

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

PRINTED: 07/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
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NAME OF PROVIDER OR SUPPLIER LIBERTY NURSING AND REHAB CTR OF MECKLENBURG CTY	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 SHAMROCK DR CHARLOTTE, NC 28215
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide a dignified dining experience for three (3) of five (5) dependent residents. Residents #65, #141 and #133 did not receive timely assistance with eating for two (2) of five (5) dining observations while other residents were eating their meals.</p> <p>The findings included:</p> <p>1. Resident #65 was admitted to the facility in 2004 with diagnoses of Alzheimer's Dementia with behavioral disturbance and End Stage Dementia. A quarterly minimum data set (MDS) assessment dated 4/4/12 assessed Resident #65 with cognitive impairment and requiring extensive assistance with meals. A care plan dated 4/11/12 documented an intervention to assist with meals.</p> <p>A breakfast meal observation on 6/29/12 from 8:55 AM until 10:18 AM revealed four residents in the dining room sitting together. Resident #65 was observed sitting in her wheelchair at the table with the other three residents and one nursing assistant (NA), NA #1. At 8:55AM Resident # 65's breakfast tray was delivered to the table from the cart in the hallway. During this observation Resident # 65 sat at the table without assistance</p>	F 241	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>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 date or dates indicated.</p> <p>F241 § 483.15(a) Dignity</p> <p>F241</p> <p><u>CORRECTIVE ACTION</u> Resident # 65, # 141 and #131 were reviewed for feeding assistance and are now in designated seats with a NA available to ensure all trays are delivered to the table with feeding assistance available for all. The NA #1 and #2 were counseled and reeducated. NA #1 is no longer employed at the facility. The Staff Development Coordinator provided in-service training to all nursing staff who provide meals to residents # 65, #141 and # 133. They were in-serviced on providing a dignified dining experience.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *John Gray* TITLE Administrator (X6) DATE 7/24/12

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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If continuation sheet Page 1 of 19
JUL 25 2012
BY: DRW

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F 241	<p>Continued From page 1</p> <p>to eat, with her breakfast tray in front of her, from 8:55 AM to 9:44 AM. Resident # 65 watched while two other residents at the table were eating and one resident had eaten and completed the breakfast meal. NA #1 at 9:44 AM reheated Resident #65's meal and at 9:48 AM the NA began to assist Resident #65 with her breakfast meal. Resident #65 waited 53 minutes to be assisted to eat. NA #1 completed feeding Resident # 65 at 10:18 AM</p> <p>An observation of the lunch meal on 6/29/12 from 12:45 PM until 1:38 PM revealed four residents in the dining room sitting together. Resident #65 was observed seated in her wheelchair at the table with three other residents and two NAs were in the dining room. At 12:47 PM, Resident # 65's lunch tray was delivered to the table from the cart in the hallway. At 1:01 PM Resident #65 clasped her hands and watched the other residents at the table eat their lunch meal. At 1:12 PM Resident #65 pushed the insulated dome lid approximately ¼ of the way off of her lunch meal. At 1:16 PM Resident #65 picked up another resident's nutritional supplement and looked inside of the container. NA #1 at 1:20 PM removed the nutritional supplement from Resident #65 and replaced the lid to her lunch meal. NA #2 at 1:27 PM reheated Resident #65's lunch meal and began to assist the Resident at 1:35 PM with eating. During this observation, Resident #65 sat at the table without assistance to eat her meal, for 48 minutes while one resident at the same table ate and then left the table and the two other residents at the table continued eating their lunch meal.</p> <p>On 6/29/12 at 2:50 PM NA #3 was interviewed.</p>	F 241	<p><u>POTENTIAL AFFECT</u></p> <p>All residents receiving feeding assistance have the potential to be affected by this alleged deficiency. An audit was conducted by the support nurses assessing the resident's need for assistance with feeding and proper seat designation to ensure timely assistance is available when tray are served to the table.</p> <p><u>SYSTEMIC CHANGES</u></p> <p>The Staff Development Coordinator provided in-service training on 7/23/2012 and 7/24/2012 to all nursing staff both Nurses and NA instructing them on the current seating charts for resident's requiring feeding assistance and to serve meal trays to those residents who sit at the same table along with procedures for feeding more than one resident and proper infection control techniques. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.</p> <p>The dining room has been re-arranged and a seating chart for resident's requiring feeding provided to accommodate staff's ability to provide assistance with meals for more than one resident at a time. Residents requiring</p>	

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F 241	<p>Continued From page 2</p> <p>NA #3 revealed that lunch trays arrived on the unit at 12:30 PM. NA #3 also stated that two NAs remained in the dining room to assist the residents who could not feed themselves.</p> <p>An interview with NA #1 on 6/29/12 at 2:54 PM revealed that she was aware that Resident #65 was waiting to be fed, but she was feeding another resident at that table who required feeding assistance. She also stated that the resident she was assisting took a longer time to eat and she thought someone else would have assisted Resident #65.</p> <p>An interview with NA #2 on 6/29/12 at 2:59 PM revealed that the delay in feeding Resident #65 was not intentional but staff spent most of the meal time redirecting, cueing and providing care to other residents. NA #2 further stated that she fed Resident #65 as soon as she finished helping another resident and realized that Resident #65 still needed assistance.</p> <p>During an interview with the Director of Nursing (DON) on 6/29/12 at 6:34 PM, the DON stated that he was aware that the unit had a lot of residents who required feeding assistance and ate slowly. The DON further explained that with the nurse staffing being poor he could not put an expectation on how long it should or would take for residents to be assisted with their meals. He did state that it could be considered a dignity concern for some residents to have to wait that long while other residents were fed.</p> <p>2. Resident #141 was re-admitted to the facility in 2009. Diagnoses included Alzheimer's Disease,</p>	F 241	<p>assistance with eating have been reviewed and meal tray times adjusted to provide sufficient time to assist with meals so all residents at the same table can enjoy the dining experience. Seating charts will be reviewed weekly for any resident request for seat changes, admissions and discharged residents.</p> <p><u>MONITORING</u></p> <p>Dining Room audits on each floor will be conducted five (5) days a week by the Department Managers for four (4) weeks and then weekly for two (2) months using the Survey QA Tool. The audit will include observation of tray delivery to residents, assistance with feeding provided, and any identified dignity issues. Any issues identified will be reported to the DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Meeting. The Committee members will include at a minimum: Administrator, DON, SDC, Support Nurse, MDS nurses, Social Services, dietary and other clinical team members as needed.</p> <p><u>DATE OF COMPLIANCE</u></p> <p>July 25, 2012</p>	

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F 241	<p>Continued From page 3</p> <p>Dementia, Dysphagia, and Diabetes Mellitus II. An annual minimum data set dated 5/10/12 assessed Resident #141 with severe cognitive impairment and totally dependent on staff for assistance with eating.</p> <p>The care plan for Resident #141 dated 5/16/12 assessed the Resident at risk for further decline in activities of daily living with interventions that included to feed Resident #141 as needed and to encourage good fluid intake.</p> <p>On 6/29/12 at 8:55 AM, Resident #141 was observed in the dining room of the second floor seated at a dining room table with three other Residents. The meal tray for Resident #141 was placed in front of her and her breakfast meal was set up by staff. The remaining Residents at the same table received their breakfast meal while Resident #141 stared at her meal. Resident #141 was observed sleeping at the dining room table at 9:30 AM. At 9:42 AM nursing assistant #2 (NA #2) reheated the breakfast meal for the Resident. NA #2 sat down to feed her at 9:45 AM after Resident #141 waited 50 minutes while other residents ate.</p> <p>On 6/29/12 at 2:59 PM, NA #2 was interviewed and stated that the delay in feeding Resident #141 was not intentional but staff spent most of the meal time redirecting, offering cueing and providing care to other residents. NA #2 further stated that she sat to feed the resident as soon as she could.</p> <p>During an interview with licensed nurse (LN) #1 on 6/29/12 at 3:25 PM, she revealed that she was aware that it took a while for Residents to receive</p>	F 241			

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F 241	<p>Continued From page 4</p> <p>assistance with eating. She further commented that the decrease in staff has affected her ability to assist the nursing assistants with the meal service in the dining room.</p> <p>During an interview with the Director of Nursing (DON) on 6/29/12 at 6:34 PM, the DON stated that he was aware that the second floor had a lot of Residents who required assistance with eating and ate who slowly. The DON further explained that with the nurse staffing numbers being poor he could not put an expectation on how long it should or would take for Residents to be assisted with their meals. He did state that it could be considered a dignity concern for some residents to have to wait that long while other residents were fed.</p> <p>3. Resident #133 was admitted to the facility in 2008. Diagnoses included Alzheimer's Disease and Osteoarthritis. A quarterly minimum data set dated 5/16/12 assessed Resident #133 with severe cognitive impairment and requiring extensive assistance with eating.</p> <p>A care plan updated June 2012 identified Resident #133 at risk for decline in her ability to participate with self care and feeding herself. Interventions included to set up her meal tray, allow and encourage her to feed herself and to provide assistance as needed.</p> <p>On 6/29/12 at 8:55 AM, Resident #133 was observed in the dining room of the second floor at a table with three other Residents and staff. Staff set up her breakfast meal and she was left to feed herself while staff assisted other Residents.</p>	F 241			

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F 241	<p>Continued From page 5</p> <p>Resident #133 was observed for 32 minutes from 8:55 AM until 9:27 AM to take a few bites of her food and a sip of her juice, watch the other residents eat and talk to herself without receiving staff assistance to eat. At 9:28 AM, Resident #133 spilled coffee in her lap, staff moved the Resident with her meal to another table. Resident #133 was observed for 10 minutes to talk to herself from 9:28 AM until 9:38 AM without assistance with her meal. At 9:38 AM, the Resident took a bite of her food and continued talking to herself for 30 minutes until 10:08 AM at which time nursing assistant #2 (NA #2) sat down to assist her with breakfast.</p> <p>On 6/29/12 at 2:59 PM, NA #2 was interviewed and stated that the delay in feeding Resident #133 was not intentional but staff spent most of the meal time redirecting, offering cueing and providing care to other residents. NA #2 further stated that she sat to feed the Resident as soon as she could.</p> <p>During an interview with licensed nurse (LN) #1 on 6/29/12 at 3:25 PM, she revealed that she was aware that it took a while for Residents to receive assistance with eating. She further commented that the decrease in staff has affected her ability to assist the nursing assistants with the meal service in the dining room.</p> <p>During an interview with the Director of Nursing (DON) on 6/29/12 at 6:34 PM, the DON stated that he was aware that the second floor had a lot of Residents who required assistance with eating and who ate slowly. The DON further explained that with the nurse staffing numbers being poor he could not put an expectation on how long it</p>	F 241		
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F 241	Continued From page 6 should or would take for Residents to be assisted with their meals. He did state that it could be considered a dignity concern for some residents to have to wait that long while other residents were fed.		F312 §483.25 (a) ADL Care Provided for Dependent Residents	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide appropriate incontinence care for (1) one of (2) two sampled residents observed for incontinence care (Resident # 108) as evidenced by not changing the bath water after cleaning away stool. Findings include: A facility policy dated 10/01/2001 entitled: Perineal Care revealed that soiled linens were to be disposed of appropriately. Resident #108 was readmitted in 2012 with diagnoses of Dementia, Parkinson's disease and Osteoarthritis. An annual Minimum Data Set (MDS) assessment dated 5/23/12 indicated cognitive impairment and total dependence on staff assistance for toileting and bathing. On 6/27/12 at 10:49 AM, Resident #108 was	F 312	F312 <u>CORRECTIVE ACTION</u> The NA #1 has been counseled and reeducated and is no longer employed by the facility. The Staff Development Coordinator provided in-service training to all nursing staff. They were in-serviced and educated on proper incontinent care and bed bath procedures including being mindful of infection control while giving incontinent care. This was done by the SDC on 7/23/2012 and 7/24/2012. <u>POTENTIAL AFFECT</u> All residents who receive bed baths or incontinent care have the potential to be affected by this alleged deficient practice. In-service training for all nursing assistant staff as outlined under systemic changes was completed to correct this deficient practice. <u>SYSTEMIC CHANGES</u> The Staff Development Coordinator provided in-service training on 7/23/2012 and 7/24/2012 to all nursing staff particularly nursing assistants. 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-	

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F 312	<p>Continued From page 7</p> <p>observed receiving a bed bath and incontinence care. Nursing assistant (NA) #1 prepared a basin with water and placed two clean washcloths into the basin. She turned Resident #108 on her left side. NA #1 placed the washcloth (#1) into her hand, applied soap and wiped the peri-rectal area from back to front removing stool from the peri-rectal area. She rinsed the washcloth (#1) in the basin of water and used the washcloth (#1) to rinse the peri-rectal area. The NA turned the resident on her back and removed the other washcloth (#2) from the basin of water, applied soap to it and washed Resident #108 perineal area from front to back. NA #1 rinsed the washcloth (#2) in the basin of water and then rinsed the perineal area. NA#1 did not change the basin of water after she removed and rinsed stool from washcloth (#1) into the basin. Stool was observed on the washcloth in the basin of water.</p> <p>During an interview with NA #1 on 6/27/12 at 1:42 PM, NA #1 stated that the washcloth with fecal matter should have been discarded into a bag and not placed back into the basin of water with the clean washcloth that was used to provide perineal care.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 6/28/12 at 10:41 AM, the ADON was interviewed regarding incontinence care and staff training. The ADON stated staff should be providing incontinence care as per their annual perineal care training. She commented that staff had been taught to never place a washcloth back into the basin of water once it became contaminated with stool.</p> <p>During an interview with the Director of Nursing</p>	F 312	<p>service topics included infection control practices during bed baths including pericare. The proper steps in bed bathing and pericare were also demonstrated. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher course for NAs and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.</p> <p><u>MONITORING</u></p> <p>The Support Nurses will monitor incontinent care using the Survey QA Tool. The monitoring will include observing five (5) staff members giving incontinent care to ensure that infection control procedures are followed for the residents. Any issues identified will be reported immediately to the DON or Administrator for appropriate action. This will be done weekly for four weeks and then bi-monthly for three months or until resolved by the weekly Quality Assurance committee. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The Committee members will include at a minimum: Administrator, DON, SDC, Support Nurse, MDS nurses, Social Services, dietary and other clinical team members as needed.</p> <p><u>DATE OF COMPLIANCE</u></p> <p>July 25, 2012</p>		

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F 312	Continued From page 8 (DON) on 6/28/12 at 4:09 PM, the DON commented that staff should not place soiled washcloths back into the basin of water. He stated that staff should change the basin of water if contaminated before continuing with incontinence care and discard the soiled washcloth.	F 312			
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observations, facility menu review and staff interviews the facility failed to provide six residents (Resident #91, #3, #84, #134, #121 and #147) with coffee and milk as per the facility menu during two (2) of five (5) meal observations. The findings include: 1. A continuous meal observation was made on 6/26/12 from 8:22 AM until 9:10 AM in the dining room on the 300 unit. At 8:55 AM Residents #91, #3 and #84 were observed seated at the same table. Resident #91, #84 and #134 were observed with only a four ounce (oz.) cup of juice on their meal tray. Additionally, Resident #3 was also observed with a carton of milk on his breakfast meal tray. Review of the tray cards for all Residents revealed they were to receive a four	F 363	F363 § 483.35© Menus Meet Resident Needs/Prep in Advance/Followed F363 <u>CORRECTIVE ACTION</u> Residents #91, #3, #134, #121 were interviewed by dietary or nursing and asked what their two (2) favorite beverages are. Residents will have their favorite two (2) beverages listed on their meal ticket. These two (2) beverages must be provided to the resident. Other beverages will be available and offered as requested. Resident #147 has a diagnosis of progressive chronic diseases and dysphagia after consultation with family and medical team; the resident has had a G-tube inserted. Resident # 147 is provided fluids and nutrition per MD orders.		

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F 363	<p>Continued From page 9</p> <p>oz. juice of choice, a cup of milk and one cup of coffee or hot tea. Each Resident left the dining room during the observation with no other fluids offered.</p> <p>During an observation on 6/26/12 at 9:12 AM Resident #121 was in his bed and had just completed his breakfast meal. Resident #121 received a four oz. cup of juice and was observed drinking his juice with a straw. There were no other fluids observed on his tray. Review of his tray card revealed he was to receive a four oz. juice of choice, one cup of milk and one cup of coffee or hot tea. An interview with Resident #121 on 6/26/12 at 9:15 AM revealed that he liked coffee and he was not offered any coffee or milk with his breakfast.</p> <p>An interview with Resident #91 on 6/26/12 at 9:30 AM revealed that he enjoyed coffee and milk and usually drank a cup of coffee and milk with breakfast, but was not offered these beverages with his meal that morning.</p> <p>During an interview with Dietary Manager (DM) #2 on 6/26/12 at 10:01 AM, DM #2 explained that the nursing assistants (NAs) on the units provided the fluids listed on the tray card and that dietary staff sent up coolers with cold drinks for each meal as well as stocked the unit pantries with items needed to make tea/ coffee.</p> <p>A continuous observation of the breakfast meal was made on 6/27/12 from 8:29 AM until 9:25 AM in the dining room on the 300 unit. Resident #121 was observed with an empty four oz. cup of juice. At 8:41 AM Resident #121 exited the dining room with no other fluids offered.</p>	F 363	<p><u>POTENTIAL AFFECT</u></p> <p>All residents have the potential to be affected by this alleged deficiency. All residents who are at risk for dehydration or who have an order to encourage fluids were reviewed for signs and symptoms of dehydration including poor skin turgor, dry mouth, decreased urinary output, no tears, sunken eyes, delayed capillary refill or change in BP. Recent labs were reviewed for electrolytes and BUN not within acceptable limits per Physician review. No residents were identified with issues.</p> <p><u>SYSTEMIC CHANGES</u></p> <p>Dietary assessment will be completed on admission and quarterly to evaluate residents for nutrition and hydration needs. Also resident's likes and dislikes will be reviewed including fluid choices. Any changes will be updated on the resident's menu card. Recommendations for change in diet, consistency or thickened liquids will be approved by MD and a MD order obtained. The Staff Development Coordinator provided in-service training on 7/23/2012 and 7/24/2012 to all nursing staff, instructing them that all residents must be offered all beverages listed on their meal ticket as well as any other liquid the resident may request that the facility has available. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/29/2012
NAME OF PROVIDER OR SUPPLIER LIBERTY NURSING AND REHAB CTR OF MECKLENBURG CTY			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 SHAMROCK DR CHARLOTTE, NC 28215		
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F 363	<p>Continued From page 10</p> <p>During an interview with nursing assistant (NA) #2 on 6/27/12 at 8:46 AM, NA #2 revealed that the tray card indicated the amount and type of fluid to be given to residents at every meal.</p> <p>On 6/27/12 at 9:00 AM Residents #91, #3 and #84 were observed seated at the same table in the dining room on the 300 unit, each Resident received a four oz. cup of juice and a cup of milk with their breakfast. On 6/27/12 at 9:20 AM Resident #134 was observed with a four oz. cup of juice and a cup of milk on his meal tray. Review of the tray card for each Resident revealed they were to receive a four oz. juice of choice, one cup of milk and one cup of coffee or hot tea. Each Resident left the dining room during the observation with no other fluids offered.</p> <p>A review of the menu for 6/26/12 and 6/27/12 revealed the breakfast meal included a juice of choice, milk and coffee or hot tea.</p> <p>During a follow-up interview with NA #2 on 6/27/12 at 9:29 AM, NA #2 revealed that it was the responsibility of all the NAs on the unit to offer fluids to residents according to the tray card. She also stated that coffee was offered to the residents who typically wanted coffee. She further explained that Residents #91, #3, #84, and #134 drank coffee and she thought that they received a cup. She explained that she did not know that Resident #121 liked coffee and thought that someone else had offered milk and coffee to Resident #121.</p> <p>During an interview with NA #3 on 6/27/12 at 9:35 AM, NA #3 stated that it was the responsibility of</p>	F 363	<p>refresher courses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.</p> <p><u>MONITORING</u></p> <p>Dining Room audits on each floor will be conducted five days a week by the Unit Support Nurses for four weeks and then weekly for two months using the Survey QA Tool. The audit will include observation of the meal ticket making sure that staff is offering to the resident the beverages listed on the meal ticket. Any issues identified will be reported immediately to the DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The Committee members will include at a minimum: Administrator, DON, SDC, Support Nurse, MDS nurses, Social Services, dietary and other clinical team members as needed.</p> <p><u>DATE OF COMPLIANCE</u></p> <p>July 25, 2012</p>		

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NAME OF PROVIDER OR SUPPLIER LIBERTY NURSING AND REHAB CTR OF MECKLENBURG CTY			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 SHAMROCK DR CHARLOTTE, NC 28215	
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F 363	<p>Continued From page 11</p> <p>the NAs to prepare and offer coffee and tea to the residents. She also stated that she did not know that coffee was not made or offered to all the residents and thought that someone else had given the residents milk and coffee.</p> <p>A follow-up interview with DM #2 on 6/28/12 at 9:51 AM revealed that the tray card listed the amount and type of fluids to be offered to residents according to the menu with every meal. She further stated that fluids were offered to residents by nursing staff on the units.</p> <p>An interview with the Director of Nursing on 6/29/12 at 4:12 PM revealed that he expected the NAs to provide fluids as indicated on the meal card and dietary menu.</p> <p>2. On 6/27/12 a continuous observation of the breakfast meal for Resident #147 was conducted from 9:31 AM until 10:18 AM. During the observation, Resident #147 was observed seated upright in bed while nursing assistant #1 (NA #1) set up the Resident's breakfast meal. Review of the tray card for Resident #147 revealed she was to receive juice, milk and coffee or hot tea with her breakfast meal. The Resident received and drank low fat milk and cranberry juice with her breakfast. At 10:18 AM, NA #1 removed the breakfast tray for Resident #147 and placed the meal tray on the cart located outside of the Resident's room. Resident #147 was not offered coffee with her breakfast.</p>	F 363		



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NAME OF PROVIDER OR SUPPLIER LIBERTY NURSING AND REHAB CTR OF MECKLENBURG CTY			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 SHAMROCK DR CHARLOTTE, NC 28215	
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F 363	Continued From page 12 On 6/27/12 at 10:19 AM, NA #1 was interviewed and stated that she regularly assisted Resident #147 with her breakfast meal. When asked if Resident #147 usually drank anything else with her breakfast, NA #1 stated that in the past the Resident asked for coffee for breakfast, but lately the Resident had not asked for it. NA #1 stated she stopped offering coffee to Resident #147 with her breakfast because the Resident did not ask for it. NA #1 further stated that it was the responsibility of the nursing staff to offer residents beverages according to the resident's tray card. An interview with Dietary Manager #2 on 6/28/12 at 9:51 AM revealed that each resident's tray card listed the amount and type of fluids to be offered to the residents according to the menu with every meal. She further stated that fluids were offered to residents by nursing staff on the units. On 6/29/12 at 8:58 AM, Resident #147 was observed in the dining room with her breakfast meal tray. The Resident received and drank skim milk, cranberry juice and coffee with her breakfast. The Resident stated "Yes" when asked if she liked to have coffee with her breakfast. A review of the breakfast menus for 8/27/12 and 6/29/12 revealed the breakfast meal included a juice of choice, milk and coffee or hot tea. An interview with the Director of Nursing on 6/29/12 at 4:12 PM revealed that he expected the nursing staff to provide fluids as indicated on the resident's meal card and dietary menu.	F 363		
F 371 SS*E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	<p>Continued From page 13</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities, and</p> <p>(2) Store, prepare, distribute and serve food under sanitary condltions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, policy and vendor invoice review and staff interviews the facility failed to monitor, label and date a thawed pork loin in (1) one of (2) refrigerated coolers and five frozen food items in (1) one of (1) freezer units.</p> <p>The findings include:</p> <p>A facility policy, undated, entitled Food and Supply Storage Procedures recorded in part: "Date and rotate items; label and date containers and wrap food tightly to prevent freezer burn."</p> <p>A facility policy, undated, entitled Actions in Response to Deviant Temperatures revealed: "Determine if any foods have thawed. Move thawed foods to refrigerated storage and make necessary menu changes to utilize these foods Do not refreeze "</p> <p>On 6/25/12 at 6 55 PM an observation of the walk-in refrigerated cooler revealed one box containing one individually wrapped thawed pork loin. The pork loin was soft to touch with a grayish</p>	F 371	<p>F371</p> <p><u>FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY</u></p> <p>F371</p> <p><u>CORRECTIVE ACTION</u></p> <p>The pork loin and all items not labeled and dated were discarded. Staff was in-serviced on 06/26/12 on the topics of proper freezing protocol, labeling/ dating of food inventory, discarding of leftovers, proper food rotation, food and supply storage procedures and USDA freezer guidelines</p> <p><u>POTENTIAL AFFECT</u></p> <p>All residents have the potential to be affected. Failure to properly label, date, rotate stock or follow freezer protocol could result in compromised food integrity, as well as, food safety. During the week of June 26-29, 2012, an addition to the Healthcare Services Group Sanitation Audit was implemented in order to combat any further instances that may cause future deficiencies.</p> <p><u>SYSTEMIC CHANGES</u></p> <p>On June 26th, 27th and July 10th, 2012, the Directors of Nutrition Services provided food safety education information to all full-time, part-time and newly hired dietary employees, instructing them on how to correctly freeze/ thaw food products, label/ date food inventory, length of storage for cooked food items, proper food rotation, food and supply storage techniques, and USDA freezer guidelines. This information has been integrated immediately (June 26th,</p>	

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F 371	<p>Continued From page 14</p> <p>beige hue. The pork loin was not labeled or dated with the date of receipt and had no expiration date on it. The box was labeled with a date of 6/4/12.</p> <p>An interview with the Dietary Supervisor and Dietary Manager (DM) #1 on 6/25/12 at 7:15 PM revealed that both dietary staff confirmed the date on the box of 6/4/12 was the delivery date of the pork loin.</p> <p>On 6/25/12 at 7:30 PM an observation of the freezer revealed (1) ½ bag of frozen broccoli wrapped in saran wrap; (1) ½ bag breaded okra wrapped in saran wrap; an undated box labeled Harvest Vegetables with (1) brown bag opened and not wrapped which contained hash browns and (2) brown bags wrapped in saran wrap contents unknown. The items observed were not labeled or dated.</p> <p>An interview with Dietary Manager (DM) #1 on 6/25/12 at 7:50 PM revealed that he expected dietary staff to label and date any opened item placed in the freezer and refrigeration units.</p> <p>On 6/26/12 at 4:40 PM an observation of the freezer revealed a frozen prepackaged pork loin on the bottom shelf of the freezer.</p> <p>During an interview with DM #1 on 6/26/12 at 4:56 PM, DM #1 revealed that the pork loin observed in the freezer was the same pork loin noted to be in the refrigerated cooler on 6/25/12. DM #1 further explained that because the pork loin had been maintained at a temperature of 41 degrees in the refrigerated cooler that he placed it in the freezer for future use.</p>	F 371	<p>2012) and permanently into the daily Sanitation Audit conducted by the Directors of Nutrition Services and the Shift Supervisors. Each day the auditors (DNS and SS) are to look thoroughly through all refrigeration and freezer units identifying the following:</p> <ol style="list-style-type: none"> 1.) Thawed items are labeled and dated 2.) Any items pulled from the freezer are labeled and dated when pulled 3.) All individual items thawed in cooler are removed from box and individually labeled and dated <p>The Directors of Nutrition Services are to serve as a secondary auditor to the Shift Supervisor, who is responsible for conducting this audit at the beginning of their shift.</p> <p><u>MONITORING</u> The results of the Sanitation Audit will be presented at the weekly Quality Assurance meeting by the Director of Nutrition Services.</p> <p><u>DATE OF COMPLIANCE</u> July 25th, 2012</p>		

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F 371	<p>Continued From page 15</p> <p>During an interview with the Corporate DM on 6/26/12 at 5:18 PM, the Corporate DM explained that the facility did not refreeze meats and that the pork loin should have been discarded per facility policy. She also stated that anything opened and placed in the freezer or refrigeration units should be labeled and dated when opened.</p> <p>An interview with DM #1 on 6/27/12 at 4:40 PM revealed that all meats were delivered frozen to the refrigerated cooler and then immediately placed in the freezer. He explained that meats were taken out of the freezer and placed into the refrigerated cooler 48-72 hours in advance of use for thawing. DM #1 explained that the pork loin was delivered on 6/4/12 for use on 6/10/12 per the menu, and removed from the freezer for thawing on either 6/7/12 or 6/8/12. He then explained that his staff typically removed four (4) pork loins from the freezer for use and since the facility census was low staff may have pulled too many pork loins and forgot to return the unused pork loin to the freezer. DM #1 stated that he could not confirm that the pork loin in the box had been the pork loin delivered on 6/4/12 since the individual pork loin was neither dated nor labeled. DM #1 also stated that it was not the facility's practice to date and label items that were in a dated box and unopened.</p> <p>A review of the facility vendor invoices dated 6/4/12 and 6/18/12 confirmed delivery of six pork loins each weighing nine pound (lbs) on 6/4/12 and 6/18/12. A review of the facility menu for the month of June 2012 confirmed that pork loin was served on 6/10/12, 6/15/12 and 6/23/12.</p>	F 371			

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F 371	Continued From page 16 An interview with the Registered Dietitian on 6/27/12 at 4:45 PM revealed that refreezing of thawed meat should never occur due to the potential for bacteria to form before the meat reaches a frozen state. She also stated that for a geriatric population meats should not be thawed and frozen again. An interview with DM #2 on 6/27/12 at 5:20 PM revealed that it was the responsibility of the dietary supervisor as well as the dietary managers to ensure that expired items were removed from refrigeration and all items were labeled and dated. She further explained that the refrigerated coolers and freezer were monitored daily by the dietary supervisor and the dietary managers for expired items and unlabeled and/or undated items. DM #2 stated that the pork loin and frozen items must have been missed during their checks of the refrigerated cooler and freezer.	F 371			
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	F514 \$483.75(1)(1) Resident Records- Complete/Accurate/Accessible F514 <u>CORRECTIVE ACTION</u> Resident # 208 continues to receive the correct dose per MD original order. The MD was notified and a clarification order was written. The resident computer MD orders and Medication Administration Record (MAR) were corrected to reflect the correct dosage.		

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F 514	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews and staff interviews the facility failed to accurately transcribe the correct dose of medication (Lopressor 25 mg) to the Physician order sheets and the Medication Administration Records for one (1) of twelve (12) residents observed for medication administration. (Resident #208)</p> <p>The findings include:</p> <p>Resident #208 was admitted to the facility in May 2012. The admitting diagnoses for Resident #208 included hypertension and hyperlipidemia. Resident #208 was observed for medication administration on 6/27/2012 at 8:35 AM. Licensed Nurse (LN) #3 was observed administering medications including one tablet of Lopressor 25 mg as per pharmacy label.</p> <p>A review of the admission physician orders included, to administer "one half" of Lopressor 50 mg tablet amounting to Lopressor 25 mg two times daily. Further review of monthly consolidated physician orders and Medication Administration Records (MAR) for the month of May 2012 and June 2012 revealed that Lopressor 50 mg was incorrectly transcribed as "one" tablet or 50 mg two times daily rather than half a tablet or 25 mg two times daily.</p> <p>An interview with LN #3 on 6/27/2012 at 9:00 AM revealed that she had not noticed the discrepancy in the physician order sheet or in the MAR's and had followed the instructions per pharmacy label to administer Lopressor 25 mg.</p>	F 514	<p><u>POTENTIAL AFFECT</u></p> <p>All residents who are admitted to the facility have the potential to be effected by this alleged practice. All admissions from 06/1/2014 thru 07/04/2012 has had physicians orders verified and check. Admission Physician Orders were compared to the computer monthly physician orders and the pharmacy dispensed medication cards to ensure accuracy of medication, dosage and schedule. All resident's orders were transcribed correctly and appropriate dosage administered.</p> <p><u>SYSTEMIC CHANGES</u></p> <p>Any resident admitted to the facility will have medications verified by two Nurses that the medications are transcribed from the hospital discharge summary and verified by the attending physician are correctly transcribed to the facility admitting orders and the MAR. Pharmacy will enter the medications into the computer and Support Nurses will compare the printed computer monthly physician orders to the original admission orders to ensure accuracy of med and dosage. The nurse will sign the bottom of the printed orders in the nurse reviewed section.</p> <p>The Staff Development Coordinator provided in-service training on 7/23/2012 and 7/24/2012 to all nursing staff of the importance of double checking the transcription of orders. All orders for new admissions and re-admissions must now be checked by two (2) nurses and each is to</p>	

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F 514	Continued From page 18 Further interview on 6/29/12 at 9:10 AM with the Licensed Nurse #4 who was the supervisory nurse, revealed that once the original physician orders were faxed to the pharmacy, the data entry was completed at the facility and the physician order sheets and MAR's were printed at the facility. The interview revealed that at the beginning of each month all physician order sheets and the MAR's were checked for accuracy for all physician orders by an assigned supervisory nurse. Any discrepancy found was corrected with a clarification order for accuracy. Interview with Director of Nursing on 6/29/12 at 9:15 AM confirmed the data entry and physician order process and he stated that it was his expectation that all transcriptions were accurate and the nurse supervisor was responsible for accurate transcriptions. The DON was not aware of the transcription errors for Resident #208.	F 514	sign off verifying accuracy. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses and observations of medication administration for all nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. <u>MONITORING</u> The QA Nurse will audit five (5) new admissions or re-admissions per week, if available, for accuracy to make sure all orders were transcribed accurately to the Medication Administration Record. Any issues identified will be reported immediately to the DON or Administrator for appropriate action. This will be done weekly for four weeks and then bi-monthly for three months or until resolved by the weekly Quality Assurance committee. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The Committee members will include at a minimum: Administrator, DON, SDC, Support Nurse, MDS nurses, Social Services, dietary and other clinical team members as needed. <u>DATE OF COMPLIANCE</u> July 25, 2012		