to ensure the resident is pulled up while in the bed. All residents with a PEG tube have a risk of being affected by this deficient practice. All licensed nurses in-serviced by the Staff Development Coordinator on verifying PEG 	04/23/2011
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X5) DATE 4/27/11
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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.

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F 282	<p>Continued From page 1</p> <p>During observation of a medication pass on 3/23/11 at 9:22 AM, Resident #98 was observed in bed. The head of his bed was elevated approximately 30 degrees, but the resident had slid down in bed so that his head was elevated approximately 20-25 degrees. Nurse #6 was observed to administer the resident's medications through the PEG tube without checking tube placement or residual, or repositioning the resident so that he would be elevated at least 30 degrees to lower the risk of aspiration.</p> <p>During an interview on 3/23/11 at 9:30 AM, Nurse #6 acknowledged that the resident's head was only elevated between 20 - 25 degrees.</p> <p>During an interview on 3/24/11 at 10:20 AM, Resident #98 indicated that he was usually semi-sitting in bed when he received his medications and feedings and added that he could breathe better when sitting.</p> <p>During an interview on 3/24/11 at 11:05 AM, nursing assistant (NA) #1 indicated that she frequently took care of Resident #98. NA#1 indicated that she was not aware that the resident was care planned for keeping the head of his bed elevated 45 degrees. NA#1 indicated that if she had any concerns regarding positioning requirements, she would ask the nurse.</p> <p>During an interview on 3/24/11 at 11:10 AM, the Director of Nursing (DON) indicated that the flow sheet books used by the NAs should have care guides for each resident, and that the care guide should specify requirements for positioning. The DON reviewed the flow sheet book and acknowledged that there were no care guides for many of the residents, including Resident #98.</p>	F 282	<p>tube placement prior to utilizing it and to check residual. All licensed nurses and certified nursing assistants in-serviced by the Staff Development Coordinator that all residents with a PEG tube must have the head of the bed elevated to 45 degrees at all times except during personal and/or incontinent care; while the head of the bed is lowered, the tube feeding must be put on HOLD, when care is done, the certified nursing assistant is to notify the licensed nurse to turn the tube feeding back on; and to ensure that residents are pulled up in the bed.</p> <ul style="list-style-type: none"> All licensed nurses and certified nursing assistants hired after the completion date will be in-serviced by the Staff Development Coordinator during orientation on verifying PEG tube placement prior to utilizing it and to check residual. All licensed nurses and certified nursing assistants in-serviced by the Staff Development Coordinator that 		

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F 282	Continued From page 2	F 282		
F 286 SS=B	<p>During an interview on 3/25/11 at 10:50 AM, the MDS nurse indicated that care guides were only used for new admissions. After the resident had resided in the facility a while, the care guide should be removed and NAs were expected to use the care plan or ask the nurse.</p> <p>483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS</p> <p>A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain the 15 months of assessments in the resident's active medical records for 5 (Residents # 33, # 98, #68, #112 & #15) of sampled residents.</p> <p>1. Resident # 33 was admitted to the facility on 07/12/09. Review of the resident's chart revealed one Minimum Data Set (MDS) assessment which was a quarterly assessment dated 01/13/11. The rest of the assessments were kept in the file cabinet inside a locked storage room. The assessments kept in the file cabinet were the quarterly assessments dated 04/21/10 and 07/22/10 and an annual assessment dated 10/20/10.</p> <p>On 03/23/11 at 4:10 PM, the storage room was observed. It was located near the nurse's station. A file cabinet was inside the storage room where the MDS assessments were stored. The storage room was locked at all times. One nurse on each</p>	F 286	<p>all residents with a PEG tube must have the head of the bed elevated to 45 degrees at all times except during personal and/or incontinent care; while the head of the bed is lowered, the tube feeding must be put on HOLD, when care is done, the certified nursing assistant is to notify the licensed nurse to turn the tube feeding back on; and to ensure that residents are positioned correctly while in the bed.</p> <ul style="list-style-type: none"> Director of Nursing/designee to audit 100% of residents with a PEG tube utilizing the "PEG Tube Audit" tool to ensure that nurses verify PEG tube placement prior to use and check residual and that residents with PEG tubes have the head of bed elevated to 45 degrees, is positioned properly while in the bed, and if the head of the bed is lowered for care, the tube feeding is put on HOLD. The audits will be done weekly x 4, then monthly x 3, then quarterly. All findings brought to the monthly QA&A meeting for review. 	Ongoing

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F 286	<p>Continued From page 3 wing has a key to the storage room.</p> <p>On 03/24/11 at 4:19 PM, the MDS Nurse was interviewed. She stated that she always kept the most recent MDS assessment in the chart and the rest of the assessments were kept in the file cabinet in a locked storage room. She further stated that the nurse has a key to the storage room.</p> <p>2. Resident # 98 was admitted to the facility on 11/15/10. Review of the resident's chart revealed one assessment which was an admission assessment dated 11/22/10. The quarterly assessment dated 02/22/11 was kept in the file cabinet in a locked storage room</p> <p>On 03/23/11 at 4:10 PM, the storage room was observed. It was located near the nurse's station. A file cabinet was inside the storage room where the MDS assessments were stored. The storage room was locked at all times. One nurse on each wing has a key to the storage room.</p> <p>On 03/24/11 at 4:19 PM, the MDS Nurse was interviewed. She stated that she always kept the most recent MDS assessment in the chart and the rest of the assessments were kept in the file cabinet in a locked storage room. She further stated that the nurse has a key to the storage room.</p> <p>3. Resident # 68 was admitted to the facility on 04/15/10. Review of the resident's chart revealed one assessment which was a quarterly assessment dated 01/17/11. The admission assessment dated 04/20/10 and 07/21/10 and the</p>	F 286	<ul style="list-style-type: none"> The Minimum Data Set (MDS) Assessments for residents #33, #98, #68, #112, and #15 were placed in an unlocked file cabinet at the nurses' station. All licensed nurses were in-serviced by the Staff Development Coordinator on the new location of the Minimum Data Set (MDS) assessments. All residents have the potential to be affected by this deficient practice. All resident Minimum Data Set (MDS) assessments were removed from the locked file cabinets in the rooms off of each wing and placed in an unlocked file cabinet at each nurses' station. The file cabinets are labeled "MDS". All licensed nurses in-serviced by the Staff Development Coordinator of the location of the Minimum Data Set (MDS) assessments. 	04/23/2011	

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F 286	<p>Continued From page 4</p> <p>annual assessment dated 10/21/10 were in the file cabinet in the locked storage room.</p> <p>On 03/23/11 at 4:10 PM, the storage room was observed. It was located near the nurse's station. A file cabinet was inside the storage room where the MDS assessments were stored. The storage room was locked at all times. One nurse on each wing has a key to the storage room.</p> <p>On 03/24/11 at 4:19 PM, the MDS Nurse was interviewed. She stated that she always kept the most recent MDS assessment in the chart and the rest of the assessments were kept in the file cabinet in a locked storage room. She further stated that the nurse has a key to the storage room.</p> <p>4. Resident # 112 was admitted to the facility on 03/20/09. Review of the resident's chart revealed two quarterly MDS assessments dated 11/10/10 and 01/25/11. The significant change in status assessment dated 06/02/10 and the quarterly assessment dated 08/24/10 were in the file cabinet in a locked storage room.</p> <p>On 03/23/11 at 4:10 PM, the storage room was observed. It was located near the nurse's station. A file cabinet was inside the storage room where the MDS assessments were stored. The storage room was locked at all times. One nurse on each wing has a key to the storage room.</p> <p>On 03/24/11 at 4:19 PM, the MDS Nurse was interviewed. She stated that she always kept the most recent MDS assessment in the chart and the rest of the assessments were kept in the file</p>	F 286	<ul style="list-style-type: none"> All Minimum Data Set (MDS) assessments except the most recent, will be kept in an unlocked file cabinet located at each nurses' station. The file cabinet is labeled "MDS". The most recent Minimum Data Set (MDS) assessment is kept on the residents' chart at each nurses' station. The DON/designee will conduct 5 staff interviews each week x 4, then 5 staff interviews monthly, then 5 staff interviews quarterly to ensure the licensed nurses are aware of where the Minimum Data Set (MDS) assessments are located. <p>Interviews will be conducted using an interview tool titled, "Nurses' Interview on Minimum Data Set (MDS) location". All findings to be brought to the monthly QA&A meeting.</p>	Ongoing

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F 286	Continued From page 5 cabinet in a locked storage room. She further stated that the nurse has a key to the storage room. 5. Resident #15 was readmitted to the facility on 11/5/10. Review of the resident's chart revealed a quarterly MDS dated 1/5/11; no other MDS's were on the chart. During an interview on 3/22/11 at 4:15 PM, the Activity Director (AD) indicated that additional MDS's were locked in a file cabinet. The AD then revealed a locked file cabinet in a storage room near the Unit 2 nurses' station. During an interview on 3/23/11 at 3:53 PM, the MDS nurse indicated that only the most recent MDS was kept on the chart, the others were locked in the file near each nurses' station. The MDS nurse indicated that a nurse on each unit had a key. On 3/24/11 at 2:30 PM, Nurse #7 was asked to open the MDS file cabinet. Nurse #7 indicated that Nurse #5 had the key. Nurse #7 was observed asking Nurse #5 for the key. Nurse #5 indicated that she did not know she had a key for the MDS file. Nurse #7 indicated that the keys for the nurse on medication cart #1 (Nurse #5 was assigned to medication cart #1) included the MDS key. Nurse #5 gave Nurse #7 the keys. After trying 4 different keys, Nurse #7 was able to unlock the MDS file. During an interview on 3/25/11 at 11:50 AM, Nurse #5 indicated that she worked as needed, and did not know that she had a key for the MDS file.	F 286			
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS	F 322	<ul style="list-style-type: none"> The head of the bed for resident #98 was elevated to 45 degrees, he was pulled up in the bed, his PEG tube was verified for placement, and residual checked. All licensed nurses were in-serviced by the Staff Development Coordinator on checking PEG tube placement and residual prior to utilizing the PEG tube. All licensed nurses and certified nursing assistants in-serviced by the Staff Development Coordinator that all residents with a PEG tube must have the head of the bed elevated to 45 degrees at all times except during personal and/or incontinent care; while the head of the bed is lowered, the tube feeding must be put on HOLD, when care is done, the certified nursing assistant is to notify the licensed nurse to turn the tube feeding back on; and to ensure that residents are pulled up in the bed. 	04/23/2011	

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F 322	<p>Continued From page 6</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to check tube placement and ensure safe positioning prior to medication administration for 1 of 2 residents (Resident #98) with a feeding tube. The findings included:</p> <p>A facility policy revised 10/2007 entitled "Administering Medications through an Enteral Tube" read in part, "Assist the resident to semi or high Fowler's position (30 degrees to 45 degrees), if tolerated by the resident's physical or medical condition." "For gastrostomy tubes, check placement and gastric contents" "auscultate the abdomen while injecting air from syringe into the tubing, listen for a 'whooshing' sound to check placement of the tube in the stomach. Pull back gently on the syringe to aspirate stomach content."</p> <p>Resident #98 was admitted to the facility on 11/15/10. Cumulative diagnoses included status post stroke and percutaneous endoscopic gastrostomy (PEG) tube. The quarterly minimum data set dated 2/16/11 revealed that the resident had no memory problems or cognitive</p>	F 322	<ul style="list-style-type: none"> All residents with a PEG tube have a risk of being affected by this deficient practice. All licensed nurses were in-serviced by the Staff Development Coordinator on checking PEG tube placement and residual prior to utilizing the PEG tube. All licensed nurses and certified nursing assistants in-serviced by the Staff Development Coordinator that all residents with a PEG tube must have the head of the bed elevated to 45 degrees at <u>all times except during personal and/or incontinent care</u>; while the head of the bed is lowered, the tube feeding must be put on HOLD, when care is done, the certified nursing assistant is to notify the licensed nurse to turn the tube feeding back on; and to ensure that residents are pulled up in the bed. All licensed nurses hired after the completion date will be in-serviced by the Staff Development Coordinator during orientation on verifying PEG tube placement and checking residual prior to using 		

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F 322	Continued From page 7 impairment, needed extensive assistance of 2 for bed mobility and had a feeding tube. During observation of a medication pass on 3/23/11 at 9:22 AM, Resident #98 was observed in bed. The head of his bed was elevated approximately 30 degrees, but the resident had slid down in bed so that his head was elevated approximately 20-25 degrees. Nurse #6 was observed to administer the resident's medications through the PEG tube without checking tube placement or residual, or repositioning the resident so that he would be elevated at least 30 degrees to lower the risk of aspiration. During an interview on 3/23/11 at 9:30 AM, Nurse #6 acknowledged that she had forgotten to check tube placement or residual. The nurse also acknowledged that the resident's head was elevated between 20 - 25 degrees. The nurse obtained assistance to pull the resident up in bed prior to administering the tube feeding formula. During an interview on 3/24/11 at 10:20 AM, Resident #98 indicated that he was usually semi-sitting in bed when he received his medications and feedings, and added that he could breathe better when sitting.	F 322	a PEG tube. All licensed nurses and certified nursing assistants in-serviced by the Staff Development Coordinator that all residents with a PEG tube must have the head of the bed elevated to 45 degrees at all times except during personal and/or incontinent care; while the head of the bed is lowered, the tube feeding must be put on HOLD, when care is done, the certified nursing assistant is to notify the licensed nurse to turn the tube feeding back on; and to ensure that residents are pulled up in the bed. • Director of Nursing/designee to audit 100% of residents with a PEG tube utilizing the "PEG Tube Audit" tool to ensure that licensed nurses verify PEG tube placement and check residual prior to utilizing the PEG tube, that the head of the bed is elevated to 45 degrees at all times except during personal and/or incontinent care, if the head of the bed is lowered for care, the tube feeding is on HOLD and the certified nursing assistant alerts the licensed	Ongoing	
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329			

F322

nurse to turn the tube feeding back on, and the resident is pulled up in the bed. The audits will be done weekly x 4, then monthly x 3, then quarterly. All findings brought to monthly QA&A meeting for review.

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F 329	<p>Continued From page 8 combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and record reviews the facility failed to monitor behaviors of 1 of 10 residents receiving psychoactive medications (Resident #95).</p> <p>Resident # 95 was admitted to the facility on 5/03/2010 and readmitted on 10/25/2010 and 11/28/2010 with diagnoses of Dementia, Alzheimer ' s disease, and Anxiety disorder.</p> <p>The most current quarterly MDS (minimum data set) dated 1/06/2011 was reviewed and revealed Resident #95 had no long term or short term memory problems and his cognition was intact. The MDS indicated " no behaviors were exhibited. "</p> <p>A review of the physician orders revealed a physician ' s order dated 1/14/2011 for a referral</p>	F 329	<ul style="list-style-type: none"> A behavior monitoring form was placed on resident #95 Medication Administration Record. All licensed nurses in-serviced by the Staff Development Coordinator on utilizing behavior forms for all residents on psychoactive medications and all residents who have behaviors. If a resident is on a psychoactive medication but does not have behaviors the form should say "monitor resident for behaviors". If the resident has behaviors, each behavior is to be listed on the behavior monitoring form and licensed nurses to document each time the resident exhibits that behavior. All residents have the potential to be affected by this deficient practice. All licensed nurses in-serviced by the Staff Development Coordinator on utilizing behavior forms for all residents on psychoactive medications and all residents who have behaviors. If a resident is on a psychoactive medication but does not have 	04/23/11

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NAME OF PROVIDER OR SUPPLIER LIBERTYWOOD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360		
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F 329	<p>Continued From page 9</p> <p>to a neurologist for episodes of confusion. The same order included a referral for the psychologist due to the residents' mood.</p> <p>The most current care plan that was last reviewed on 1/25/2011 did not include behaviors to be monitored related to the psychoactive drug Xanax. The interventions were to give the medications as ordered. A trial gradual dose reduction would be tried, as indicated. There would be a psychiatric consult for medication management and psychotherapy as needed.</p> <p>During an interview on 3/23/11 at 8:30am with the resident he verbalized his concern about " people trying to take control of his money and property. "</p> <p>A neurological evaluation note dated 2/01/2011 revealed Resident #95 presented for an " evaluation of his ongoing confusion and delusional state. " He was accompanied by a staff from the facility. The history indicated there was no known event that preceded the symptoms onset. The symptoms were constant with daily episodes. The note indicated that Resident #95 was aware a competency exam was recommended. He told the Neurologist that " people were trying to take control of his money. " He refused to have the competency exam but did consent to the requested labs.</p> <p>A neurological note dated 3/01/2011 indicated Resident #95 returned for a follow up laboratory test results. The Neurologist assessment and plan stated, " Lab work negative for any significant findings. Patient remains delusional. Will start a low dose of Seroquel at bedtime to see if it helps. "</p>	F 329	<p>behaviors the form should say "monitor resident for behaviors". If the resident has behaviors, each behavior is to be listed on the behavior monitoring form and licensed nurses to document each time the resident exhibits that behavior. 100% audit performed on 4/4/11 on all resident Medication Administration Records by the Director of Nursing to ensure all residents who have behaviors or who are on psychotropic medications have a behavior monitoring form on their Medication Administration Record.</p> <ul style="list-style-type: none"> All licensed nurses hired after the completion date will be in-serviced by the Staff Development Coordinator on utilizing behavior forms for all residents on psychoactive medications and all residents who have behaviors. If a resident is on a psychoactive medication but does not have behaviors the form should say "monitor resident for behaviors". If the resident has 		

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F 329	<p>Continued From page 10</p> <p>A review of the physician orders revealed an order dated 3/15/2011 for Seroquel 25 mg at HS (hour of sleep) and Xanax 0.5 mg at bedtime. A review of the MAR (medication administration record) dated March, 2011 revealed the resident received Seroquel 25mg at HS (hour of sleep) and Xanax 0.5mg at bedtime. Seroquel is an atypical antipsychotic drug used in the treatment of schizophrenia. Xanax is used in the treatment of anxiety.</p> <p>The Consulting Pharmacist Drug Regime Review for the months of January, February, and March, 2011 were reviewed and there was no mention of monitoring targeted symptoms or behaviors for the Xanax order. The most current Consulting Pharmacist Drug Regime Review was dated 3/01/2011 and revealed labs were reviewed.</p> <p>The Medical Record did not indicate targeted symptoms or behaviors to be monitored for the Seroquel or Xanax orders. No flow sheets were found for monitoring either medication (Seroquel or Xanax).</p> <p>At 9:22am on 3/23/2011 the Medication Nurse (Nurse #2) was asked if anyone was monitoring the psychoactive medications for this resident and he could not find a monitoring sheet. At 10am he presented a copy of a form titled, " Behavior/Intervention Monthly Flow Record " with Resident # 95 ' s name and target behavior written in " Delusions. " At the bottom was written Seroquel 25 mg p.o. q (every) hs (bedtime). The first documentation on the form was 3/23/2011. In the 7a-3p box for number of episodes on 3/23/2011 was a " 0 ' and Nurse #2 ' s initials. In the box on 3/23/2011 for outcomes was a " + " sign and Nurse #2 ' s initials. Nurse</p>	F 329	<p>behaviors, each behavior is to be listed on the behavior monitoring form and licensed nurses to document each time the resident exhibits that behavior.</p> <ul style="list-style-type: none"> The Director of Nursing will audit 10% of resident medical records including the Medication Administration Record to ensure the Behavior Monitoring tool is in place and being filled out correctly weekly x 4 weeks, then monthly x 3 months, then quarterly. All findings to be brought to the monthly QA&A meeting for review. 	Ongoing

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F 329	Continued From page 11 #2 said he was not monitoring the psychoactive drugs Seroquel and Xanax and the inquiry about monitoring caused him to remember that he needed to be monitoring if the medications were effective or not. On 3/23/2011 at 11:46 am., the Director of Nursing (DON) indicated that when a psychoactive medication is ordered, the form for monitoring targeted symptoms usually comes from the pharmacy and is kept with the Medication Administration Record (MAR). If the form did not accompany the psychoactive medication from the pharmacy, the DON indicated it was the responsibility of the nurse to implement the form.	F 329			
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility had a medication error rate of 15.38% as evidenced by 7 medication errors out of 52 opportunities for 6 of 10 sampled residents observed during medication pass (Residents # 5, #67, #79, #33, #16, #4 and #1). The findings included: 1. During a medication pass observation on 3/23/11 at 7:55 AM, Nurse #6 removed a potassium chloride extended release (ER) tablet from the bubble pack card. A sticker was affixed to the card that read "take with food; do not	F 332	<ul style="list-style-type: none"> Director of Nursing reviewed the medical records of resident's #5, 67, 79, 33, 16, 4, and 1 to ensure the residents did not have any negative outcomes related to medication errors referenced in the 2567 on April 22, 2011. Findings reported to the pharmacy consultant and physician. All licensed nurses with medication errors involving residents #5, 67, 79, 33, 16, 4, and 1 received education on proper medication administration. All residents have the potential to be affected by this deficient practice. All licensed nurses in-serviced on "Preventing Medication Errors" by Northwestern AHEC on 4/21, 2011. 	04/23/2011	

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F 332	<p>Continued From page 12</p> <p>crush". Nurse #6 crushed the potassium chloride ER tablet prior to administering it to Resident #5, who had a diagnosis of hypertension and was on diuretic therapy.</p> <p>Nurse #6 indicated during an interview on 3/23/11 at 7:58 AM that she had checked the "do not crush" medication list in the front of the Medication Administration Record book but did not see potassium chloride ER listed. Nurse #6 said she did not read the sticker and acknowledged that the potassium chloride ER should not have been crushed.</p> <p>2. March 2011 physician orders for Resident #67 included Pepcid 10 milligrams (mg) 2 tablets before meals for gastroesophageal reflux.</p> <p>During a medication pass observation on 3/23/11 at 8:30 AM, Nurse #7 administered 2 tablets of Pepcid 10 mg. Resident #67 had his breakfast tray in front of him and indicated that he had finished eating.</p> <p>Nurse #7 stated during an interview on 3/23/11 at 8:33 AM that the Pepcid should have been given before the resident ate. Nurse #7 added that it was difficult to see the scheduled time on the Medication Administration Record for the Pepcid (7:30 AM) due to the time being highlighted in blue.</p> <p>3. A facility policy dated 10/07 entitled "Medication Administration Eye Drops" read in part, "Pull the lower eyelid down and away from the eyeball to form a pocket." "Place one drop into the pocket." "Wait a sufficient contact time of approximately 3-5 minutes before applying additional medication to the eye."</p>	F 332	<ul style="list-style-type: none"> All new licensed nurses hired after the completion date, will be in-serviced by the Staff Development Coordinator during orientation utilizing the AHEC information on "Preventing Medication Errors". The Staff Development Coordinator will complete a medication pass audit utilizing the "Medication Administration Observation Report" tool on all newly hired licensed nurses during their orientation period. All Licensed nurses who commit medication error(s) will be in-serviced 1:1 by the Staff Development Coordinator on proper medication administration utilizing the AHEC information on "Preventing Medication Errors". Staff Development Coordinator to complete Medication Pass audit utilizing the "Medication Administration Observation Report" tool on licensed nurses who commit medication errors. The findings from the medication pass audit will be reviewed by the Director 		

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F 332	Continued From page 13 March 2011 physician orders for Resident #79 included brimonidine 0.15% (eye drops) 2 drops to the left eye for glaucoma. During a medication pass observation on 3/23/11 at 4:05 PM, Nurse #8 administered 2 drops of the brimonidine to Resident #79's left eye with less than a 5 second pause between the drops. Nurse #8 indicated during an interview on 3/23/11 at 4:07 PM that it was not necessary to wait between drops of the same medication. 4a. Resident #33 had a doctor's order dated 10/28/10 for Oyst Cal D 500 mgs(milligram) by mouth twice a day with meals for Osteopenia. On 03/23/11 at 7:25 AM, Nurse #1 was observed to prepare and to administer the resident's medications including Oyst Cal D 500 mgs. The resident was observed to have his breakfast served at 8:10 AM. On 03/23/11 at 8:34 AM, Nurse #1 was interviewed. She stated that she tried to administer the resident's medication ordered with food/meals as closed to meal time. She agreed that she administered the Oyst Cal before breakfast. 4b. Resident #33 had a doctor's order dated 12/17/09 for Dolobid 500 mgs 1 tablet by mouth 3 times a day with food for Gout. On 03/23/11 at 7:25 AM, Nurse #1 was observed to prepare and to administer the resident's medications including Dolobid 500 mgs. The resident was observed to have his breakfast served at 8:10 AM. On 03/23/11 at 8:34 AM, Nurse #1 was	F 332	of Nursing. Any licensed nurse identified during the medication pass audit, with medication errors, will receive appropriate remedial corrective action by the Director of Nursing. • Staff Development Coordinator will conduct medication pass audit utilizing the "Medication Administration Observation Report " tool on 5 nurses per week x 4 weeks, then 5 nurses , monthly x 3 months, and then 5 nurses quarterly. The Medication Administration Observations are to be completed on licensed nurses on all shifts. Any licensed nurse identified during the medication pass audit with medication errors, will receive appropriate remedial corrective action by the Director of Nursing. All findings to be brought to the monthly QA&A meeting.	Ongoing

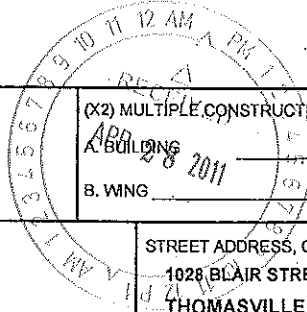
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F 332	<p>Continued From page 14</p> <p>interviewed. She stated that she tried to administer the resident's medication ordered with food/meals as closed to meal time. She agreed that she administered the Dolobid before breakfast.</p> <p>5. Resident # 4 had a doctor's order dated 05/29/07 for Flomax 0.4 mgs 1 capsule by mouth daily - give 30 minutes after meals for Benign Prostatic Hypertrophy (BPH). On 03/23/11 at 7:55 AM, Nurse #1 was observed to prepare and to administer the resident's medications including Flomax 0.4 mgs. The resident had not had breakfast yet.</p> <p>On 03/23/11 at 8:34 AM, Nurse #1 was interviewed. She stated that she was not aware that the order for Flomax was to give 30 minutes after meals. She acknowledged that she had administered the Flomax before meals.</p> <p>6. Resident #1 had a doctor's order dated 06/14/10 for Zoloft 50 mgs - 2 tablets (100 mgs) by mouth daily for Depression. On 03/23/11 at 7:43 AM, Nurse #1 was observed to prepare and to administer the resident's medications including Zoloft 50 mgs 1 tablet.</p> <p>On 03/23/11 at 8:34 AM, Nurse #1 was interviewed. She stated that she was not aware that the order for Zoloft was to give 2 tablets. She acknowledged that she had administered only 1 tablet to the resident.</p> <p>7. Resident # 16 had a doctor's order dated</p>	F 332			

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F 332	Continued From page 15 09/30/10 for Novolin R 10 units SQ (subcutaneous) with lunch for Diabetes Mellitus. On 03/23/11 at 11:28 AM, Nurse #2 was observed to prepare and to administer the Novolin R insulin 10 units to the resident. At 11:55 PM, the resident was still waiting for his lunch.	F 332		
F 364 SS=E	On 03/23/11 at 11:50 AM, Nurse #2 was interviewed. He stated that he administers medication ordered with food/meals at least 30 minutes before and after the meal. He further stated that lunch was served at 12 noon. 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on test tray observation, policy review, resident and staff interviews, the facility failed to maintain hot and cold temps during breakfast for 4 of 6 sampled residents (Residents # 48, 94, 104 and 105) as well as failed to serve grits and sausage in an appetizing manner for 2 of 6 sampled residents (Residents #72 and 95). The findings include: A review of the facility's "Food Handling Guidelines" undated policy revealed the following expectations: Food Handling: Foods should be held hot for	F 364	<ul style="list-style-type: none"> Dietary Manager has met with Residents #48, 94, 104, and 105 to discuss food and beverage temperatures during breakfast. Temperature of the food and beverage for these identified residents' breakfast trays were measured and recorded at the time of the tray service on Monday April 25, 2011, Wednesday April 27, 2011, and Friday April 29, 2011. These identified residents were encouraged to report any dissatisfaction with breakfast meal temperatures to the Dietary Manager, Activities Director, Director of Social Services, or Administrator. Dietary Manager will monitor the preparation of grits and sausage as well as other breakfast foods to ensure they are served to residents #72 and 95 in an appetizing manner. 	04/23/11

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F 364	<p>Continued From page 16 serving at > 150 degrees. Foods should be covered during hot holding to minimize effects of evaporative cooling on the surface. Hold potentially hazardous foods at temperatures above 140 degrees and below 40 degrees Fahrenheit, except during necessary periods of preparation, service and chilling.</p> <p>1. On 3/21/11 at 3:20pm an interview was held with Resident #72. He was asked to comment on his meals and responded that sometimes the grits served have lumps and that they do not taste good. He had not voiced his concerns to anyone in the dietary department.</p> <p>2. On 3/21/11 at 3:41pm an interview was held with Resident # 115. He was asked to comment on his meals and responded that half of the time, the food is too cold. He stated that he eats his meals in his rooms and didn't ask for the food to be reheated.</p> <p>3. On 3/21/11 at 4:43pm an interview was held with Resident # 108. He was asked to comment on his meals and responded that the meals at lunch and dinner could be warmer. He eats his meals in his room and was observed during lunch meal on 3/24/11. He ate a small amount of his food, stating that the food was cold, yet didn't want to ask staff to reheat his meal.</p> <p>4. On 3/22/11 at 9:48am an interview was held with Resident # 94. He was asked to comment on his meals and responded that his meals are hardly ever hot. He continued by stating that his eggs are usually cold, the coffee was already placed in a cup and has been lukewarm. He shared that he doesn't bother to ask staff to</p>	F 364	<ul style="list-style-type: none"> All residents have the potential to be affected by this deficient practice. Dietary Manager has met with resident council to discuss food and beverage temperatures. All residents were encouraged to report any dissatisfaction with breakfast meal temperatures to the Dietary Manager, Activities Director, Director of Social Services, or Administrator. Dietary Manager will monitor the preparation of all food and beverages to ensure they are served to residents in an appetizing manner. All current dietary employees in-serviced on April 14, 2011 by the Dietary Manager on the proper setting of the warming plate. 		

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F 364	<p>Continued From page 17 reheat the food.</p> <p>5. On 3/22/11 at 10:09am an interview was held with Resident #48. He was asked to comment on his meals and responded that with all of his meals, the food was served on cold plates and sits for awhile before the tray was brought to him.</p> <p>6. On 3/22/11 at 10:53am an interview was held with Resident #95. He was asked to comment on his meals and responded that the sausage served during breakfast, appears to float in oil. He has complained to the cook, but it continued to be served to him.</p> <p>On 3/23/11 at 7:25am an observation of the trayline at breakfast revealed the following. Upon entering the kitchen, it was noted that a stack of pre-poured coffee cups were on a rolling cart as well as uncovered food items on the steam table.</p> <p>The cook was interviewed and stated that the dietary staff calibrate the thermometer daily and that it was last done yesterday, at dinner. She proceeded to take food temperatures of the following items on the menu. Scrambled eggs were 179 degrees, Grits were 198 degrees, oatmeal was 198 degrees, pureed eggs were 168 degrees, pureed sausage was 170 degrees, ground sausage were 179 degrees, french toast at 175 degrees and coffee at 149 degrees and the sausage patty, was in a container, full of a thin golden brown liquid, were 178 degrees.</p> <p>Next to the tray line, was a double sided food warmer. The cook commented that the targeted range for meats were 160 degrees, 145 degrees for eggs, 165 degrees for hot cereals and coffee at 190 degrees. Cold items were expected to be</p>	F 364	<ul style="list-style-type: none"> Dietary Manager/Designee to conduct resident interviews, using the "resident interview for meal satisfaction" audit tool regarding food temperatures and palatability. These will be conducted on 5 residents weekly x 4 weeks, then 5 residents monthly x 3 months, then 5 residents quarterly. All interview findings to be brought to monthly QA&A. All dietary staff hired after the completion date will be in-serviced by the Dietary Manager during orientation regarding proper setting of the warming plate. Maintenance Director closed the vents over the steam table on March 23, 2011. Maintenance Director will check to ensure the vents over the steam table are closed during monthly maintenance rounds and document on the Preventative Maintenance log all findings. Maintenance Director adjusted the plate warmer on March 23, 2011 to the appropriate setting. 	Ongoing

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F 364	<p>Continued From page 18 at 40 degrees.</p> <p>The cook as well as the two dietary aides, stated that they had not heard any negative feedback about breakfast meal items.</p> <p>The tray line began promptly at 7:30am. Food items were placed on plates, then covered with an insulated lid. All beverage containers had a thin plastic lid affixed to the cups. The grits were noted to be thick.</p> <p>On 3/23/11 at 8:30am the test tray was sampled. The grits were described by the Dietary Manager to be thick. She stated that they could possibly add water to the grits while on the tray line. The scrambled eggs were recorded at 93 degrees, the sausage was recorded at 94 degrees. The coffee was served at 116 degrees. The milk was served at 44 degrees. With the exception of the grits, recorded at 150 degrees, the food was barely warm. The Dietary Manager stated that she had not received any negative feedback about food temps or breakfast meal items.</p> <p>On 3/23/11 at 9:00 am, the Dietary Manager stated that she went back to the kitchen and noted that one side of the plate warmer was not turned to the most optimum setting of 3 (1=low, 4=high) which might have contributed to the food not remaining warm during meal transport. She in-serviced the cook to adjust the temperature whenever she uses the device.</p> <p>On 3/23/11 at 5:00pm, the District Food Manager stated that their department recently purchased new insulater cups for beverages and was surprised that the heat was not held for the coffee. He stated that their targeted range was</p>	F 364	<p>Maintenance will ensure the plate warmer is on the appropriate setting during his monthly maintenance rounds and document on the Preventative Maintenance log all findings. Administrator will review Preventative Maintenance Logs on a Quarterly basis. Daily audits of the plate warmer utilizing the "Plate warmer daily audit tool" to be conducted by the Dietary manager/designee daily x 1 month, then 3 x week x 2 weeks, then 1 x per week x 1 month on an ongoing basis. All findings to be brought to monthly QA&A meeting. Dietary Manager/designee to conduct test trays 3x week x 4 weeks, then weekly x 2 months, then monthly x 3 months, then quarterly to ensure food/beverage temperatures are within acceptable range. All audit findings will be brought to monthly QA&A.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345520	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/25/2011
NAME OF PROVIDER OR SUPPLIER LIBERTYWOOD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360		
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F 364	Continued From page 19 190 degrees but that's too hot for some residents, so they constantly strive to find a happy medium. Regarding the sausage he pointed out that they place the sausage in a liquid broth and that it was not oil.	F 364	<ul style="list-style-type: none"> No residents found to have been affected. All residents have the potential to be affected by this deficient practice. 100% audit of all medication refrigerators, medication storage areas, and medication carts. All expired medications discarded according to pharmacy policy and procedure. All medications found not labeled discarded according to pharmacy policy and procedure. All medications found in the refrigerator with a temperature below the acceptable range were sent back to the pharmacy and replaced according to pharmacy policy and procedure. The refrigerator was defrosted and temperature setting placed on correct setting. All licensed nurses in-serviced by the Staff Development Coordinator on discarding of expired medications, and the expiration times of medications. All licensed nurses in-serviced by the Staff Development 	04/23/11	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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.	F 431			

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F 431	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review and facility's "Refrigerator Temperature Log" form, the facility failed to discard expired Advair on 1 of 4 medication carts (medication cart #1 on Unit 2) and failed to maintain the appropriate temperature range for 1 of 2 medication refrigerators (Unit 2 medication refrigerator). The findings included: 1. The facility policy dated 10/07 entitled "Medications with Special Expiration Date Requirements" read in part, "Advair powder for inhalation: (Expiration Date is) 30 days after removal from foil pack." On 3/23/11 at 5:45 PM, medication cart #1 on Unit 2 was observed with an Advair inhaler, dated as opened on 2/8/11. During an interview on 3/23/11 at 5:45 PM, Nurse #4 indicated that the Advair should have been discarded 30 days after opening. 2. A form entitled "Refrigerator Temperature Log" that hung near the refrigerator read in part, "The normal temperature range of the refrigerator is 36-46 degrees Fahrenheit (F). If the temperature exceeds the normal range, please document in the 'comments' section any actions taken." The form was dated March 2011 and included a column numbered 1-31 for the day of the month, a column for the temperature each day, a column for the initials of the person checking the temperature, and a column for comments.	F 431	Coordinator on monitoring the medication refrigerator temperatures daily by the 11pm-7am nurse, and defrosting the medication refrigerators weekly by the 11pm-7am nurse. • All licensed nurses hired after the completion date will be in-serviced by the Staff Development Coordinator during orientation. Medication refrigerator temperatures to be monitored daily by the 11pm-7am licensed nurse. All medication refrigerators to be defrosted weekly (Wing I on Saturday, Wing II on Sunday) by the 11pm-7am licensed nurse. All licensed nurses to check medication carts daily for expired medications and send all expired medications back to pharmacy to be discarded. All licensed nurses to label and date all medications when opened. Weekend Supervisor to check medication rooms for expired medications weekly and discard appropriately. • Director of Nursing/designee to audit all medication carts, medication storage rooms, medication refrigerators for expired medications using the • Medication Storage Checklist form weekly x 4, then monthly x 3, then quarterly. All findings brought to the monthly QA&A meeting for review. Director of	

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F 431	Continued From page 21 Temperature readings were documented for 3/4/11 - 3/6/11, 3/12/11, 3/13/11, 3/19/11 and 3/20/11. The readings ranged from 36 - 38 degrees F. Observation, with Nurse #5, of the Unit 2 medication refrigerator on 3/25/11 at 11:55 AM revealed a temperature reading of 32 degrees F per the thermometer inside the refrigerator. Nurse #5 indicated that she did not know who was responsible for monitoring the refrigerator temperatures. During an interview on 3/25/11 at 12:05 PM, the Director of Nursing (DON) indicated that the facility was unaware that the medication refrigerator temperature was too cold. The DON indicated that temperatures should have been checked and recorded daily. The DON said she would contact the pharmacy for direction on what to do with the medications in the refrigerator.	F 431	Nursing to audit medication refrigerator temperature logs using the "Medication Refrigerator Temperature Audit" form weekly x 4, then monthly x 3, then quarterly. All findings to be brought to the monthly QA&A meeting for review. Director of Nursing/designee to monitor the medication refrigerators to ensure they are defrosted and temperature is at appropriate setting utilizing the "Medication Refrigerator Defrost and Temperature Control" form weekly x 4, then monthly x 3, then quarterly. All findings brought to monthly QA&A meeting for review.	Ongoing
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to promptly inform the attending physician of the laboratory report for 1 (Resident #33) of 10 sampled residents. The finding includes: Resident #33 was admitted to the facility with multiple diagnoses including Seizure Disorder. The quarterly MDS assessment dated 01/13/11	F 505	<ul style="list-style-type: none"> Director of Nursing reviewed the medical record and the Medication Administration Record including the laboratory values and physician orders for resident #33 on March 23, 2011 for any negative outcomes related to the Dilantin laboratory value, physician notification, medication administration, and completeness of the clinical 	04/23/11

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F 505	<p>Continued From page 22</p> <p>indicated that the resident had a severe cognitive impairment.</p> <p>Review of the chart revealed that Resident #33 was on Dilantin for Seizure Disorder. The resident's Dilantin level on 09/04/10 was 18.4 with normal range of 10-20. On 10/18/10, the attending physician had changed the order to Phenytoin Na Ext 100 mgs (milligram) cap (capsule) - take 2 capsules by mouth 2 times a day at 8 AM and 8 PM. On 12/13/10, there was an order to draw Dilantin level and fax the report to the neuro (neurology) science center. On 12/15/10, the Dilantin level was 37, the physician was informed with orders. Dilantin was withheld and the Dilantin dose was changed to 100 mgs in AM and 200 mgs in PM and to draw Dilantin level next week. On 10/22/10, the Dilantin level was 26.4, the physician was informed with new orders to hold the PM dose and to restart in AM and to check the Dilantin level next week. On 12/31/10, the Dilantin level was 25.9. On 01/03/11, the physician was informed with an order to hold the Dilantin and to draw the level in AM. On 01/04/11, the Dilantin level was 20.2, the physician was informed and new order to discontinue current Dilantin and to start Dilantin 125 mgs/5 ml (milliliter) give 5 ml twice a day. On 02/28/11, there was an order to repeat Dilantin level. On 03/16/11, the physician had reviewed the resident's records and found no Dilantin level result in the chart for 02/28/11. The physician had written in the telephone order dated 03/16/11 " a Dilantin level was ordered 02/28/11, result not in chart. "</p> <p>On 03/24/11, the resident's chart was reviewed. There was no Dilantin level result found in the chart for 02/28/11.</p>	F 505	<p>record. Director of Nursing evaluated the process of receiving lab reports and communicating those values to the physician. All licensed nurses in-serviced by the Staff Development Coordinator on April 19, 2011 on the proper procedure for obtaining labs, the licensed nurses responsibility of reviewing the lab values, communicating the results to the physician, and putting the lab results on the chart.</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the deficient practice. Assistant Director of Nursing audited 100% of the current residents' medical records to ensure all labs ordered by the physician had been obtained and results reviewed by the physician and then put on the chart. All licensed nurses in-serviced by the Staff Development Coordinator on April 19, 2011 on the proper procedure for obtaining labs, the licensed nurses responsibility of reviewing the lab values, 		

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F 505	<p>Continued From page 23</p> <p>On 03/24/11 at 9:34 AM, the ADON (Assistant Director of Nursing) was interviewed. She stated that she would look for the result of the Dilantin level. At 10:05 AM, the ADON had provided a copy of the result of the Dilantin level. She stated that she got it from the medical records. The report indicated that the collection date was 03/01/11 and the report date was 03/02/11. The Dilantin level was 5.6 (low). The report form had an initial from the Nurse Practitioner with the date of 03/18/11 indicating that she had reviewed the report that date. The form also indicated that the report was faxed to the physician on 03/17/11. The ADON further indicated that she did not know when the report was faxed to the facility. The ADON further stated that starting 03/15/11, she had an audit tool to monitor if the ordered laboratory was drawn and the result was in the chart. She stated that she had not seen any audit tool for the laboratory prior to 03/15/11.</p> <p>On 03/24/11 at 4:25 PM, Nurse #3 was interviewed. She stated that she did not call the laboratory for the Dilantin level. She indicated that normally the laboratory results were faxed from the laboratory to the facility and the nurse faxed them to the physician's office. She stated that she found the Dilantin result in the fax machine the day she faxed it to the physician's office which was on 03/17/11.</p>	F 505	<p>communicating the results to the physician, and putting the lab results on the chart.</p> <ul style="list-style-type: none"> All licensed nurses hired after the completion date to be in-serviced by the Staff Development Coordinator during orientation on the proper procedure for obtaining labs, the licensed nurses responsibility of reviewing the lab values, communicating the results to the physician, and putting the lab results on the chart. Director of Nursing to review pink copy of each Physician Interim/Telephone Order form daily (5 x week). All pink copies with lab orders on them will be given to the Assistant Director of Nursing. The Assistant Director of Nursing to log in all labs ordered utilizing the "Lab Audit Tool" to follow up on the date the lab is ordered, the date the lab is drawn, the date the physician reviews the results, and the date the results are placed on the chart. Director of Nursing to review the findings of the "Lab Audit Tool" and report the results of the review to the monthly QA&A meeting. 	Ongoing	

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 05/03/2011 the linen storage room is being used as a storage room (greater than 100 sq.feet) and is not covered by the sprinkler. B. Based on observation on 05/03/2011 there are two (2) Soiled linen rooms near the beauty shop that are not covered by the sprinkler system. 42 CFR 483.70 (a)	K 029	<ul style="list-style-type: none"> Estimates to install a sprinkler system in the linen storage room scheduled for 05/17/2011. Estimates to install a sprinkler system in the 2 soiled linen rooms near the beauty shop scheduled for 05/19/2011. 100% of all linen storage rooms checked to ensure they are sprinkled. 100% of soiled linen rooms checked to ensure they are sprinkled. Linen storage rooms and the 2 soiled linen rooms near the beauty shop to have sprinklers installed by June 17, 2011. Maintenance Director to check the linen storage rooms and the soiled linen rooms monthly as part of the Preventative Maintenance audit. All findings to be brought to the facility monthly QA&A meeting for review. 	6-18-11 or per phone conv. w/ Bill CWT
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99	K 076		Ongoing

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MAY 24 2011
CONSTRUCTION SECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE ADMINISTRATOR (X6) DATE 5/20/11

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.

K076

- Oxygen tanks that are full are placed in a separate area labeled "Full Oxygen Cylinders". Those that were empty were placed in a separate area labeled "Empty Oxygen Cylinders". All oxygen tanks placed in an oxygen cylinder holder.
- 100% of oxygen cylinders checked in the facility. All oxygen cylinders placed in a container, so they are not free-standing. All oxygen cylinders that were full were placed in the area labeled "Full Oxygen Cylinders" and those that are empty were placed in the area labeled "Empty Oxygen Cylinders".
- All facility staff in-serviced on the proper place to store empty or full oxygen cylinders and that ALL oxygen cylinders must be stored in a cylinder holder and may not be free-standing.
- A weekly audit will be performed on the oxygen cylinder storage areas by the Director of Nursing/designee to ensure all full oxygen cylinders are stored in the "Full Oxygen Cylinder" area and all empty oxygen cylinders are stored in the "Empty Oxygen Cylinder" area. All oxygen cylinders also audited to ensure they are stored in a supportive area and are not free-standing.

G-18-11
as per
phone con

Ongoing

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NAME OF PROVIDER OR SUPPLIER LIBERTYWOOD NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360
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K 076	Continued From page 1 4.3.1.1.2, 19.3.2.4	K130 K076	<ul style="list-style-type: none"> The combustion area of the gas fired dryers was immediately cleaned of any lint. 100% of the gas fired dryers were checked to ensure lint was not present on top. 100% of laundry employees were in-serviced on cleaning the lint off of the dryers and checking the combustion area of the gas fired dryers at least every 2 hours to ensure this area is free of lint. 	6-18-11
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130	<ul style="list-style-type: none"> Housekeeping Supervisor/designee is to audit the combustion area of the gas fired dryer at least daily to ensure there is no lint present. All findings to be brought to facility monthly QA&A meeting. 	Ongoing
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2	K 147	<ul style="list-style-type: none"> Quotes obtained to add an emergency receptacle to the medication rooms. Receptacles were installed on 05/12/11 by J.D. Hill Electric Company. All Medication refrigerators were checked to ensure they were plugged into an emergency receptacle. 100% of nurses in-serviced that all medication refrigerators must be plugged into an emergency receptacle. 	6-18-11
	This STANDARD is not met as evidenced by: A. Based on observation on 05/03/2011 the combustion area of the gas fired dryers was very heavy with lint.			
	This STANDARD is not met as evidenced by: A. Based on observation on 05/03/2011 the med. refrigerator on wing two (2) was not plugged into an emergency receptacle. 42 CFR 483.70 (a)		<ul style="list-style-type: none"> Director of Nursing/designee to audit Medication Refrigerators to be audited weekly to ensure they are plugged into an emergency receptacle. All findings brought to the facility monthly QA&A meeting for review. 	Ongoing