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

FEB 13 2012

PRINTED: 01/25/2012
FORM APPROVED
OMB NO. 0938-0391

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 01/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

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F 000	INITIAL COMMENTS This complaint investigation survey was initially conducted on 01/05/2012 to 01/06/2012. The survey team returned to the facility on 01/10/2012 to get more information and do interviews.	F 000		2/4/12
F 157 SS=D	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.	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. **F157** **Corrective Action for Resident Affected:** For Resident # 1, was transported to Johnston Memorial Hospital on 1/2/11 due to changes noted in her condition. She was admitted with a diagnosis of Small bowel obstruction.	2/4/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jacqueline Summore RN
TITLE: LNHA
(X6) DATE: 2/9/12

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 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician interview, the facility failed to notify the physician of a significant change in vomits for 1 of 1 sampled resident (Resident #1). Resident #1 was admitted on 12/16/11. Cumulative diagnoses included Rehabilitation, History of Falls, Hypertension, Hypothyroidism and Anemia. The 14-day admission Minimum Data Set (MDS) completed on 12/28/11 indicated Resident #1 had no indicated problems with short and long term memory. The MDS revealed Resident #1 required extensive assistance with walk in the room. A review of the nurse's note completed on 12/30/11 at 5:03 PM, revealed the NP (Nurse Practitioner) was informed due to Resident #1 vomited a light-brown colored liquid. As an intervention, the NP evaluated Resident #1, and discontinued phenergan due to ineffective, and ordered zofran to be administered. A review of the nurse's note completed on 12/31/11 at 6:22 AM, indicated "Patient received zofran at 5:00 AM for nausea/vomiting. Emesis small amount phlegm like yellowish-green; medication effective." Resident's #1's NP or physician was not documented, as notified of the change in the emesis (vomits) description. A review of the nurse's note completed on 1/1/12 at 1:15 AM stated Resident #1 "Complained of nausea/vomiting at bed time. Emesis was	F 157	**Corrective Action for Resident Potentially Affected:** All resident's have the potential to be affected by the alleged deficient practice. On 1/7/12, the charge nurses with the supervision of the unit managers, MDS nurse and Staff Development Coordinator assessed all residents for change in conditions, including any Nausea and Vomiting and the attending physician was notified immediately of any identified changes. 96 out of 96 residents were assessed and 5 were noted to have a change in which the physician was notified (Attachment A). **Systemic Changes** An in-service was conducted on 1/6/12 by the Staff Development Coordinator (Attachment B). Those who attended were all RN's and LPN's, FT, PT, and PRN. The facility specific inservice was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included: Abdominal distention or swelling of the abdomen can be caused	2/4/12

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F 157	Continued From page 2 yellow/green in color and mucous like in consistency. Medicated once with moderate results." Resident's #1's NP or physician was not documented as notified, of the change in the vomits description. A review of the 24 hour nurse communication report sheets dated 12/31/11 and 1/1/12 for 7a-3p; 3p-11p; and 11p-7a shifts revealed no documentation regarding the observed yellow-greenish colored emesis (vomits). In an interview on 1/6/12 at 12:25 PM, the Director of Nursing indicated she expected the physician/NP to be notified, with a description of the vomits color change; from the NP's last evaluation on 12/30/11. In an interview on 1/6/12 at 2:00 PM, the Medical Director stated there was a twenty-four hour on-call answering service for the physician/NP to be notified. He concluded it was his expectation to be notified of the yellow-greenish vomits. In an interview on 1/10/12 at 8:45 AM, Resident #1 stated she had not vomited yellow-greenish vomits prior to being admitted into the facility. In an interview on 1/10/12 at 10:15 AM, a family representative revealed Resident #1 did not have a history of yellowish-greenish vomits prior to admission into the nursing facility. In an interview on 1/12/12 at 1:45 PM, Nurse #1 indicated she did not notify the physician/NP that Resident #1 vomited yellow-greenish vomits during her shift. She added she was not aware that Resident #1 had vomited light-brownish	F 157	by overeating or eating gas producing foods but when combined with pain, vomiting or nausea further assessment is needed. When a resident displays signs and symptoms such as distention, vomiting, nausea or abdominal pain then an abdominal assessment should be conducted. This assessment includes vital signs, bowel sounds, tenderness, and distention. If vomitus is noted then the contents (blood, undigested food) and color should be noted. Additionally the nurse should assess the resident to ensure that bowel movements are occurring. Smart charting documentation can be quickly checked by pulling up the "No bowel movement report" on your AHT menu. This will give you a quick review to see if a bowel movement has been documented but your assessment should not stop there. Regardless of the documentation, if the above signs/symptoms are present then the nurse should interview the resident and staff to verify that bowel movements have occurred within 3 days and that they are a regular size and consistency. Stool that is hard or overly soft could indicate constipation or impaction. Signs and symptoms of constipation include Infrequent bowel movements and/or difficulty having bowel	2/4/12

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F 157	Continued From page 3 vomits prior. In an interview on 1/12/12 at 2:30 PM, Nurse #2 revealed she did not notify the physician/NP that Resident #1 vomited yellow-greenish vomits during her shift. She concluded she did not see the vomits as an immediate concern, due to Resident #1/family representatives indicated Resident #1 had ongoing pancreatic and gallbladder problems.	F 157	movements, swollen abdomen or abdominal pain, pain, vomiting. If there is any doubt then a rectal inspection may be necessary to check for impaction. Once the assessment is complete then the MD must be notified as described below. PRN medications to promote a bowel movement and anti-nausea medications may be useful if ordered. The results of the assessment, notification of the doctor, resident and family should be documented and any orders that have been obtained should be implemented. See below for contacting the MD and Order Processing. After MD notification, if vomiting or abdominal symptoms continue then put resident on PEC list at the nurses station for review. Some residents experience abdominal signs and symptoms for a prolonged period of time. Once an MD has been made aware of the signs and symptoms and treatments initiated the nurse must still continue to assess for changes. Changes might include worsening pain, worsening distention, increased frequency of vomiting or nausea, change in type or color or characteristic of the vomitus. When a change in these conditions occur, then the nurse should once again contact the MD to notify	2/4/12
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to inform the resident's family of the resolution of a grievance for 1 of 1 sampled resident. (Resident #2). Findings included: Review of the facility's policy and procedure dated 09/2002, read in part, "This policy is designed to encourage the resolution of grievances at the lowest possible level. It focuses on the mediation and settlement of issues as soon as possible after they arise. All resident grievances concerning services shall be heard under the procedures set forth below: E. Procedure after Grievance Filing: 1. As soon as possible after filing a grievance report, the	F 166		

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F 166	Continued From page 4 Resident Rights Officer or designee will interview the grievant, interview appropriate other parties, examine relevant records and take any action which will enable a full understanding of the issue. The inquiry, disposition and decision will be completed within seven (7) days of receipt of a grievance, unless the administrator authorizes an additional five (5) days for reasonable cause with written notice to the grievant." 2. "A written response to the grievance will be required within 14 calendar days of the grievance being filed that should include the results of the investigation and response." Resident #2 was originally admitted to the facility on 10/20/11 with diagnoses including Congestive Heart Failure, Diastolic Heart Failure, Atrial Fibrillation, Chronic Kidney Disease Stage II and Bilateral Macular Degeneration with Legal Blindness. Review of the facility's Grievance Report Form dated 11/14/11, Date of Occurrence: 11/13/11, Under A. Concerns, read in part, "Male Nurse doesn't speak to resident in a kind manner, snaps when asked for something. He also put meds. (medication) and water down and left . She is Blind." Under B. Describe anything you have done about the Grievance/concern: "Told the front office. Talked with Nurse on duty." Under D. Action Taken by the facility: "Nurse was pulled from room and hall. Upon investigation, it was determined that it was in best interest to terminate employee." There was a signature of an Investigator/Department Head, dated 12/5/11. The section under E. Resolution, Concerned party notified by telephone/in Person, was blank. "Note: Concerned party MUST be notified either	F 166	them of the changes and implement any additional orders that are received. 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** The Director of Nursing or designee will monitor this issue using the "GI QA Tool" for monitoring resident condition and changes (Attachment C). The monitoring will look at any change of condition, notation in nurses notes, and notification of MD of changes. This will be completed Five times a week times two weeks by the Director of Nurses or Unit Managers, then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee by the Administrator and corrective action initiated as appropriate.	2/4/12

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F 166	Continued From page 5	F 166	F 166	2/4/12

by phone or in person."

During an interview on 1/5/12 at 3:30PM, the facility Social Worker stated Resident #2's family member completed the grievance form. She revealed the staff member the grievance was filed against was terminated. The Social Worker further stated the resolution part of the grievance form was blank so the family might not have been notified about the results of the investigation.

During an interview on 1/6/12 at 11:00AM, Nursing Assistant #4/Medication Technician that administered medication stated Resident #2 was legally blind. She stated Resident #2 would ask what pills she was taking, would remove pills from her medication cup and take her pills whole. NA#4/Med. Tech added that Resident #2 determined what pill she was taking by the shape and the feel of the pill. She stated all of Resident #2's medication was in pill form. She revealed the resident would take big pills first and then take the rest of her medication. NA#4/Med. Tech. stated she did not leave medication in the resident's room.

During an interview on 1/6/12 at 11:10AM, Staff Nurse #3 stated they took care of the (grievance) issue immediately. She revealed they moved the named staff to another hall and the staff person was subsequently terminated. Staff Nurse #3 revealed she got side tracked and did not follow-up with Resident #2 ' s family member. She stated she would usually get back with the family in person. Staff Nurse #3 revealed she went to talk to Resident #2's family member the next day in the resident's room however she was pulled for something else. She stated she

Corrective Action for Resident Affected:

For Resident # 2, the grievance was addressed by the Director of Nursing on 11-15-11 and resolved on 12-5-11.

Corrective Action for Resident Potentially Affected:
All resident's have the potential to be affected by the alleged deficient practice. All open grievances were reviewed by the Administrator and notification of all concerned parties were completed by the Director of Nurses, Unit Managers and Administrator by 1/30/12, 12 grievances were followed up on.

Systemic Changes
An in-service was conducted on 1/30/12 by the Administrator (attachment D). Those who attended were all Administrative staff, Director of Nursing, Lead Support Nurse, Unit Manager, Housekeeping Supervisor, Maintenance Director, Activities Director, SCDU Coordinator, MDS Nurse, Social Worker, Business Office Manager, Medical Records Director, Marketing Director. Any administrative staff member who did not receive in-

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F 166	Continued From page 6 attempted to call the family member but she did not get an answer at the family member's home. During an interview on 1/6/12 at 1:00PM, the Administrator revealed the process for resolving a grievance was to follow-up on the grievance within seven days, just to make sure the issue was resolved. She stated usually the person that filed the grievance was called to let them know the issue was resolved. She stated staff followed up on grievances and grievance forms were signed when they were returned to the Administrator. She revealed she had been made aware of the situation with Resident #2 but she was not given the grievance form. The Administrator stated the employee was terminated but she did not know if follow-up was made with the family member. She explained the expectation was to have the grievance form back within 48 hours after the form had been turned over to the appropriate department.	F 166	service training will not be allowed to work until training has been completed. The in-service topics included: Policy and procedure of filing a grievance and the follow up required. This information has been integrated into the standard orientation training for Administration staff and in the required in-service refresher courses for all Administrative employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Administrator will monitor this issue using the "Grievance Log QA Tool" for monitoring follow up of grievances (Attachment E). The monitoring will look at follow up documentation and notification of concerned parties. This will be completed weekly x 4 weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee by the Administrator and corrective action initiated as appropriate.	2/4/12
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		

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F 514	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interview, the facility failed to document accurate bowel pattern for 1 of 3 sample residents (Resident #1) reviewed for bowel elimination. Resident #1 was admitted on 12/16/11. Cumulative diagnoses included Rehabilitation, History of Falls, Hypertension, Hypothyroidism and Anemia. The 14-day admission Minimum Data Set (MDS) completed on 12/28/11 indicated Resident #1 had no indicated problems with short and long term memory. The MDS revealed Resident #1 required extensive assistance with walk in the room. The MDS also indicated Resident #1 was continent of bowel. A review of the completed care task sheet documented by NA (Nurse Aides) for bowel pattern revealed Resident #1 did not have a bowel movement on 12/27/11, 12/2811, 12/29/11, 12/30/11, 12/31/11, 1/1/12, and 1/2/12. A review of the nurses' notes dated 12/27/11, 12/28/11, 12/29/11, 12/30/11, 12/31/11, 1/1/12, and 1/2/12 revealed no documentation that Resident #1 had a bowel movement. The nurse's noted dated 1/3/12 stated "She was sitting on the toilet." There was no description of the type of bowel movement reported by Resident #1, or the nurse's observation/description of a bowel movement. A review of the 24 hour nurse communication report sheets dated 12/27/11, 12/28/11, 12/29/11,	F 514	**F 514** **Corrective Action for Resident Affected:** For Resident # 1, was transported to Johnston Memorial Hospital on 1/2/11 due to changes noted in her condition. She was admitted with a diagnosis of Small bowel obstruction. **Corrective Action for Resident Potentially Affected:** All resident's have the potential to be affected by the alleged deficient practice. On 1/6/12 under the supervision of the Director Of Nursing, all residents who were listed on the no bowel movement list were assessed for impaction and the need for a laxative, if indicated, by the charge nurse. Note findings here: 5 residents were found to be on the bowel movement report on 1-6-12. 1 of 5 residents required milk of magnesium (Attachment F). **Systemic Changes** An in-service was conducted on 1/6/12 by the Staff Development Coordinator (Attachment B). Those who attended	2/4/12

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F 514	Continued From page 8 12/30/11, 12/31/11, 1/1/12, and 1/2/12 for 7a-3p; 3p-11p; and 11p-7a shifts; revealed no documentation of Resident's #1 report of a bowel movement, or staff description of an observed bowel movement. In an interview on 1/6/12 at 12:25 PM, the DON (Director of Nursing) revealed she could not locate a documented bowel movement for Resident #1 from 12/27/11-1/2/12. In an onsite hospital interview on 1/10/12 at 8:45 AM, Resident #1 stated while she resided at the nursing facility, she had a soft-formed bowel movement no less than every other day. In an interview on 1/10/12 at 10:40 AM, NA (Nurse Aide) #1 indicated when she documented "No" on the completed care task sheet for bowel pattern, her documentation was indicative that Resident #1 did not have a bowel movement; validated by observation or inquiry from Resident #1. In an interview on 1/10/12 at 10:55 AM, NA #2 stated her documentation of "No" on the completed care task sheet for bowel pattern; meant Resident #1 stated to her she did not have a bowel movement. In an interview on 1/10/12 at 11:25 AM, NA #3 stated her documentation of "No" on the completed care task sheet for bowel pattern conveyed that Resident #1 indicated to her she needed to have a bowel movement; but did not have one. In an interview on 1/10/12 at 12:15 PM the DON	F 514	were all RN's and LPN's, FT, PT, and PRN. The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included: Abdominal distention or swelling of the abdomen can be caused by overeating or eating gas producing foods but when combined with pain, vomiting or nausea further assessment is needed. When a resident displays signs and symptoms such as distention, vomiting, nausea or abdominal pain then an abdominal assessment should be conducted. This assessment includes vital signs, bowel sounds, tenderness, and distention. If vomitus is noted then the contents (blood, undigested food) and color should be noted. Additionally the nurse should assess the resident to ensure that bowel movements are occurring. Smart charting documentation can be quickly checked by pulling up the "No bowel movement	2/4/12

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F 514	Continued From page 9 stated she expected the NA's to report to the nurse if Resident #1 did not have a bowel movement in 3 days, as documented on the completed care task bowel pattern sheet, or if Resident #1 reported to the staff; she was unable to have a bowel movement.	F 514	report" on your AHT menu. This will give you a quick review to see if a bowel movement has been documented but your assessment should not stop there. Regardless of the documentation, if the above signs/symptoms are present then the nurse should interview the resident and staff to verify that bowel movements have occurred within 3 days and that they are a regular size and consistency. Stool that is hard or overly soft could indicate constipation or impaction. Signs and symptoms of constipation include Infrequent bowel movements and/or difficulty having bowel movements, swollen abdomen or abdominal pain, pain, vomiting. If there is any doubt then a rectal inspection may be necessary to check for impaction. Once the assessment is complete then the MD must be notified as described below. PRN medications to promote a bowel movement and anti-nausea medications may be useful if ordered. The results of the assessment, notification of the doctor, resident and family should be documented and any orders that have been obtained should be implemented. See below for contacting the MD and Order Processing. After MD notification, if vomiting or abdominal symptoms continue then put	2/4/12

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

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FORM APPROVED
OMB NO. 0938-0391

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 01/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

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