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 _____	C 09/30/2011

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LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

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F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to notify the physician	F 157	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. **F 157** **Corrective Action for Resident Affected:** For Resident # 2, discharged to the hospital and deceased **Corrective Action for Resident Potentially Affected:** All resident's have the potential to be affected by the alleged deficient practice. All residents are potentially affected by this practice. On 9/29/2011, the charge nurses with the supervision of unit manager, MDS nurse and staff development coordinator assessed all current residents for changes in conditions and the attending physician was notified immediately of any identified changes. 92 out of 92 residents were assessed and 4 were noted to have change in conditions. The attending physicians were contacted by the staff nurses and orders were received and implemented. This included a 1. Resident who was experiencing nausea, vomiting and loose stools and received orders for	10/24/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jacqueline Dillemore RN. DHA		10/24/11

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.

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F 157	Continued From page 1 of a change in mental status of Resident #2 after returning from the hospital with diagnoses of a concussion and laceration to the forehead after a fall. This was evident in 1 of 7 residents in the survey sample that had a change in status. Immediate jeopardy began on 7/30/11 when she returned to the facility from the hospital with diagnoses of a concussion and laceration to the forehead after she fell at the facility. The jeopardy was removed on 9/30/11. The facility remains out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training. Findings included: Resident #2 was readmitted to the facility on 6/17/11 with cumulative diagnoses which included Late Effect CVA (cerebral vascular accident) with left sided Hemiplegia, Chronic Kidney Disease (Stage IV) and Atrial Fibrillation. Review of the quarterly MDS (minimum data set) assessment dated 6/30/11 revealed Resident #2 was alert to person and time, able to make her needs known and required extensive assistance from the staff for ADLs (activities of daily living). Review of the Nurses' Notes (NN) dated 7/30/11 at 6:45 am revealed the resident was observed on the floor with bleeding from a wound to the forehead. A medical emergency service of 911 was summoned and transferred the resident to the hospital. Review of the NN dated 7/30/11 at 12:05 pm	F 157	phenergan, immodium, clear liquid diet, intravenous fluids and rocephin. 2. Resident who complained of pain, and was medicated for pain and received orders for a urine analysis and culture, 3. Resident who developed rash and received orders for hydrocortisone, benedryl, prevacid, to hold heparin, and foley catheter 4. resident who was experiencing some hallucinations and received an order to be evaluated by physician elder care on 9/30/2011. Order obtained have been implemented by the staff nurses . These resident will remain on the acute charting list and will be assessed every shift for 72 hours after treatment has stopped. If improvement is not noted within 24 hours the physician will be contacted by the staff nurse assigned to the resident for follow up instructions/orders. This assessment includes the following: **o Observing for lacerations; if present, clean and apply dry, sterile dressing. Note size, depth and amount of bleeding or drainage.** **o Observing for swelling and discoloration; if present, chart size, site, amount and color.** **o Observing for convulsions; chart time began, precipitating factors, duration, vital signs and time ended. Also chart whether or not resident had difficulty breathing.** **o Observing and inquire if resident has headache or pain.**	

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F 157	Continued From page 2 completed by Nurse #1 revealed the resident returned to the facility. During a telephone interview on 09/30/11 at 7:45 am with Nurse #1, who admitted resident back from ER [emergency room], she stated "I readmitted the resident but I do not remember how she looked, [regarding her mental status] or any other bruises than what I documented in my notes, she looked tired." Nurse #1 stated Resident #2 was sleeping the whole time when she returned from the hospital. Her face had a large bump on her forehead, stitches with no dressing on it. The nurse stated "I thought it was odd that she was sent back so soon after sustaining a head injury. I know in the hospital they gave her a dose of Tylenol #3, and I am not sure if that had anything to do with her being sleepy." She continued "I only work every other weekend, so I really did not know this resident's normal behavior or alertness." Continued interview with Nurse #1 indicated Resident #2 did not follow commands upon return from the hospital as she did prior to the fall. Nurse #1 indicated that, after her return from the ER, the resident would respond by smiling. This nurse indicated she did not feel it was necessary to contact the physician because the resident had just returned from the hospital, so Nurse #1 expected the resident to be tired. During an interview with NA #5 on 9/30/11 at 3:15 pm, who worked Saturday (7/30/11), Sunday (7/31/11) and Monday (8/1/11) during the day shift and cared for Resident #2, she stated "she (Resident #2) was very different when she came back from the ER, she stayed in the bed and slept more. Her appetite was poor. The	F 157	o Observing for personality changes. o Observing for alterations in consciousness. o Observing for incontinence. o Observing for sensory weakness. o Observing for generalized weakness. o Observing for speech disorder. o Observing for gait, posture or balance disorder. o Observing for stiff neck. o Observing for proper reflexes (response to painful stimuli). o Observing for abdominal spasm or pain. o Observing for bleeding from ears, nose, throat. o Observing for unequal pupils. o Observing for dyspnea or variations in respirations (irregular). o Observing for flushing or cyanosis. o Observing for pain. o Observing for abduction, adduction, shortening or improper position of extremities. o Taking vital signs by the	

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F 157	Continued From page 3 resident's family had to assist her and encourage her to eat. She did not eat Sunday breakfast or lunch, and I told the nurses." (Nurse #1 on Saturday and Sunday and Nurse # 5 on Monday"). NA #5 indicated on interview that the decreased eating or needing assistance with meals was unusual. Review of NN dated 7/30/11 at 9:00 PM completed by Nurse #2 revealed Resident #2 had no signs and symptoms of acute distress or shortness of breath. Resident #2 complained of pain at 7:00 PM, an as needed pain medication, Tylenol #3, was administered and was effective. She was resting in bed with respirations even and unlabored. Vital signs at 6:00 PM were documented as blood pressure (BP) 138/73, pulse (P) 97, respirations (R) 19, and oxygen saturation 92%. During an interview on 9/30/11 at 2:55 PM with Nurse #2, who worked 7/30/11 (3-11 PM) she stated "she (Resident #2) appeared to be tired and sleepy. She ate about 50% of her dinner, but the NA informed me she had a poor appetite even with a lot of encouragement, and her family fed her. She was moaning about 8:30 pm, I think because she had pain in her head. She took her meds, but was unable to describe where the pain actually was. She did shake her head to indicate her head hurt. It was obvious there was something different about the way she acted and responded, I just thought it was from the bump on her head. I told the oncoming nurse (Nurse # 3) about her behavior during report. I did the neuro checks and documented them. I did not notice any difference [in her vitals signs]." She indicated	F 157	**nursing assistant** **Systemic Changes** On 9/29/2011 and 9/30/2011, all staff nurses were in-serviced by staff development coordinator, unit manager, the nurse consultant and the administrator how to contact the physician and how to document significant changes. 24 out of 30 staff nurses have received this education (*see Attachment A*) The exact in-service content is as follows: **Credible Allegation In-service** • **After all resident falls, injuries or changes in physical or mental function, the charge nurse will monitor the following every shift for 72 hours:** o **Observe for lacerations; if present, clean and apply dry, sterile dressing. Note size, depth and amount of bleeding or drainage.** o **Observe for swelling and discoloration; if present, chart size, site, amount and color.** o **Observe for convulsions; chart time began, precipitating factors, duration, vital signs and time ended. Also chart whether or not resident had difficulty breathing.** o **Observe and inquire if resident has headache or pain.**	

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F 157	Continued From page 4 even though she had a poor appetite, needed encouragement from her family to eat, complained of discomfort that she was unable to describe and slept a lot during the shift,] "I did not think it was necessary to call the doctor." During an interview with NA #3 on 09/30/11 at 3:10 pm; who worked with Resident #2 on Saturday and Sunday; 3:00pm-11:00 pm shift. NA #3 stated "the resident did not eat and I tried to encourage her to eat. She slept a lot and she was more sedated than usual. Before she went to the hospital she was usually out of bed in her wheelchair and ate her meals in the dinning room. I told the Nurse (Nurse # 6), that she was sleeping more and not as hungry or eating like she usually did." During an interview with NA #4 on 09/30/11 at 3:12 pm who also worked on Saturday and Sunday from 3:00 pm-11:00 pm NA #4 stated "The resident was very sleepy and did not respond to me like she did before she fell. Usually she would smile at me and assisted me when it was time to change her clothes. That weekend she did not assist with any of her care. I told the Nurse (Nurse #6) and she told me she had a head injury and was taking pain medication, it was to be expected." Review of NN dated 7/31/11 at 2:32 am completed by Nurse #3 revealed Resident #2 was easily aroused but did not follow commands; she was sleepy. She moaned and groaned when she was moved or was encouraged taking fluids or waking up. She did not answer the nurse's questions because she was too sedated. Nurse #3 gave the resident pain medications per PRN	F 157	o Observe for personality changes. o Observe for alterations in consciousness. o Observe for incontinence. o Observe for sensory weakness. o Observe for generalized weakness. o Observe for speech disorder. o Observe for gait, posture or balance disorder. o Observe for stiff neck. o Observe for proper reflexes (response to painful stimuli). o Take vital signs and include temperature. o Observe for abdominal spasm or pain. o Observe for bleeding from ears, nose, throat. o Observe for unequal pupils. o Observe for dyspnea or variations in respirations (irregular). o Observe for flushing or cyanosis. o Observe for pain. o Observe for abduction, adduction, shortening or improper position of extremities.	

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F 157	Continued From page 5 (when necessary) order due to moaning and crying out. The nurse continued to monitor the resident. Her vital signs at 6:00 am were: T (temperature) 98.7, P109, R 16 BP 124/70. Review of NN dated 7/31/11 at 5:00 am completed by Nurse #3 revealed Resident #2 in bed resting quietly. NAD (no acute distress) noted. She was easily aroused but drowsy, and did not follow commands because she was too sedated. She was not moaning and crying out as much as before the pain medication was administered. Resident #2 would not squeeze the nurse's hands when asked but she had some strength in upper extremities as evident by pulling arms back when "we were trying to get her vital signs. No apparent distress noted from previous fall. Will con't (continue) to monitor." Vital signs were T 97.4, R 16, P 108, BP 139/84. During an interview with Nurse #3 on 9/30/11 at 9:32 am she indicated she (Resident #2) slept most of the shift. Pain medication was administered. She stated "she (Resident #2) would not respond, and I was not sure how far out of "norm" that was for her, anytime I cared for her she usually slept the whole time. I did the neuro checks, I think they were done every 2 hours, from what I was told by the NAs she was usually coherent at times and was able to follow commands and express her needs." Nurse #3 continued "this was the first time I cared for her when she required medication. She did moan and cry out at times and made facial grimacing; it appeared to me (nurse) that she was in pain. The resident was hard too arouse, I thought it was from medication."	F 157	• **Have someone stay with the resident while the nurse is calling the attending physician, if necessary. The physician should be called promptly (within 15 minutes) after completion of an assessment that determines that a change of condition as outlined above has occurred. The phone numbers for the physicians are in the rolodexes located at each nurses station. The physician should be called for any change of condition as outlined above 24 hours a day and 7 days a week. This process does not change due to time or day of the week.** • **If you are unable to reach the attending physician or the physician on call, call the RN on call within 30 minutes of contacting the primary physician for further instructions. The RN on call phone number is 1-919-820-3214.** • **This assessment should be documented in the nursing notes.** • **The nurse will note any concerns or changes noted by other staff or family** • **Additionally, neurological assessments should be completed any time there is an physician order, when a fall causes an impact to the head, when there is an un-witnessed fall or any other time the nurses deems necessary. The nurse should document using the form for neurological checks.**	

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F 157	Continued From page 6 Review of NN dated 7/31/11 at 10:34 am completed by Nurse #1 revealed that Resident #2 was resting in bed and appeared disoriented. Her speech was somewhat clear with rambling comments. Pt (patient) will hold the nurse's hand when asked but when asked to squeeze the nurse's hand; Resident #2 would "pet" the nurse's hand. Pt. ate approximately 25% of am meal. Her vital signs 128/68, 92, 18, 98.3. Review of NN dated 7/31/11 at 2:35 pm completed by Nurse #1 revealed the neuro checks continued and she (Resident #2) would respond to verbal stimuli by opening her eyes and attempted to verbally respond. She continued to ramble "row, row, row". She did not eat her lunch even with the staff's encouragement. During a telephone interview with Nurse #1 09/30/11 at 7:45 am revealed Resident #2 was very sleepy and stated her family member kept trying to wake her up and get her to drink and eat. Nurse #1 stated "I just thought it was because she had been through a lot from the fall. I did not think it was necessary to notify the doctor. I continued the neuro checks like ordered. Her vital signs were okay, I did not realize her pulse was elevated since her return from the hospital. " Interview with Nurse #3 (who worked on 7/31/11 from 11:00 pm to 7:00 am and 08/01/11 from 11:00 pm to 7:00 am) on 9/30/11 at 9:32 am revealed "I did not continue to do the neuro checks on Sunday evening. I was told in report by the reporting nurse (Nurse #6) that it was no longer necessary." Nurse #3 concluded the interview by stating "All my documentation was from the resident's reactions on Saturday and	F 157	**Neurological checks should be completed every hour times 4 hours and then every shift for a total of 48 hours. A neurological assessments includes the following:** **o Date and time the assessment was completed** **o Level of Consciousness: Is resident alert, drowsy, stuporous or comatose** **o Pupil response: Is the resident's pupil equal and reactive to light. Also document the pupil response in each eye as either brisk, sluggish, non-reactive, pinpoint, dilated or fixed.** **o Motor functions: Document the hand grasp as either equal, the right greater than left, left greater than right, if the resident is unable to participate or if hand grasp is absent. Also document whether the resident is able to to move all extremities. If unable to move all extremities then document which extremities they are able to move. Complete this for the right arm, left arm, right leg and left leg, checking all that apply. If the resident is unable to**	

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F 157	Continued From page 7 Sunday at night, I usually only saw her when she was sleeping. All her vital signs seemed normal; I did not realize her pulse rate was fast. I spoke with the NAs and they said she was not acting like she usually did. I am not sure what her baseline was. She had a head injury, I expected her to be groggy from head injury. I did not notify the doctor, but told the oncoming nurse of her condition." During an interview at 7:07 am 09/30/11 with Nurse #5 who cared for resident on 08/01/11 7:00 am -3:00 pm, she stated "the resident was not acting herself; I told the DON (Director of Nursing) and thought she (the DON) was going to speak to the doctor. She revealed the resident was lethargic and not really herself, she did not want to drink or eat and refused her breakfast and lunch. She (Nurse #5) stated "I should have put more information in my nursing note about her change in condition; I thought the DON was going to contact the doctor after I spoke to her that morning. " Review of the NN dated 8/1/11 completed by Nurse #4 revealed the resident was found at 7:00 pm while the nurse was making rounds to be unresponsive and wheezing. The nurse applied oxygen and tried to suction the resident. She contacted the doctor and sent her to the ER for evaluation. During a telephone interview with Nurse #4 on 9/30/11 at 5:20 pm (worked 3:00 pm -11:00pm on 8/1/11 and sent Resident #2 to ER) she stated "she was not familiar with this resident." She indicated Resident #2 seemed to be doing ok, when she initially saw her at 4:00 pm, she was	F 157	**follow commands or if they are absent any extremities indicate that as well.** **o Pain response: Document if the resident has an appropriate pain response, inappropriate pain response or no pain response.** **o Vital Signs: Document blood pressure, pulse, respirations and temperature** **o Observations: Document any additional observations such as seizure, headache, vomiting or paralysis** **o Sign you name in the box indicated on the form.** **• Complete an incident, accident or risk management report per facility policy.** **• Notify resident's responsible party.** **• If a new order is received by the physician then the order should be documented by the nurse who received the order on the telephone order sheet. Then the order should be transcribed to medication administration record or treatment administration record as appropriate depending on the type of order. Other non-medication/treatment orders should be initiated based on order type. This transcription should be**	

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F 157	Continued From page 8 alert, she was talking incoherently like a mumble. According to the NAs she was not acting like she did before she fell. Nurse #4 indicated during her medication pass at about 7:00 pm, she could hear Resident #2 wheezing from her room door. She went and got O2, and put it on the resident. She stated "I was concerned that she was fed dinner that evening by her family. My thought was that she could have aspirated." She continued she called the doctor and the resident was sent to the hospital. Resident #2 was sent to the ER on 8/1/11 for evaluation of unresponsiveness. Review of the Hospital Records for treatment of unresponsiveness dated 08/02/11 read: Chief complaint: unresponsiveness. "Admitted for altered mental status. She underwent an x-ray confirming focal lingular infiltrates and a urinalysis showing evidence of a urinary tract infection." Resident #2 expired on 8/6/11 in the hospital. Interview with the Administrator on 09/29/11 at 3:45 pm revealed her expectation of the nursing staff was that when a resident was readmitted from the hospital; the nurse would complete a head to toe assessment of the resident and also if necessary start neuro checks to be done per facility policy for 48 hours. Most importantly, the nurse or staff are to notify the physician, the on call nurse, DON or myself if they have any concerns about the residents status and /or orders. The neuro checks were stopped on Sunday evening. The facility policy is that the neuro checks are done for 48 hours and changes were to be reported to the doctor and the	F 157	**completed by the staff nurse receiving the order. The 11-7 nurse is to complete a chart check every night where every chart is reviewed for new orders. If new orders (within the last 24 hours) are identified the night shift nurse is to verify that the order was transcribed appropriately to the medication/treatment record or implemented appropriately. If a problem or concern is identified then the night shift nurse must notify the Director of Nursing that morning by either phone or note placed in the Director of Nursing's box at the nursing station.** **• Any concerns identified by this audit will be corrected or addressed by the Director of Nursing and will be reviewed weekly at the Quality Assurance Committee Meeting describe in this document.** An in service on 9-30-2011 has been provided to the Nursing Assistants by the Staff Development Coordinator, Nurse Consultant, Nurse manager and MDS Coordinator to report any changes to the resident to the nurse on the unit as soon as identified (*see attachment B*). The staff development coordinator will ensure that any nursing assistant who does not complete the in-service training by 9/30/2011 will not be allowed to work until	

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F 157	Continued From page 9 supervisor." During an interview with Administrator on 09/30/11 at 6:10 am revealed it was her understanding that the physician was not notified of any changes because she was told by the DON that Resident #2 was assessed by the admitting nurse to be at her baseline for mentation when she returned from the hospital. After reviewing the records, there was no indication of that assessment or documentation and she would have expected the staff to have notified the doctor of the change in Resident #2's mental status changes or changes in her behavior. During an interview with the director of nursing (DON) on 09/29/11 at 9:04 am the DON stated "I was made aware during the Monday morning meeting (administrative staff meeting) that the resident had a head injury and went to the hospital and got stitches and was returned to the facility on the same day." The DON stated "It is actually the nurse who admitted the resident from the hospital who is responsible to assess the resident, transcribe the orders from the hospital to the appropriate places in the chart and notify the physician the resident had returned to the facility. That nurse is also responsible to make sure she informs the on-call nurse if she had any concerns about the resident's condition or orders the resident returned from the hospital with, so the on-call nurse can clarify these things and contact the physician if necessary. She further indicated it was ultimately the DON's responsibility to make sure changes in resident condition were reflected in the chart, to make sure the orders were clear and all staff was aware	F 157	the training is completed. 32 out of 69 have completed this training. This in-service was incorporated into the new employee facility orientation. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** A quality assurance monitor will be completed five times a week for two weeks by the Administrator or Director of Nursing and then will continue weekly for three months and then monthly until resolved by the Quality Assurance Committee. Reports of the MD notification audit will be given by the director of nursing to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support Nurse and Health Information Management and meets weekly. This monitor will include reviewing all residents who went to the emergency room or hospital charts to ensure that the physician was notified of any changes in condition when they were first documented	

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F 157	Continued From page 10 of any changes or new needs of the resident and contact the physician to inform him of any changes. The nurses were also to notify the physician if they feel there were any changes in the resident's condition. She stated "as I reviewed the chart after the resident was sent to the hospital on Monday, there was no assessment of the resident when she returned from the hospital and there was a change in resident, but the staff did not notify the doctor." She continued "the assessment should have been written, so we (the nurses) had a picture of what the resident was like when she returned from the hospital. According to the NN she was definitely acting differently from before she went to the hospital. The nurses should have called the doctor or the on-call nurse if they had a question or concern. No one told me they had a concern about her behavior or mental status changes until after she went to the hospital." During an interview with UM #2 at 8:48 am on 09/29/11, UM #2 indicated her responsibilities as a unit manager was to help the nurses, she reviewed the charts whenever there was an admission, re-admission or new orders to make sure all the orders were clarified. The chart (referring to resident #2) was reviewed during the critical care meeting on Monday (8/1/11) morning after the DON had reviewed the chart first. She stated "the DON usually looks through the charts to make sure everything was in place; like orders, referrals, treatments and physician notifications. As they reviewed the chart in the critical care meeting they realized the neuro checks were not completed properly and the orders for the head laceration were not clear or transcribed to the	F 157	by staff, if the physician responded and if the staff notified the medical director and RN on call if needed. This review will be completed on 100 % of residents who go to the emergency room or hospital (*see attachment C*).	

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F 157	Continued From page 11 TAR (Treatment Administration Record), there was no assessment of the resident's change in status from the nurses and the doctor was never notified." Interview with the Physician on 09/30/11 at 11:45 am revealed he was unaware Resident #2 had a fall or was returned back to the facility. He stated "the staff should have contacted me if there was a change in the resident's condition (example: change in vital signs, pain, sleepiness, lethargy, poor appetite, difficult to arouse, anything that was different from her baseline behavior). They (the nurses) received discharge orders/instructions from the hospital and they stated to contact the physician immediately if there was a change. She was diagnosed with a concussion; I would have expected them to call me." The Administrator was notified of the Immediate Jeopardy on 9/29/11 at 12:45 pm.	F 157		
	The facility presented a credible allegation of compliance on 9/30/11 at 3:41 pm which included: "Resident # 2 was discharged to the hospital on 8/1/2011. On 7/30/2011, she sustained a fall and was treated at the emergency room. She returned to the facility on 7/30/2011 with orders for the staff nurses to complete neurological checks per facility protocol for 48 hours and a diagnosis of concussion. On 8/1/2011 at 8:30 PM, she was noted to have respiratory distress and was sent to _____(name of hospital)			

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F 157	Continued From page 12 where she was admitted and later died from aspiration pneumonia. On 8/11/2011 in-service training was completed by the Director of Nursing and staff development. All staff nurses attended this in-service. The exact in-service included: "In-service 8-9-11 Neurochecks are done as ordered. If you have a resident with a head injury there must be done using the flow sheet that is attached. Any changes in neuro status, the MD, must be notified. Checks are q 15 mins x1 hour, q30 mins x 1 hour q hour x 4 hours, q4 hour x 24 hours. When orders are received, the nurse transcribing should initial and date on the MAR. If received at the end of month, it should be transcribed on new month MARS's as well. Weekly charting and vital signs is to be done on every resident. Documentation is to be done on any change in condition, medication, or education. This is to be done prior to leaving your shift. Any change of condition, or medication that is reported, should be written on 24 hour acute charting sheet as well. Third checks should be completed on all orders. Falls witnessed and unwitnessed, neuro checks must be done. Any change in mental status must be followed up with Physician and RP Notified. Family R/P must be notified on all incidents. Medication changes or change in condition When notifying the residents RP, you are to only use the facility phone. Cell Phone use during work hours is prohibited. (Please refer to policy). Nurses are to do walking rounds with your report sheet and if there is an incident or if it is reported to the oncoming nurse, it must be placed on the 24 hour report sheet. Documentation must be	F 157		

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F 157	Continued From page 13 done in the residents chart. " All residents are potentially affected by this practice. On 9/29/2011, the charge nurses with the supervision of unit manager, MDS nurse and staff development coordinator assessed all current residents for changes in conditions and the attending physician was notified immediately of any identified changes. 92 out of 92 residents were assessed and 4 were noted to have change in conditions. The attending physicians were contacted by the staff nurses and orders were received and implemented. This included a 1. Resident who was experiencing nausea, vomiting and loose stools and received orders for phenergan, immodium, clear liquid diet, intravenous fluids and rocephin. 2. Resident who complained of pain and received orders for a urine analysis and culture, 3. Resident who developed rash and received orders for hydrocortisone, benedryl, prevacid, to hold heparin, and foley catheter 4. resident who was experiencing some hallucinations and received an order to be evaluated by physician elder care on 9/30/2011. Order obtained have been implemented by the staff nurses. These resident will remain on the acute charting list and will be assessed every shift for 72 hours after treatment has stopped. If improvement is not noted within 24 hours the physician will be contacted by the staff nurse assigned to the resident for follow up instructions/orders. This assessment includes the following: Observing for lacerations; if present, clean and apply dry, sterile dressing. Note size, depth and amount of bleeding or drainage. Observing for swelling and discoloration; if present, chart size, site, amount and color. Observing for convulsions; chart time began,	F 157		

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F 157	Continued From page 14 precipitating factors, duration, vital signs and time ended. Also chart whether or not resident had difficulty breathing. Observing and inquire if resident has headache or pain. Observing for personality changes. Observing for alterations in consciousness. Observing for incontinence. Observing for sensory weakness. Observing for generalized weakness. Observing for speech disorder. Observing for gait, posture or balance disorder. Observing for stiff neck. Observing for proper reflexes (response to painful stimuli). Observing for abdominal spasm or pain. Observing for bleeding from ears, nose, throat. Observing for unequal pupils. Observing for dyspnea or variations in respirations (irregular). Observing for flushing or cyanosis. Observing for pain. Observing for abduction, adduction, shortening or improper position of extremities. Taking vital signs by the nursing assistant On 9/29/2011 and 9/30/2011, all staff nurses were in-serviced by staff development coordinator, unit manager, the nurse consultant and the administrator how to contact the physician and how to document significant changes. 24 out of 30 staff nurses have received this education. The exact in-service content is as follows: Credible Allegation In-service After all resident falls, injuries or changes in physical or mental function, the charge nurse will	F 157		

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F 157	Continued From page 15 monitor the following every shift for 72 hours: Observe for lacerations; if present, clean and apply dry, sterile dressing. Note size, depth and amount of bleeding or drainage. Observe for swelling and discoloration; if present, chart size, site, amount and color. Observe for convulsions; chart time began, precipitating factors, duration, vital signs and time ended. Also chart whether or not resident had difficulty breathing. Observe and inquire if resident has headache or pain. Observe for personality changes. Observe for alterations in consciousness. Observe for incontinence. Observe for sensory weakness. Observe for generalized weakness. Observe for speech disorder. Observe for gait, posture or balance disorder. Observe for stiff neck. Observe for proper reflexes (response to painful stimuli). Take vital signs and include temperature. Observe for abdominal spasm or pain. Observe for bleeding from ears, nose, throat. Observe for unequal pupils. Observe for dyspnea or variations in respirations (irregular). Observe for flushing or cyanosis. Observe for pain. Observe for abduction, adduction, shortening or improper position of extremities. Have someone stay with the resident while the nurse is calling the attending physician, if necessary. The physician should be called promptly (within 15 minutes) after completion of an assessment that determines that a change of condition as outlined above has occurred. The	F 157		

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F 157	Continued From page 16 phone numbers for the physicians are in the rolodexes located at each nurses station. The physician should be called for any change of condition as outlined above 24 hours a day and 7 days a week. This process does not change due to time or day of the week. If you are unable to reach the attending physician or the physician on call, call the RN on call within 30 minutes of contacting the primary physician for further instructions. The RN on call phone number is 1-919-820-3214. This assessment should be documented in the nursing notes. The nurse will note any concerns or changes noted by other staff or family Additionally, neurological assessments should be completed any time there is an physician order, when a fall causes an impact to the head, when there is an un-witnessed fall or any other time the nurses deems necessary. The nurse should document using the form for neurological checks. Neurological checks should be completed every hour times 4 hours and then every shift for a total of 48 hours. A neurological assessments includes the following: Date and time the assessment was completed Level of Consciousness: Is resident alert, drowsy, stuporous or comatose Pupil response: Is the resident's pupil equal and reactive to light. Also document the pupil response in each eye as either brisk, sluggish, non-reactive, pinpoint, dilated or fixed. Motor functions: Document the hand grasp as either equal, the right greater than left, left greater than right, if the resident is unable to participate or if hand grasp is absent. Also document whether the resident is able to to move all extremities. If unable to move all extremities then	F 157		

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F 157	Continued From page 17 document which extremities they are able to move. Complete this for the right arm, left arm, right leg and left leg, checking all that apply. If the resident is unable to follow commands or if they are absent any extremities indicate that as well. Pain response: Document if the resident has an appropriate pain response, inappropriate pain response or no pain response. Vital Signs: Document blood pressure, pulse, respirations and temperature Observations: Document any additional observations such as seizure, headache, vomiting or paralysis Sign you name in the box indicated on the form. Complete an incident, accident or risk management report per facility policy. Notify resident's responsible party. If a new order is received by the physician then the order should be documented by the nurse who received the order on the telephone order sheet. Then the order should be transcribed to medication administration record or treatment administration record as appropriate depending on the type of order. Other non-medication/treatment orders should be initiated based on order type. This transcription should be completed by the staff nurse receiving the order. The 11-7 nurse is to complete a chart check every night where every chart is reviewed for new orders. If new orders (within the last 24 hours) are identified the night shift nurse is to verify that the order was transcribed appropriately to the medication/treatment record or implemented appropriately. If a problem or concern is identified then the night shift nurse must notify the Director of Nursing that morning by either phone or note placed in the Director of	F 157		

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F 157	Continued From page 18 Nursing's box at the nursing station. Any concerns identified by this audit will be corrected or addressed by the Director of Nursing and will be reviewed weekly at the Quality Assurance Committee Meeting describe in this document. The staff development coordinator will ensure that any staff nurse who does not complete the in-service training by 9/30/2011 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation. An in service on 9-30-2011 has been provided to the Nursing Assistants by the Staff Development Coordinator, Nurse Consultant, Nurse manager and MDS Coordinator to report any changes to the resident to the nurse on the unit as soon as identified. The staff development coordinator will ensure that any nursing assistant who does not complete the in-service training by 9/30/2011 will not be allowed to work until the training is completed. 32 out of 69 have completed this training. This in-service was incorporated into the new employee facility orientation. A quality assurance monitor will be completed five times a week for two weeks by the Administrator or Director of Nursing and then will continue weekly for three months and then monthly until resolved by the Quality Assurance Committee. Reports of the MD notification audit will be given by the director of nursing to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support	F 157		

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F 157	Continued From page 19 Nurse and Health Information Management and meets weekly. This monitor will include reviewing all residents who went to the emergency room or hospital charts to ensure that the physician was notified of any changes in condition when they were first documented by staff, if the physician responded and if the staff notified the medical director and RN on call if needed. This review will be completed on 100 % of residents who go to the emergency room or hospital. Completion Date: 9/30/2011 Validation of the credible allegation of compliance was done on 09/30/11 from 3:58 pm to 5:15 pm. Validation of the credible allegation of compliance was done on 09/30/11 from 3:58 pm to 5:15 pm. Interviews with nurses and nursing assistants and licensed nursing staff confirmed they had received training on 09/30/11 on nursing assessment, use of the new neuro check policy for assessment and when/ whom to notify for acute changes in resident condition. Documentation of training, auditing and new protocols was reviewed. Immediate Jeopardy was removed on 09/30/2011 at 6:39 pm.	F 157		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F 309 10/24/11 **Corrective Action for Resident Affected:** For Resident # 2 **who was discharged to the hospital and deceased.** **Corrective Action for Resident Potentially Affected:** All resident's have the potential to be affected by the alleged deficient practice.	

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F 309	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to identify a change in mental status and notify the physician of one resident (Resident #2) when Resident #2 exhibited sleepy, lethargic and inappropriate responses after returning from the hospital post fall which resulted in a concussion and a 3 centimeter laceration to the forehead. This was evident in 1 of 7 residents in the survey sample that had a change in status. Immediate jeopardy began on 7/30/11 when she returned to the facility from the hospital with diagnoses of a concussion and laceration to the forehead after she fell at the facility. The jeopardy was removed on 9/30/11. The facility remains out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training. Findings included: Review of the Facility Policy for Neuro Checks for nursing dated 10/01/01 revealed the purpose of the policy is to assess the patient's condition and stability and to provide pertinent information to the physician. Observations should note the presence or absence of specific resident conditions. These specific conditions were not identified in the policy. Resident #2 was readmitted to the facility on	F 309	All residents are potentially affected by this practice. On 9/29/2011, the charge nurses with the supervision of unit manager, MDS nurse and staff development coordinator assessed all current residents for changes in conditions and the attending physician was notified immediately of any identified changes. 92 out of 92 residents were assessed and 4 were noted to have change in conditions. The attending physicians were contacted by the staff nurses and orders were received and implemented. This included a 1. resident who was experiencing nausea, vomiting and loose stools and received orders for phenergan, immodium, clear liquid diet, intravenous fluids and rocephin 2. Resident who complained of pain, and was medicated for pain, and received orders for a urine analysis and culture, 3. Resident who developed rash and received orders for hydrocortisone, benedryl, prevacid, to hold heparin, and foley catheter 4. resident who was experiencing some hallucinations and received an order to be evaluated by physician elder care on 9/30/2011. Order obtained have been implemented by the staff nurses . These resident will remain on the acute charting list and will be assessed every shift for 72 hours after treatment has stopped. If improvement is not noted within 24 hours the physician will be contact by the staff nurse assigned to the resident for follow up instructions/orders. This assessment includes the following:	

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F 309	Continued From page 21 6/17/11 with cumulative diagnoses which included Late Effect CVA (cerebral vascular accident) with left sided Hemiplegia, Chronic Kidney Disease (Stage IV) and Atrial Fibrillation. Review of the quarterly MDS (minimum data set) assessment dated 6/30/11 revealed Resident #2 was alert to person and time, able to make her needs known and required extensive assistance from the staff for ADLs (activities of daily living). Review of the Nurses' Notes (NN) dated 7/30/11 at 6:45 am revealed the resident was observed on the floor, positioned on her left side in front of the wheelchair. A pool of bright red blood was observed from a wound to the forehead. This nurse's note indicated pressure and ice was applied to stop the bleeding. A 3 centimeter (cm) open area was noted to the forehead. Resident #2's vital signs were temperature at 98.7 degrees Fahrenheit, pulse rate at 54 beats per minute, respirations at 22 breaths per minute and blood pressure reading of 96/40. A medical emergency service of 911 was summoned and transferred the resident to the hospital. An interview on 9/29/11 at 6:30 am with nurse #7 who responded to Resident #2 on 7/30/11 indicated he heard the nursing assistant (NA) call for help. He looked at the nurses' station and saw Resident #2 on the floor, with her head facing down, and he saw red blood on the floor. He applied pressure and ice to her forehead. He stated she was moaning and "I explained to her that she fell and hit her head." The NA (nursing assistant) stayed with the resident and another NA came and helped keep her still. He stated "I was surprised that she fell because she never	F 309	o Observing for lacerations; if present, clean and apply dry, sterile dressing. Note size, depth and amount of bleeding or drainage. o Observing for swelling and discoloration; if present, chart size, site, amount and color. o Observing for convulsions; chart time began, precipitating factors, duration, vital signs and time ended. Also chart whether or not resident had difficulty breathing. o Observing and inquire if resident has headache or pain. o Observing for personality changes. o Observing for alterations in consciousness. o Observing for incontinence. o Observing for sensory weakness. o Observing for generalized weakness. o Observing for speech disorder. o Observing for gait, posture or balance disorder. o Observing for stiff neck. o Observing for proper reflexes (response to painful stimuli). o Observing for abdominal spasm or pain.	

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F 309	Continued From page 22 tried to get up or move out of her wheelchair." He continued "the wheelchair was sitting upright against the wall to the nurses' station and the brakes were locked. I do not understand how she fell. When she was lying on the floor she was lying towards her left side, which is her weak side from her previous stroke." Review of the NN dated 7/30/11 at 12:05 pm completed by Nurse #1 revealed the resident returned to the facility. Review of the Hospital Discharge Orders/Instructions revealed the resident sustained a laceration on the forehead and a concussion. Review of NN dated 7/30/11 at 12:45 pm completed by Nurse #1 revealed the resident was asleep, Stitches intact, no active bleeding with discoloration and swelling to the forehead. During a telephone interview on 09/30/11 at 7:45 am with Nurse #1, who admitted resident back from ER [emergency room], she stated "I readmitted the resident but I do not remember how she looked, [regarding her mental status] or any other bruises than what I documented in my notes, she looked tired." Nurse #1 stated Resident #2 was sleeping the whole time when she returned from the hospital. Her face had a large bump on her forehead, stitches with no dressing on it. She indicated she reviewed the short synopsis narrative discharge orders/instructions from the ER. She stated "I did not get a report [referring to a verbal report] from the hospital, no one called to tell us she was returning." The papers she (the resident) brought	F 30	**o Observing for bleeding from ears, nose, throat.** **o Observing for unequal pupils.** **o Observing for dyspnea or variations in respirations (irregular).** **o Observing for flushing or cyanosis.** **o Observing for pain.** **o Observing for abduction, adduction, shortening or improper position of extremities.** **o Taking vital signs by the nursing assistant** **Systemic Changes** On 9/29/2011 and 9/30/2011, all staff nurses were in-serviced by staff development coordinator, unit manager, the nurse consultant and the administrator how to contact the physician and how to document significant changes. 24 out of 30 staff nurses have received this education (*see attachment A*). The exact in-service content is as follows: **Credible Allegation In-service** **• After all resident falls, injuries or changes in physical or mental function, the charge nurse will monitor the following every shift for 72 hours:** **o Observe for lacerations; if present, clean and apply dry, sterile dressing. Note size, depth and amount of bleeding or drainage.**	

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F 309	Continued From page 23 back from the ER indicated what to look for with a concussion, how to clean the laceration, they were very generic directions. I thought it was odd that she was sent back so soon after sustaining a head injury. I know in the hospital they gave her a dose of Tylenol #3, and I am not sure if that had anything to do with her being sleepy." Nurse #1 indicated the nursing assistant (NA) got her vital signs, and after the unit manager came in "I started to do the neuro checks." "I think I did them every 15 minutes for the first hour then every 30 minutes for the next 2 hours then every hour for the rest of my shift. I documented on the neuro check sheet." She continued "I only work every other weekend, so I really did not know this residents normal behavior or alertness." Continued interview with Nurse #1 indicated Resident #2 did not follow commands upon return from the hospital as she did prior to the fall. Nurse #1 indicated that, after her return from the ER, the resident would respond by smiling. Nurse #1 indicated that she did not perform a body check or assessment on the resident when she returned from the hospital. This nurse indicated she did not feel it was necessary to contact the physician because the resident had just returned from the hospital, so Nurse #1 expected the resident to be tired. During an interview with NA #5 on 9/30/11 at 3:15 pm, who worked Saturday (7/30/11), Sunday (7/31/11) and Monday (8/1/11) during the day shift and cared for Resident #2, she stated "she (Resident #2) was very different when she came back from the ER, she stayed in the bed and slept more. Her appetite was poor. The resident's family had to assist her and encourage her to eat. She did not eat Sunday breakfast or	F 309	**o Observe for swelling and discoloration; if present, chart size, site, amount and color.** **o Observe for convulsions; chart time began, precipitating factors, duration, vital signs and time ended. Also chart whether or not resident had difficulty breathing.** **o Observe and inquire if resident has headache or pain.** **o Observe for personality changes.** **o Observe for alterations in consciousness.** **o Observe for incontinence.** **o Observe for sensory weakness.** **o Observe for generalized weakness.** **o Observe for speech disorder.** **o Observe for gait, posture or balance disorder.** **o Observe for stiff neck.** **o Observe for proper reflexes (response to painful stimuli).** **o Take vital signs and include temperature.** **o Observe for abdominal spasm or pain.** **o Observe for bleeding from ears, nose, throat.** **o Observe for unequal pupils.**	

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F 309	Continued From page 24 lunch, and I told the nurses." (Nurse #1 on Saturday and Sunday and Nurse # 5 on Monday "). NA #5 indicated on interview that the decreased eating or needing assistance with meals was unusual. Review of NN dated 7/30/11 at 9:00 PM completed by Nurse #2 revealed Resident #2 had no signs and symptoms of acute distress or shortness of breath. Resident #2 complained of pain at 7:00 PM, an as needed pain medication, Tylenol #3, was administered and was effective. She was resting in bed with respirations even and unlabored. Neuro-checks continued. No falls this far during shift. Vital signs at 6:00 PM were documented as blood pressure (BP) 138/73, pulse (P) 97, respirations (R) 19, and oxygen saturation 92%. During an interview on 9/30/11 at 2:55 PM with Nurse #2, who worked 7/30/11 (3-11 PM) she stated "she (Resident #2) appeared to be tired and sleepy. She ate about 50% of her dinner, but the NA informed me she had a poor appetite even with a lot of encouragement, and her family fed her. She was moaning about 8:30 pm, I think because she had pain in her head. She took her meds, but was unable to describe where the pain actually was. She did shake her head to indicate her head hurt. It was obvious there was something different about the way she acted and responded, I just thought it was from the bump on her head. I told the oncoming nurse (Nurse # 3) about her behavior during report. I did the neuro checks and documented them. I did not notice any difference [in her vitals signs]." She indicated even though she had a poor appetite, needed	F 309	**o Observe for dyspnea or variations in respirations (irregular).** **o Observe for flushing or cyanosis.** **o Observe for pain.** **o Observe for abduction, adduction, shortening or improper position of extremities.** **• Have someone stay with the resident while the nurse is calling the attending physician, if necessary. The physician should be called promptly (within 15 minutes) after completion of an assessment that determines that a change of condition has occurred.** **The phone numbers for the physicians are in the rolodexes located at each nurses station. The physician should be called for any change of condition as outlined above 24 hours a day and 7 days a week. This process does not change due to time or day of the week.** **• If you are unable to reach the attending physician or the physician on call, on call RN within 30 minutes of contacting the primary physician for further instructions. The RN on call phone number is 1-919-820-3214.**	

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F 309	Continued From page 25 encouragement from her family to eat, complained of discomfort that she was unable to describe and slept a lot during the shift,] "I did not think it was necessary to call the doctor. " During an interview with NA #3 on 09/30/11 at 3:10 pm; who worked with Resident #2 on Saturday and Sunday; 3:00pm-11:00 pm shift. NA #3 stated "the resident did not eat and I tried to encourage her to eat. She slept a lot and she was more sedated than usual. Before she went to the hospital she was usually out of bed in her wheelchair and ate her meals in the dinning room. I told the Nurse (Nurse # 6), that she was sleeping more and not as hungry or eating like she usually did." During an interview with NA #4 on 09/30/11 at 3:12 pm who also worked on Saturday and Sunday from 3:00 pm-11:00 pm NA #4 stated "The resident was very sleepy and did not respond to me like she did before she fell. Usually she would smile at me and assisted me when it was time to change her clothes. That weekend she did not assist with any of her care. I told the Nurse (Nurse #6) and she told me she had a head injury and was taking pain medication, it was to be expected." Review of NN dated 7/31/11 at 2:32 am completed by Nurse #3 revealed Resident #2 was easily aroused but did not follow commands; she was sleepy. She moaned and groaned when she was moved or was encouraged taking fluids or waking up. She did not answer the nurse's questions because she was too sedated. Eyes PERRLA (pupils equal round and reactive to light, accommodation). VS (vital signs) stable. Nurse	F 309	• This assessment should be documented in the nursing notes. • The nurse will note any concerns or changes noted by other staff or family. • Additionally, neurological assessments should be completed any time there is an physician order, when a fall causes an impact to the head, when there is an un-witnessed fall or any other time the nurses deems necessary. The nurse should document using the form for neurological checks. Neurological checks should be completed every hour times 4 hours and then every shift for a total of 48 hours. A neurological assessments includes the following: o Date and time the assessment was completed o Level of Consciousness: Is resident alert, drowsy, stuporous or comatose o Pupil response: Is the resident's pupil equal and reactive to light. Also document the pupil response in each eye as either brisk, sluggish, non-reactive, pinpoint, dilated or fixed. o Motor functions: Document the hand grasp as either equal, the right greater than left, left greater than right, if the resident is	

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F 309	Continued From page 26 #3 gave the resident pain medications per PRN (when necessary) order due to moaning and crying out. The nurse continued to monitor the resident. Her vital signs at 6:00 am were: T (temperature) 98.7, P109, R 16 BP 124/70. Review of NN dated 7/31/11 at 5:00 am completed by Nurse #3 revealed Resident #2 in bed resting quietly. NAD (no acute distress) noted. She was easily aroused but drowsy, and did not follow commands because she was too sedated. She was not moaning and crying out as much as before the pain medication was administered. Resident #2 would not squeeze the nurse's hands when asked but she had some strength in upper extremities as evident by pulling arms back when "we were trying to get her vital signs. No apparent distress noted from previous fall. Will con't (continue) to monitor." Vital signs were T 97.4, R 16, P 108, BP 139/84. During an interview with Nurse #3 on 9/30/11 at 9:32 am she indicated she (Resident #2) slept most of the shift. Pain medication was administered. She stated "she (Resident #2) would not respond, and I was not sure how far out of "norm" that was for her, anytime I cared for her she usually slept the whole time. I did the neuro checks, I think they were done every 2 hours, from what I was told by the NAs she was usually coherent at times and was able to follow commands and express her needs." Nurse #3 continued "this was the first time I cared for her when she required medication. She did moan and cry out at times and made facial grimacing; it appeared to me (nurse) that she was in pain. The resident was hard too arouse, I thought it was from medication."	F 309	**unable to participate or if hand grasp is absent. Also document whether the resident is able to to move all extremities. If unable to move all extremities then document which extremities they are able to move. Complete this for the right arm, left arm, right leg and left leg, checking all that apply. If the resident is unable to follow commands or if they are absent any extremities indicate that as well.** **o Pain response: Document if the resident has an appropriate pain response, inappropriate pain response or no pain response.** **o Vital Signs: Document blood pressure, pulse, respirations and temperature** **o Observations: Document any additional observations such as seizure, headache, vomiting or paralysis** **o Sign you name in the box indicated on the form.**	

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F 309	Continued From page 27 Review of NN dated 7/31/11 at 10:34 am completed by Nurse #1 revealed that Resident #2 was resting in bed and appeared disoriented. Her speech was somewhat clear with rambling comments. Pt (patient) will hold the nurse's hand when asked but when asked to squeeze the nurse's hand; Resident #2 would "pet" the nurse's hand. Pt. ate approximately 25% of am meal. Her vital signs 128/68, 92, 18, 98.3. Review of NN dated 7/31/11 at 2:35 pm completed by Nurse #1 revealed the neuro checks continued and she (Resident #2) would respond to verbal stimuli by opening her eyes and attempted to verbally respond. She continued to ramble "row, row, row". She did not eat her lunch even with the staff's encouragement. During a telephone interview with Nurse #1 09/30/11 at 7:45 am revealed Resident #2 was very sleepy and stated her family member kept trying to wake her up and get her to drink and eat. Nurse #1 stated "I just thought it was because she had been through a lot from the fall. I did not think it was necessary to notify the doctor. I continued the neuro checks like ordered. Her vital signs were okay, I did not realize her pulse was elevated since her return from the hospital." During an interview with NA #6 on 09/30/11 at 3:30 pm (who was familiar with Resident #2) indicated Resident #2 was able to independently feed herself meals in the dining room (before the fall). Interview with Nurse #3 (who worked on 7/31/11 from 11:00 pm to 7:00 am and 08/01/11 from	F 309	• Complete an incident, accident or risk management report per facility policy. • Notify resident's responsible party. • If a new order is received by the physician then the order should be documented by the nurse who received the order on the telephone order sheet. Then the order should be transcribed to medication administration record or treatment administration record as appropriate depending on the type of order. Other non-medication/treatment orders should be initiated based on order type. This transcription should be completed by the staff nurse receiving the order. The 11-7 nurse is to complete a chart check every night where every chart is reviewed for new orders. If new orders (within the last 24 hours) are identified the night shift nurse is to verify that the order was transcribed appropriately to the medication/treatment record or implemented appropriately. If a problem or concern is identified then the night shift nurse must notify the Director of Nursing that morning by either phone or note placed in the Director of Nursing's box at the nursing station.	

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F 309	Continued From page 28 11:00 pm to 7:00 am) on 9/30/11 at 9:32 am revealed "I did not continue to do the neuro checks on Sunday evening. I was told in report by the reporting nurse (Nurse #6) that it was no longer necessary. " Nurse #3 concluded the interview by stating "All my documentation was from the resident's reactions on Saturday and Sunday at night, I usually only saw her when she was sleeping. All her vital signs seemed normal; I did not realize her pulse rate was fast. I spoke with the NAs and they said she was not acting like she usually did. I am not sure what her baseline was. She had a head injury, I expected her to be groggy from head injury. I did not notify the doctor, but told the oncoming nurse of her condition. " During an interview at 7:07 am 09/30/11 with Nurse #5 who cared for resident on 08/01/11 7:00 am -3:00 pm, she stated "the resident was not acting herself; I told the DON (Director of Nursing) and thought she (the DON) was going to speak to the doctor. She revealed the resident was lethargic and not really herself, she did not want to drink or eat and refused her breakfast and lunch. She (Nurse #5) stated "I should have put more information in my nursing note about her change in condition; I thought the DON was going to contact the doctor after I spoke to her that morning. " Review of the NN dated 8/1/11 completed by Nurse #4 revealed the resident was found at 7:00 pm while the nurse was making rounds to be unresponsive and wheezing. The nurse applied oxygen and tried to suction the resident. She contacted the doctor and sent her to the ER for evaluation.	F 309	• **Any concerns identified by this audit will be corrected or addressed by the Director of Nursing and will be reviewed weekly at the Quality Assurance Committee Meeting describe in this document.** • The staff development coordinator will ensure that any staff nurse who does not complete the in-service training by 9/30/2011 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation. • An in service on 9-30-2011 has been provided to the Nursing Assistants by the Staff Development Coordinator, Nurse Consultant, Nurse Manager and MDS Coordinator to report any changes to the resident to the nurse on the unit as soon as identified. The staff development coordinator will ensure that any nursing assistant who does not complete the in-service training by 9/30/2011 will not be allowed to work until the training is completed. 32 out of 69 have had this training (*See Attachment B*). This in-service was incorporated into the new employee facility orientation. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	

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F 309	Continued From page 29 During a telephone interview with Nurse #4 on 9/30/11 at 5:20 pm (worked 3:00 pm -11:00pm on 8/1/11 and sent Resident #2 to ER) she stated "she was not familiar with this resident. " She indicated Resident #2 seemed to be doing ok, when she initially saw her at 4:00 pm, she was alert, she was talking incoherently like a mumble. According to the NAs she was not acting like she did before she fell. Nurse #4 indicated during her medication pass at about 7:00 pm, she could hear Resident #2 wheezing from her room door. She went and got O2, and put it on the resident. She stated "I was concerned that she was fed dinner that evening by her family. My thought was that she could have aspirated. " She continued she called the doctor and the resident was sent to the hospital. There were no completed neuro Check sheets for review for Resident #2. Resident #2 was sent to the ER on 8/1/11 for evaluation of unresponsiveness. Review of the Hospital Records for treatment of unresponsiveness dated 08/02/11 read: Chief complaint: unresponsiveness. "Admitted for altered mental status. The patient sustained a fall last Saturday (07/30/11), after which she was assessed, underwent a CT scan, which turned out to be negative. She was sent back to the facility awake, alert and oriented; however today (Monday) she was found to be unresponsive, where she is tachycardic. She was found to be in moderate respiratory distress, she underwent an x-ray confirming focal lingular infiltrates and a urinalysis showing evidence of a urinary tract	F 309	**Quality Assurance** A quality assurance monitor will be completed five times a week for two weeks by the Administrator or Director of Nursing then will continue weekly for three months and then monthly until resolved by the Quality Assurance Committee. Reports of the this audit will be given by the director of nursing to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support Nurse and Health Information Management and meets weekly. This monitor will include reviewing the charts (nursing notes, neurological assessment forms, physician orders, and necessary documents to verify implementation of physician orders) and observation of 10 residents who have experienced an acute episode since the last review. If 10 residents have not experienced an acute episode since the last review then any residents who meet this criteria will be reviewed. The review will check to ensure that the staff nurses appropriately assessed and responded to changes in conditions. This will include identifying changes of conditions, contacting the physician and RN on call if needed, properly implementing and transcribing physician orders and completion of neurological assessment as defined by in-service training outlined above (*see attachment D*).	

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F 309	Continued From page 30 infection. " Review of Consultation for Mental Status Changes completed on 8/2/11 read: "she fell off the wheelchair and suffered a laceration on the forehead. Discharged but not doing well. She was poorly responding, she barely opened her eyes on verbal commands. She was brought into the hospital for history of mental status changes. " Resident #2 expired on 8/6/11 in the hospital. Interview with the DON (director of Nursing) on 09/29/11 at 3:30 pm, She stated "we (the administrative staff) are unable to locate the neuro check sheet used for this resident, this chart has been reviewed by a lot of people, we are checking to make sure it was not left with one of the consultants who reviewed the chart. " Interview with the Administrator on 09/29/11 at 3:45 pm revealed her expectation of the nursing staff was that when a resident was readmitted from the hospital; the nurse would complete a head to toe assessment of the resident and also if necessary start neuro checks to be done per facility policy for 48 hours. Most importantly, the nurse or staff are to notify the physician, the on call nurse, DON or myself if they have any concerns about the residents status and /or orders. The neuro checks were stopped on Sunday evening. The facility policy is that the neuro checks are done for 48 hours and changes were to be reported to the doctor and the supervisor. We did an inservice about that issue, so the staff is aware of the facility policy for neuro checks and to document the resident condition	F 309		

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 _____	C 09/30/2011

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
F 309	Continued From page 31 clearly in their nurse's notes " During an interview with Administrator on 09/30/11 at 6:10 am revealed it was her understanding that the physician was not notified of any changes because she was told by the DON that Resident #2 was assessed by the admitting nurse to be at her baseline for mentation when she returned from the hospital. After reviewing the records, there was no indication of that assessment or documentation and she would have expected the staff to have notified the doctor of the change in Resident #2's mental status changes or changes in her behavior. During an interview with the director of nursing (DON) on 09/29/11 at 9:04 am the DON stated "I was made aware during the Monday morning meeting (administrative staff meeting) that the resident had a head injury and went to the hospital and got stitches and was returned to the facility on the same day. " The DON indicated the resident's care (Resident #2) was discussed during the critical care meeting with the unit managers. In this meeting we (administrative staff) reviewed the chart, and noticed the UM (Unit Manager) #1, who was on-call, came to the facility on 7/30/11 and wrote orders for neuro checks, "pt eval, use geri chair until pt eval, add chair alarm and fall mats ", and I assumed the unit manager did an assessment of the resident. The DON stated "It is actually the nurse who admitted the resident from the hospital who is responsible to assess the resident, transcribe the orders from the hospital to the appropriate places in the chart and notify the physician the resident had returned to the facility. That nurse is also	F 309		

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F 309	Continued From page 32 responsible to make sure she informs the on-call nurse if she had any concerns about the resident's condition or orders the resident returned from the hospital with, so the on-call nurse can clarify these things and contact the physician if necessary. She further indicated it was ultimately the DON's responsibility to make sure changes in resident condition were reflected in the chart, to make sure the orders were clear and all staff was aware of any changes or new needs of the resident and contact the physician to inform him of any changes. The nurses were also to notify the physician if they feel there were any changes in the resident's condition. She stated "as I reviewed the chart after the resident was sent to the hospital on Monday, there was no assessment of the resident when she returned from the hospital and there was a change in resident, but the staff did not notify the doctor. " She continued "the assessment should have been written, so we (the nurses) had a picture of what the resident was like when she returned from the hospital. According to the NN she was definitely acting differently from before she went to the hospital. The nurses should have called the doctor or the on-call nurse if they had a question or concern. No one told me they had a concern about her behavior or mental status changes until after she went to the hospital. " During an interview with UM #2 at 8:48 am on 09/29/11, UM #2 indicated her responsibilities as a unit manager was to help the nurses, she reviewed the charts whenever there was an admission, re-admission or new orders to make sure all the orders were clarified. The chart (referring to resident #2) was reviewed during the	F 309		

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F 309	Continued From page 33 critical care meeting on Monday (8/1/11) morning after the DON had reviewed the chart first. She stated "the DON usually looks through the charts to make sure everything was in place; like orders, referrals, treatments and physician notifications. As they reviewed the chart in the critical care meeting they realized the neuro checks were not completed properly and the orders for the head laceration were not clear or transcribed to the TAR (Treatment Administration Record), there was no assessment of the resident's change in status from the nurses and the doctor was never notified. " Interview with the Physician on 09/30/11 at 11:45 am revealed he was unaware Resident #2 had a fall or was returned back to the facility. He stated "the staff should have contacted me if there was a change in the resident's condition (example: change in vital signs, pain, sleepiness, lethargy, poor appetite, difficult to arouse, anything that was different from her baseline behavior). They (the nurses) received discharge orders/instructions from the hospital and they stated to contact the physician immediately if there was a change. She was diagnosed with a concussion; I would have expected them to call me. " The Administrator was notified of the Immediate Jeopardy on 9/29/11 at 12:45 pm. The facility presented a credible allegation of compliance on 9/30/11 at 3:41 pm which included:	F 309		

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F 309	Continued From page 34 Resident # 2 was discharged to the hospital on 8/1/2011. On 7/30/2011, she sustained a fall and was treated at the emergency room. She returned to the facility on 7/30/2011 with orders for the staff nurses to complete neurological checks per facility protocol and a diagnosis of concussion. On 8/1/2011 at 8:30 PM, she was noted to have respiratory distress and was sent to _____[name of hospital] where she was admitted and later died from aspiration pneumonia. On 8/11/2011 in-service training was completed by the Director of Nursing and staff development. All staff nurses attended this in-service. The exact in-service included: "In-service 8-9-11 Neurochecks are done as ordered. If you have a resident with a head injury there must be done using the flow sheet that is attached. Any changes in neuro status, the MD, must be notified. Checks are q 15 mins x1 hour, q30 mins x 1 hour q hour x 4 hours, q4 hour x 24 hours. When orders are received, the nurse transcribing should initial and date on the MAR. If received at the end of month, it should be transcribed on new month MARS's as well. Weekly charting and vital sings is to be done on every resident. Documentation is to be done on any change in condition, medication, education. This is to be done prior to leaving your shift. Any change of condition, or medication that is reported, should be written on 24 hour acute charting sheet as well. Third checks should be completed on all orders. Falls witnessed and unwitnessed, neuro checks must be done. Any change in mental status must be followed up with Physician and RP Notified.	F 309		

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F 309	Continued From page 35 Family R/P must be notified on all incidents. Medication changes or change in condition When notifying the residents RP, you are to only use the facility phone. Cell Phone use during work hours is prohibited. (Please refer to policy). Nurses are to do walking rounds with your report sheet and if there is an incident or if it is reported to the oncoming nurse, it must be placed on the 24 hour report sheet. Documentation must be done in the residents chart. " All residents are potentially affected by this practice. On 9/29/2011, the charge nurses with the supervision of unit manager, MDS nurse and staff development coordinator assessed all current residents for changes in conditions and the attending physician was notified immediately of any identified changes. 92 out of 92 residents were assessed and 4 were noted to have change in conditions. The attending physicians were contacted by the staff nurses and orders were received and implemented. This included a 1. resident who was experiencing nausea, vomiting and loose stools and received orders for phenergan, immodium, clear liquid diet, intravenous fluids and rocephin 2. Resident who complained of pain and received orders for a urine analysis and culture, 3. Resident who developed rash and received orders for hydrocortisone, benedryl, prevacid, to hold heparin, and foley catheter 4. resident who was experiencing some hallucinations and received an order to be evaluated by physician elder care on 9/30/2011. Order obtained have been implemented by the staff nurses . These resident will remain on the acute charting list and will be assessed every shift for 72 hours after treatment has stopped. If improvement is not noted within	F 309		

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F 309	Continued From page 36 24 hours the physician will be contact by the staff nurse assigned to the resident for follow up instructions/orders. This assessment includes the following: Observing for lacerations; if present, clean and apply dry, sterile dressing. Note size, depth and amount of bleeding or drainage. Observing for swelling and discoloration; if present, chart size, site, amount and color. Observing for convulsions; chart time began, precipitating factors, duration, vital signs and time ended. Also chart whether or not resident had difficulty breathing. Observing and inquire if resident has headache or pain. Observing for personality changes. Observing for alterations in consciousness. Observing for incontinence. Observing for sensory weakness. Observing for generalized weakness. Observing for speech disorder. Observing for gait, posture or balance disorder. Observing for stiff neck. Observing for proper reflexes (response to painful stimuli). Observing for abdominal spasm or pain. Observing for bleeding from ears, nose, throat. Observing for unequal pupils. Observing for dyspnea or variations in respirations (irregular). Observing for flushing or cyanosis. Observing for pain. Observing for abduction, adduction, shortening or improper position of extremities. Taking vital signs by the nursing assistant On 9/29/2011 and 9/30/2011, all staff nurses	F 309		

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F 309	Continued From page 37 were in-serviced by staff development coordinator, unit manager, the nurse consultant and the administrator how to contact the physician and how to document significant changes. 24 out of 30 staff nurses have received this education. The exact in-service content is as follows: Credible Allegation In-service After all resident falls, injuries or changes in physical or mental function, the charge nurse will monitor the following every shift for 72 hours: Observe for lacerations; if present, clean and apply dry, sterile dressing. Note size, depth and amount of bleeding or drainage. Observe for swelling and discoloration; if present, chart size, site, amount and color. Observe for convulsions; chart time began, precipitating factors, duration, vital signs and time ended. Also chart whether or not resident had difficulty breathing. Observe and inquire if resident has headache or pain. Observe for personality changes. Observe for alterations in consciousness. Observe for incontinence. Observe for sensory weakness. Observe for generalized weakness. Observe for speech disorder. Observe for gait, posture or balance disorder. Observe for stiff neck. Observe for proper reflexes (response to painful stimuli). Take vital signs and include temperature. Observe for abdominal spasm or pain. Observe for bleeding from ears, nose, throat. Observe for unequal pupils. Observe for dyspnea or variations in respirations (irregular).	F 309		

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F 309	Continued From page 38 Observe for flushing or cyanosis. Observe for pain. Observe for abduction, adduction, shortening or improper position of extremities. Have someone stay with the resident while the nurse is calling the attending physician, if necessary. The physician should be called promptly (within 15 minutes) after completion of an assessment that determines that a change of condition has occurred. The phone numbers for the physicians are in the rolodexes located at each nurses station. The physician should be called for any change of condition as outlined above 24 hours a day and 7 days a week. This process does not change due to time or day of the week. If you are unable to reach the attending physician or the physician on call, on call RN within 30 minutes of contacting the primary physician for further instructions. The RN on call phone number is 1-919-820-3214. This assessment should be documented in the nursing notes. The nurse will note any concerns or changes noted by other staff or family. Additionally, neurological assessments should be completed any time there is an physician order, when a fall causes an impact to the head, when there is an un-witnessed fall or any other time the nurses deems necessary. The nurse should document using the form for neurological checks. Neurological checks should be completed every hour times 4 hours and then every shift for a total of 48 hours. A neurological assessments includes the following: Date and time the assessment was completed Level of Consciousness: Is resident alert, drowsy, stuporous or comatose	F 309		

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F 309	Continued From page 39 Pupil response: Is the resident's pupil equal and reactive to light. Also document the pupil response in each eye as either brisk, sluggish, non-reactive, pinpoint, dilated or fixed. Motor functions: Document the hand grasp as either equal, the right greater than left, left greater than right, if the resident is unable to participate or if hand grasp is absent. Also document whether the resident is able to to move all extremities. If unable to move all extremities then document which extremities they are able to move. Complete this for the right arm, left arm, right leg and left leg, checking all that apply. If the resident is unable to follow commands or if they are absent any extremities indicate that as well. Pain response: Document if the resident has an appropriate pain response, inappropriate pain response or no pain response. Vital Signs: Document blood pressure, pulse, respirations and temperature Observations: Document any additional observations such as seizure, headache, vomiting or paralysis Sign you name in the box indicated on the form. Complete an incident, accident or risk management report per facility policy. Notify resident's responsible party. If a new order is received by the physician then the order should be documented by the nurse who received the order on the telephone order sheet. Then the order should be transcribed to medication administration record or treatment administration record as appropriate depending on the type of order. Other non-medication/treatment orders should be initiated based on order type. This transcription should be completed by the staff nurse receiving	F 309		

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LIBERTY COMMONS NSG & REH JOHN	2316 HIGHWAY 242 NORTH BENSON, NC 27504

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F 309	Continued From page 40 the order. The 11-7 nurse is to complete a chart check every night where every chart is reviewed for new orders. If new orders (within the last 24 hours) are identified the night shift nurse is to verify that the order was transcribed appropriately to the medication/treatment record or implemented appropriately. If a problem or concern is identified then the night shift nurse must notify the Director of Nursing that morning by either phone or note placed in the Director of Nursing's box at the nursing station. Any concerns identified by this audit will be corrected or addressed by the Director of Nursing and will be reviewed weekly at the Quality Assurance Committee Meeting describe in this document. The staff development coordinator will ensure that any staff nurse who does not complete the in-service training by 9/30/2011 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation. An in service on 9-30-2011 has been provided to the Nursing Assistants by the Staff Development Coordinator, Nurse Consultant, Nurse Manager and MDS Coordinator to report any changes to the resident to the nurse on the unit as soon as identified. The staff development coordinator will ensure that any nursing assistant who does not complete the in-service training by9/30/2011 will not be allowed to work until the training is completed. 32 out of 69 have had this training. This in-service was incorporated into the new employee facility orientation. A quality assurance monitor will be completed five times a week for two weeks by the Administrator or Director of Nursing then will	F 309		

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F 309	Continued From page 41 continue weekly for three months and then monthly until resolved by the Quality Assurance Committee. Reports of the this audit will be given by the director of nursing to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support Nurse and Health Information Management and meets weekly. This monitor will include reviewing the charts (nursing notes, neurological assessment forms, physician orders, and necessary documents to verify implementation of physician orders) and observation of 10 residents who have experienced an acute episode since the last review. If 10 residents have not experienced an acute episode since the last review then any residents who meet this criteria will be reviewed. The review will check to ensure that the staff nurses appropriately assessed and responded to changes in conditions. This will include identifying changes of conditions, contacting the physician and RN on call if needed, properly implementing and transcribing physician orders and completion of neurological assessment as defined by in-service training outlined above. Completion Date: 9/30/2011 Validation of the credible allegation of compliance was done on 09/30/11 from 3:58 pm to 5:15 pm. Interviews with nurses and nursing assistants and licensed nursing staff confirmed they had received training on 09/30/11 on nursing assessment, use of the new neuro check policy for assessment and when/ whom to notify for	F 309		

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F 309	Continued From page 42 acute changes in resident condition. Documentation of training, auditing and new protocols was reviewed. Immediate Jeopardy was removed on 09/30/2011 at 6:39 pm.	F 309		