| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345519 | A. BUILDING _____ B. WING _____ | 09/05/2014 |

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

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| F 278 SS=B | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>2) Resident #57 was readmitted on 3/24/14 with cumulative diagnoses of hypertension, diabetes, urinary retention, Alzheimer ' s disease, and hemiplegia (paralysis of the arm, trunk, and leg on the same side of the body). The resident ' s medical record reflected that he had an indwelling | F 278 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>To remain in compliance with all federal and state regulations the facility has taken | 9/12/14 |

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

Electronically Signed | 09/19/2014

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| F 278 | Continued From page 1<br>urinary catheter on admission.<br>The Admission Minimum Data Set (MDS) dated 3/31/14, noted Resident #57 to be cognitively intact and needed extensive assistance for all Activities of Daily Living (ADLs), and with the physical assistance of one to two persons. The MDS (Section H) indicated that Resident #57 had an indwelling urinary catheter. The Section H assessment also coded the resident as " always incontinent " of urine.<br>A review of the medical record revealed, both in nurse notes and Physician Progress Notes, that Resident #57 had an indwelling urinary catheter from the date of his admission until the date of review (9/4/14.)<br>On 9/4/14 at 4:10 PM, in an interview the MDS nurse stated that she was the person to complete the facility assessments. When asked why the area of Section H in the Bowel and Bladder assessment appliances (H0100) was coded for an indwelling catheter, and urinary continence (H0300) was coded as always incontinent, the MDS nurse replied " it was pre-populated. "<br>On 9/5/14 at 8:05 AM, in an interview, Nurse #3 stated that she did not know of anytime that Res. #57 ' s catheter had leaked.<br>On 9/5/14 at 10:45 AM, in an interview, the MDS nurse stated that she had reviewed Res. #57 MDS and she felt that she had misunderstood what the actual assessment should have been and she would need to change the coding.<br>In an interview on 9/5/14 at 11:00 AM, the facility Administrator stated that her expectation was that the MDS would be coded correctly.<br>Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect the continence of 2 of 3 sampled residents reviewed with urinary catheters (Resident #66 and Resident # 57 ). | F 278 | 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.<br><br>Corrective Action for Resident Affected<br><br>For resident #57 and # 66 on 9/4/4024 the MDS coordinator modified the identified MDS which was coded incorrectly for indwelling catheter and bladder continence.<br><br>Corrective Action for Resident Potentially Affected<br><br>On 9/12/2014, an audit of all residents who have an order for an in indwelling catheter was completed by the MDS Coordinator to ensure the most recent MDS was coded correctly. In completing this review 3 additional residents were identified with incorrect bladder incontinence coding. The MDS for the identified residents were modified for compliance which was completed on 9/12/2014 by the MDS Coordinator.<br><br>Systemic Changes<br><br>An in-service was provided to the MDS Coordinator on 9/4/2014 by the MDS Consultant in which she voiced understanding of correct coding of urinary continence and indwelling catheter on the MDS assessment. | |

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| F 278 | Continued From page 2<br><br>The findings included:<br><br>1) Resident #66 was admitted to the facility on 8/7/14 from a hospital with cumulative diagnoses which included benign prostatic hyperplasia (enlarged prostate gland) and urinary retention. A review of the resident ' s medical record revealed he had an indwelling urinary catheter in place upon admission to the facility.<br><br>Resident #66 ' s admission Minimum Data Set (MDS) assessment (Section H) dated 8/14/14 indicated the resident had an indwelling catheter. The resident was also coded as " occasionally incontinent " of urine in Section H of the MDS assessment.<br><br>Resident #66 ' s medical records, including the Physician Progress Notes and Nursing Notes, revealed he had an indwelling urinary catheter in place from the date of admission to the facility up until the date of review (9/4/14).<br><br>An interview was conducted on 9/4/14 at 4:11 PM with Nurse #2. Nurse #2 assumed responsibility for completing the facility ' s MDS assessments. During the interview, Nurse #2 reported the MDS field related to urinary continence for Resident #66 had been " pre-populated " based upon an assessment. When asked if the coding for a pre-populated field could be changed if the nurse found it to be incorrect, she stated, " Yes. "<br><br>A follow-up interview was conducted on 9/4/14 at 4:45 PM with Nurse #2 (upon her request). Nurse #2 reported that upon further review of the 8/14/14 MDS assessment for Resident #66, she believed the fields pertaining to urinary | F 278 | Quality Assurance<br><br>To ensure quality the Staff Development Coordinator will complete a monthly audit of all residents with indwelling foley catheters for bladder continence coding on the most recent MDS for a minimum of 3 months. These reports will be provided to the Quality of Life □ QA committee and corrective action initiated as appropriate. The QOL / QA Meeting is attended by Administrator, Director of Nursing, Unit Manager, other nurse managers, Health Information Manager and Dietary Manager. | |

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| F 278 | Continued From page 3<br>continence had initially been pre-populated with the correct coding. However, the nurse reported that she had erroneously changed the coding to indicate that the resident was occasionally incontinent in addition to having an indwelling urinary catheter. She re-stated that this coding was an error and that she would need to correct it.<br><br>An interview was conducted on 9/5/14 at 11:00 AM with the facility ' s Administrator. Upon inquiry, the Administrator indicated that her expectation was for information to be coded accurately on the MDS. | F 278 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. | F 280 | | 9/9/14 |

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| F 280 | Continued From page 4<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record reviews, the facility failed to update a care plan to reflect interventions added after repeated falls for one of three residents reviewed for falls (Res. #135).<br>Findings included:<br>Resident #135 was admitted on 4/14/14 with cumulative diagnoses of heart failure, rectal cancer, Alzheimer ' s disease, and chronic obstructive pulmonary disease.<br>The admission Minimum Data Set (MDS) dated 6/10/14 noted Res.#135 was cognitively impaired and needed extensive to total assistance for all Activities of Daily Living (ADLs), with the physical assistance of one to two persons. The Care Area Assessment (CAA) noted the area of falls to be a concern. A review of the CAA worksheet revealed that Res. #135 has an unstable gait and impaired balance. Res. #135 was disoriented in relation to Alzheimer ' s disease and has unawareness of safety precautions. The worksheet indicated that Res. #135 has had multiple falls related to getting out of bed or chair without assistance. Res. #135 has bed and chair alarms in place to alert staff if he attempts to stand.<br>The care plan dated 7/4/14 with a focus of falls on April 9,10, 12,18 and 27 with no injury related to Alzheimer ' s , unsteady gait, poor balance, fall on 6/27/14 with small open area to bridge of nose and bruise on forehead. The goal, revised on 6/3/14, was that the resident would resume usual activities with less incidents through the review date. Interventions were:<br>· When I am awake and family is not present keep me in an area where the staff can monitor my activities at all times. Initiated 4/15/14 | F 280 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>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.<br><br>Corrective Action for Resident Affected<br><br>On 9/8/2014 for resident #135 the Director of Nursing completed a review of the medical record, current physician orders, and fall interventions and compared it to the current care plan and updated the residents care plan with the following interventions: broda chair, fall mat, chair and bed alarm.<br><br>Corrective Action for Resident Potentially Affected<br><br>On 9/9/2014, a review of all residents with falls in the last 6 months was completed by the MDS Consultant to identify all fall interventions. This was completed by reviewing the medical record, current physician orders, and fall interventions and comparing it to the current care plan. Any care plans not having the most recent fall or fall intervention were updated. 25 | |

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| F 280 | Continued From page 5<br>· Anticipate my needs as much as possible. Initiated 4/15/14<br>· For no apparent acute injury, determine and address causative factors of the fall. Initiated4/15/14<br>· Keep frequently used objects in my reach. Initiated 4/15/14<br>· Neuro checks x 72 hours if I have a fall and hit my head or is unwitnessed. Revised 6/3/14<br>· Observe me for possible side effects from medications that may affect my gait and balance and report to nurse if I have change in my gait or balance. Initiated 4/15/14<br>· Provide activities that promote exercise and strength building where possible. Provide 1:1 activities if bedbound. Initiated 4/15/14<br>· Reinforce safety reminders frequently. Initiated 4/15/14<br>· Encourage me to call for assistance prior to transfers. Initiated 6/3/14<br>· I need Pelvic Incline to wheelchair and I can still propel around facility. Initiated 7/4/14<br>· Encourage use of activity board that includes faucet, locks and keys. Initiated 7/28/14<br>A review of the Nursing Referral for Rehab Screening revealed Res. #135 was referred on 7/2/14 for balance problems and pain when in chair in regard to a cushion. In the comments: fall risk, leaning & positioning and postural in wheel chair, safety leaning picking things off floor, falling asleep in chair.<br>A review of the Physical Therapy Screen-New Admission or Special Request, dated 7/22/14, revealed that Physical Therapy (PT) was not indicated as the resident is at baseline. The recommendation was: The Resident has anti-thrust cushion and wheel chair modifications have been made to the resident ' s wheel chair per Occupational Therapy, to promote optimal | F 280 | of 31 resident care plans reviewed were updated to reflect the appropriate fall interventions and date of reported fall.<br><br>Systemic Changes<br><br>Any post fall interventions will be updated to the care plan by the MDS Coordinator or designee in their absence daily Monday thru Friday in the Daily Quality of Life meeting. The Quality of Life / QA meeting is an interdisciplinary meeting attended by Director of Nursing, MDS Coordinator, other nurse manager, dietary manager, health information management, and other team members as appropriate.<br><br>Quality Assurance<br><br>To ensure quality the DON or designee will audit residents with falls and the recommended fall interventions to ensure this information is communicated to all staff on the care plan. This audit will be completed monthly and presented to the Quality of Life □ QA committee and corrective action initiated as appropriate. The QOL / QA Meeting is attended by Administrator, Director of Nursing, Unit Manager, other nurse managers, Health Information Manager and Dietary Manager. | |

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| F 280 | Continued From page 6 | F 280 | | |

positioning for fall prevention. Caregiver training provided to engage resident in simple activities in order to occupy his time per OT.
A review of the falls investigations revealed that after the first fall on 4/8/14 Nurse #3 documented that the Responsible Party (RP) was advised that a chair alarm would be placed in the wheel chair. After the fall on 4/9/14, in the falls report it was documented that a therapy evaluation slip was written by Nurse #3. After the fall on 4/10/14, it was documented in the falls report that the resident would continue to be monitored. No intervention was documented in the falls report on 4/12/14, or the falls report on 4/27/14. The falls report on 6/24/14 revealed that Res. #135 had nodded off during the noon meal and bumped his head on the top of the dining table. The falls report on 6/27/14 noted that Res. #135 was assessed and no intervention was documented. On 7/18/14 the falls report had documentation of Res. #135 as being helped back into the wheel chair and assessed. The falls report on 7/21/14 documented Res. #135 fell in his room and hit his head on the dresser. Neuro checks were ok, and Resident #135 was assessed for injury.
On 9/4/14 at 3:30 PM in an interview, the MDS nurse stated that if she learned of something in stand up meeting in the mornings she followed up with it and updated the care plan. She revealed a document called a Quality Of Life form that was used to communicate among the staff that was used to note residents that needed care plan updates, among other things.
On 9/5/14 at 10:00 AM, an observation was made of Res. #135 ' s room and that there was a bed alarm in place. Nurse Aide (NA) #1 stated that all the staff were aware of the chair and bed alarm. The Director of Nursing was not in the facility during the survey.

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| F 332 SS=D | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>The facility must ensure that it is free of medication error rates of five percent or greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 4 medication errors out of 27 opportunities, resulting in a medication error rate of 14.8%, for 4 of 8 residents (Resident #57, Resident #166, Resident #50, and Resident #126) observed during medication pass.<br><br>The findings included:<br><br>1) A review of the facility ' s Medication Crushing Guidelines (undated) in the Pharmacy Long Term Care Policy & Procedures, Appendix 14, included the following statement under the heading of " Medications that Should Not Be Crushed or Chewed " :<br>" The solid dosage forms of many medications should not be crushed or chewed for a variety of reasons. When a resident ' s condition prohibits the administration of solid dosage forms (tablets, capsules, etc.), the nurse administering the medication should check to see that there is no contraindication to crushing the medications in question. If crushing is contraindicated, the nurse should consult the pharmacist for assistance in obtaining the medication in liquid form, if possible. "<br><br>Resident #57 was admitted to the facility on | F 332 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>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.<br><br>Corrective Action for Resident Affected<br>For resident # 57, #166, #50, #126, immediately all residents identified for medication errors were assessed and corrected for compliant therapeutic substitution, correct medication dosing available and g-tube administration.<br><br>Corrective Action for Resident Potentially Affected<br><br>Crushing meds<br>On 9/4/2014 a report was generated of all residents with a prescribed order for pantoprazole. This report was then reviewed against recommendation to provide medication via crushed | 9/18/14 |

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| F 332 | Continued From page 8<br>3/24/14 with cumulative diagnoses which included ulcerative colitis.<br><br>On 9/3/14 at 5:40 AM, Nurse #5 was observed preparing medications for administration to Resident #57. The medications pulled for administration included one - 40 milligram (mg) pantoprazole (a medication used to decrease stomach acid secretion) delayed release tablet. The medication was placed into a plastic sleeve and crushed. The nurse administered the crushed pantoprazole to Resident #57.<br><br>A review of Resident #57 ' s physician ' s medication orders included a current order for 40 mg pantoprazole delayed release tablet given by mouth once daily with the following notation, " *Do not crush*. "<br><br>A review of product information from the manufacturer(s) of pantoprazole indicated the delayed-release tablets should be swallowed whole; do not crush or chew.<br><br>During an interview with Nurse #5 on 9/3/14 at 6:10 AM, the nurse confirmed the pantoprazole administered to Resident #57 during the medication administration had been crushed. Upon review of the Medication Administration Record (MAR) instructions for Resident #57 ' s pantoprazole, Nurse #5 acknowledged the instructions on the MAR included a notation, " *Do not crush*. " The nurse stated, " I overlooked that. "<br><br>An interview was conducted with Nurse #1 on 9/4/14 at 2:06 PM. Nurse #1 was identified by the facility's Administrator as the nursing staff contact person (in the absence of the Director of | F 332 | administration. Two residents were identified and their medication order was changed immediately to a therapeutic substitution. This was completed by RN Unit Manager.<br><br>Calcium with Vitamin D<br>On 9/10/2014 all residents on calcium were assessed by RN Unit Manager to validate that the prescribed dose of supplemental calcium with vitamin D was the current doses being administered. The provider authorized a utilization of one standard dose of calcium with Vitamin D combination supplement for all residents in the facility, Calcium with Vitamin D 600/400. 16 residents were identified to be at risk for the deficient practice. 11 out of 16 residents were changed to the Calcium plus Vitamin D 600/400 dosing. On 9/19/2014, all other Calcium with Vitamin D doses were removed from the medication carts by RN Unit Manager.<br><br>G-tube<br>An in-service was conducted on 9/11/14, 9/12/14 and 9/18/14 by the staff development coordinator and Director of Nursing. Those who attended were all RNs, LPNs, and 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. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning | |

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| F 332 | Continued From page 9<br>Nursing). During the interview, Nurse #1 indicated the expectation would be for all medications to be given as instructed by the physician orders.<br><br>2) A review of the facility ' s Medication Crushing Guidelines (undated) in the Pharmacy Long Term Care Policy & Procedures, Appendix 14, included the following statement under the heading of " Medications that Should Not Be Crushed or Chewed " :<br>" The solid dosage forms of many medications should not be crushed or chewed for a variety of reasons. When a resident ' s condition prohibits the administration of solid dosage forms (tablets, capsules, etc.), the nurse administering the medication should check to see that there is no contraindication to crushing the medications in question. If crushing is contraindicated, the nurse should consult the pharmacist for assistance in obtaining the medication in liquid form, if possible. "<br><br>Resident #166 was admitted to the facility on 4/7/14 with cumulative diagnoses which included herniation of the diaphragm.<br><br>On 9/3/14 at 5:47 AM, Nurse #5 was observed preparing medications for administration to Resident #166. The medications pulled for administration included one - 40 milligram (mg) pantoprazole (a medication used to decrease stomach acid secretion) delayed release tablet. The medication was placed into a plastic sleeve and crushed. The nurse administered the crushed pantoprazole to Resident #166.<br><br>A review of Resident #166 ' s physician ' s medication orders included a current order for 40 | F 332 | them to the facility for a temporary assignment. 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 included:<br>-proper enteral tube administration<br>-proper enteral tube flushes before and after medication administration<br>-hand washing between residents while administering medications<br>-review the proper process of administering each medication separate with enteral tube administration.<br>- In addition to this, in-service was provided on the correct administration via g-tube of Lansoprazole dispersible tablets.<br><br>The in-service included:<br>Proper g-tube medication administration: flushing before, after and in between medications with water and the importance of administrating each medication separately.<br><br>Systemic Changes<br>Crushing Medications<br>A list of medications which are not to be crushed was provided by our contracted pharmacy and placed on each Medication Administration Record (MAR) book for reference.<br>An in-service was conducted on 9/11/14, 9/12/14 and 9/18/14 by the staff development coordinator and Director of Nursing. Those who attended were all RNs, LPNs, and FT, PT, and PRN. The facility specific in-service was sent to Hospice Providers whose employees give | |

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| F 332 | Continued From page 10<br>mg pantoprazole delayed release tablet given by mouth once daily with the following notation, " *Do not crush*. "<br><br>A review of product information from the manufacturer(s) of pantoprazole indicated the delayed-release tablets should be swallowed whole; do not crush or chew.<br><br>During an interview with Nurse #5 on 9/3/14 at 6:10 AM, the nurse confirmed the pantoprazole administered to Resident #166 during the medication administration had been crushed. Upon review of the Medication Administration Record (MAR) instructions for Resident #166 ' s pantoprazole, Nurse #5 acknowledged the instructions on the MAR included a notation, " *Do not crush*. " The nurse stated, " I overlooked that. "<br><br>An interview was conducted with Nurse #1 on 9/4/14 at 2:06 PM. Nurse #1 was identified by the facility's Administrator as the nursing staff contact person (in the absence of the Director of Nursing). During the interview, Nurse #1 indicated the expectation would be for all medications to be given as instructed by the physician orders.<br><br>3) A review of the facility ' s policy, " Preparation of Medication Administration; #6. Enteral Tube Medication Administration " (undated) in the Pharmacy Long Term Care Policy & Procedures included the following statement:<br>" f) Enteral tubes are flushed before administering medications and after all medications have been administered with a least 30 ml of water. " | F 332 | residents care in the facility to provide training for staff prior to returning to the facility to provide care. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. 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 included the correct process to assess which medicines are to be crushed and which are not to be crushed. Also included assessing labels on resident medication cards with alerts to include do not crush, residents with g-tube if they require a crushed medicine to request a therapeutic substitution and communicate with the provider if any medication is contraindication regarding crushing and administration.<br><br>Calcium with Vitamin D<br>The facility went to a standard dosing of calcium with vitamin D supplement , Calcium with Vitamin D 600/400. An in-service was conducted on 9/11/14, 9/12/14 and 9/18/14 by the staff development coordinator. Those who attended were all RNs, LPNs, and 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. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff | |

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| F 332 | Continued From page 11<br>Resident #50 was admitted to the facility on 4/5/12 with cumulative diagnoses which included gastrostomy (a surgical opening into the stomach whereby a feeding tube may be inserted and used for feeding) and hypothyroidism (a condition in which the body lacks sufficient thyroid hormone).<br><br>On 9/3/14 at 5:50 AM, Nurse #5 was observed preparing medications and a tube feeding formula (one-240 milliliter (ml) can of Osmolite 1.5, a high calorie, high protein nutritional formulation which may be used for a tube feeding) for administration to Resident #50. The medications pulled for administration included one - 30 milligram (mg) lansoprazole dispersible tablet (brand name Prevacid SoluTab, a medication used to decrease stomach acid secretion); and one - 112 micrograms (mcg) levothyroxine tablet (a medication used in the treatment of hypothyroidism). The two medications were placed into a plastic sleeve and crushed together. The nurse stirred the crushed medications into 6 ounces of water and poured the Osmolite 1.5 into a separate cup. Nurse #5 then poured an unmeasured amount of the water/medication mixture into the barrel of a syringe connected to Resident #50 ' s gastrostomy feeding tube; followed by pouring an unmeasured amount of Osmolite 1.5 into the barrel of the syringe. The nurse continued to alternate administration of the water/medication mixture with the Osmolite 1.5 formula three more times, ending with the water/medication mixture. At that time, Nurse #5 stirred the remaining water/medication mixture into the remaining amount of Osmolite 1.5 formula and administered the combination by pouring it into the barrel of the syringe. Plain water flushes were not observed at any point in | F 332 | prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed.<br><br>G-tube<br>An in-service was conducted on 9/11/14, 9/12/14 and 9/18/14 by the staff development coordinator. Those who attended were all RNs, LPNs, and 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. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. 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 included:<br>-proper enteral tube administration<br>-proper enteral tube flushes before and after medication administration<br>-hand washing between residents while administering medications<br>-review the proper process of administering each medication separate with enteral tube administration.<br>- In addition to this, in-service was provided on the correct administration via g-tube of Lansoprazole dispersible tablets.<br><br>Quality Assurance | |

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| F 332 | Continued From page 12<br>time during the process of administering the medications (or tube feeding formula).<br><br>A review of Resident #50 ' s physician ' s medication orders included a current order for 30 mg lansoprazole dispersible tablet given via gastrostomy tube once daily. The physician ' s order included the following instructions for administration of the lansoprazole dispersible tablet which read: " Place one tablet in syringe and draw up 10 ml of water, shake gently to allow quick dispersal. After dispersal inject through g-tube (gastrostomy tube) into stomach within 15 minutes, refill with 5 ml water, shake gentle, flush tube. "<br><br>Further review of Resident #50 ' s physician ' s medication orders revealed an order included in the signed September 2014 Order Summary read, "Flush g-tube with 30 ml of water before and after meds;" and, "Flush g-tube with 150 ml water after bolus (Osmolite 1.5 formula) feeds."<br><br>A review of product information from the manufacturer(s) of lansoprazole dispersible tablets indicated the tablets should not be swallowed whole, broken, cut or chewed. The manufacturer ' s instructions for administration using an oral syringe read as follows: "Place the 30 mg tablet in an oral syringe and draw up approximately 10 ml water. After tablet has dispersed, administer within 15 minutes. Refill the syringe with water (5 ml for the 30 mg tablet), shake gently, then administer any remaining contents."<br><br>During an interview with Nurse #5 on 9/3/14 at 6:10 AM, the nurse confirmed that both the lansoprazole and levothyroxine tablets | F 332 | A medication administration observation worksheet was provided by the consulting pharmacist which will be utilized by the RN unit manager to observe the staff nurses on their medication pass. These observations will be completed 2 per week for the first 4 weeks. After 4 weeks these observations will be completed 2 per month for a minimum of 3 months by nursing and consulting pharmacy. Each of these weekly observations will be completed on an equally distributed number of nursing shifts (7A-7P, 7P-7A). Additionally, the consulting pharmacist or designee will be completing monthly med pass review with a minimum of one nurse with a concentration on g-tube administration and crushing medications. The consulting pharmacist will also focus on these areas with the monthly drug regimen review. | |

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| F 332 | Continued From page 13 | F 332 | | |

administered to Resident #50 during the medication administration had been crushed, stirred into a cup of water, and administered together. Upon review of the Medication Administration Record (MAR) instructions for Resident #50 ' s lansoprazole, Nurse #5 acknowledged the instructions on the MAR included specific instructions for the administration of lansoprazole dispersible tablets. Upon inquiry as to what the facility ' s policy was in regards to medication administration and tube feeding administration, the nurse stated that she always administered the tube feeding and medications using the procedures observed, stating, " It helps the flow. "

An interview was conducted with Nurse #1 on 9/4/14 at 2:06 PM. Nurse #1 was identified by the facility's Administrator as the nursing staff contact person (in the absence of the Director of Nursing). During the interview, Nurse #1 indicated the expectation would be for all medications to be given as instructed by the physician orders. She also stated it was the facility's policy that each medication administered via a gastrostomy tube should be administered separately; and that plain water should be used to flush the tubing between each medication given. Additionally, Nurse #1 stated the facility's policy was to flush the tubing before and after each bolus feeding given via the gastrostomy tube.

4) Resident #126 was admitted to the facility on 11/8/13 with cumulative diagnoses which included osteoporosis.

On 9/4/14 at 7:38 AM, Nurse #4 was observed preparing medications for administration to Resident #126. The medications pulled for

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| F 332 | Continued From page 14<br>administration included one - calcium plus vitamin D tablet (a combination tablet containing 600 mg calcium with 800 units of vitamin D). The nurse administered the calcium plus vitamin D tablet to Resident #126.<br><br>A review of Resident #126 ' s physician ' s medication orders included a current order for calcium plus vitamin D (a combination tablet containing 600 mg calcium with 400 units of vitamin D) to be given as one tablet by mouth once daily.<br><br>An interview was conducted with Nurse #4 on 9/4/14 at 8:10 AM. Upon review of the Medication Administration Record (MAR) and label on the bottle of the calcium plus vitamin D given to Resident #126, the nurse confirmed the calcium plus vitamin D tablet administered to Resident #126 during the medication administration was a different dose than the prescribed medication. The nurse reported that the bottle of calcium plus vitamin D on the medication cart was a relatively new product that the facility had just started getting in. Nurse #4 stated, " I didn ' t notice it was 800 units of vitamin D. "<br><br>An interview was conducted with Nurse #1 on 9/4/14 at 2:06 PM. Nurse #1 was identified by the facility's Administrator as the nursing staff contact person (in the absence of the Director of Nursing). During the interview, Nurse #1 indicated the expectation would be for all medications to be given in accordance with the physician orders. | F 332 | | |
| F 333 SS=D | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS | F 333 | | 9/18/14 |

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| F 333 | Continued From page 15<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interviews, the facility failed to prevent a significant medication error, when a resident (Res. # 135) was given another resident ' s medication (Res. # 145), resulting in a hospital visit for evaluation and monitoring , for one of five residents reviewed for unnecessary medications.<br>Findings included:<br>Resident #135 was admitted on 4/14/14 with cumulative diagnoses of congestive heart failure, hypertension, heart failure, rectal cancer, Alzheimer ' s disease, kidney disease, and chronic obstructive pulmonary disease.<br>The admission Minimum Data Set (MDS) dated 6/10/14 noted Res.#135 was cognitively impaired and needed extensive to total assistance for all Activities of Daily Living (ADLs), with the physical assistance of one to two persons.<br>A review of the nurse notes on 8/2/14 revealed that Nurse #6 was called by Nurse Aide (NA) #1 to assess Resident #135, because he did not seem as alert as earlier in the shift. Res. #135 was assessed and vital signs were taken. Res. #135 blood pressure was 131/74, pulse 73, respirations 18, and temperature 98.3. Nurse #6 reviewed the medications to check for adverse side effects, and realized that the medications given were for Res. #145, not for Res. #135. The Medication Administration Record (MAR) revealed that Ziac 5-6.25 milligram (mg) by mouth 1 tablet (a diuretic), and Medpass 90 milliliters (ml) by mouth, (a liquid dietary | F 333 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>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.<br>Corrective Action for Resident Affected<br><br>On 8/2/14 immediate action was taken by the nurse to assess the resident by taking vital signs and assessing resident for any harm or effects of the medications given. The on-call physician was contacted and orders provided to give oxygen therapy and send to the Emergency Room for evaluation. The resident was returned to facility later in the day with no new orders and had no additional treatment during ER observation.<br><br>Corrective Action for Resident Potentially Affected<br>On 8/6/14 a root cause analysis was completed with DON, SDC, staff nurse, and nurse practitioner in attendance to explore events which occurred to prevent | |

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| F 333 | Continued From page 16<br>supplement), were supposed to be given to Res. #135.<br>A review of the nurse notes for Res. #135 revealed that the medications given were:<br>· Aspirin 81mg by mouth 1 tablet<br>· Cardizem CD 120 mg by mouth 1 capsule, to control blood pressure<br>· Multivitamin by mouth 1 tablet<br>· Seroquel 50 mg by mouth 1 tablet, an antipsychotic<br>· Vitamin B12 1000 micrograms (mcg) by mouth 1 tablet<br>· Oxycontin Extended Release (ER) 10mg by mouth 1 tablet, pain medication<br>In an interview on 9/4/14 at 2:40 PM, the NA #1 stated that she had gotten Res. #135 out of bed and into his chair, and that Res. #135 had a sitter on the morning of 8/2/14, who usually was with the Resident while he ate his breakfast in the dining room. NA #1 stated that she had walked into the dining room and was met there by Res. #135 ' s sitter who stated that she could not get Res. #135 to wake up. NA #1 stated that she went to Res. #135 and tried to wake him up, but could not. NA #1 stated that she went to Nurse # 6 and told the nurse that the Resident would not wake up.<br>On 9/4/14 at 3:45 PM, in an interview, Nurse #7 stated that NA #1 had come to her on the morning of 8/2/14 and stated that Res. #135 did not look " right " . Nurse #7 indicated that Res. #135 was sitting in his chair and looked to be asleep, but was drooling. Nurse #7 stated that she tried to arouse the Resident, but could not. Nurse #7 indicated that she wiped Res. #135 ' s face and hands with a dampened cloth, and the Resident responded, but continued to droop his head as if he were sleeping. Nurse #7 stated that she noticed that Res. #135 was drooling more at | F 333 | reoccurrence of medication errors for potential affected residents. This root cause analysis meeting determined it to be an isolated event from one nurse which failed to correctly identify the correct resident before administering medications.<br><br>Systemic Changes<br><br>From the quality assessment review meeting, the committee recommended ensuring all Medication administration records be reviewed to ensure photo identification of residents. This was completed immediately following the quality assurance review on 8/6/2014.<br>An in-service was conducted on 9/11/14, 9/12/14 and 9/18/14 by the staff development coordinator and Director of Nursing. Those who attended were all RNs, LPNs, and 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. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. 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 included: the necessity to identify residents by photo on MAR or asking resident their name before administering medications if alert | |

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| F 333 | Continued From page 17<br>this time. Nurse #7 checked vital signs at this time. Res. #135 blood pressure was 89/72, pulse 72, respirations 16, and temperature 98.6. Nurse #7 indicated that she then asked Nurse#6 if he had given the Resident his medications, and Nurse #6 indicated that the medications were given. Nurse #7 stated that she told Nurse #6 to check the medications for indications of side effects. Nurse #7 stated that Nurse #6 checked the Medication Administration Record (MAR), and told Nurse #7 that he thought he had given the wrong meds to Res. #135. Nurse #7 indicated that the Nurse Manager was called and Nurse #7 was instructed to call the physician. The physician instructed Nurse #7 to send Res. # 135 to the Emergency Room. Nurse # 7 stated that she then went to Res. #135 and stayed with the Resident until Emergency Medical Services arrived.<br>A review of hospital records dated 8/2/14, revealed that Resident # 135 arrived at the ER sleeping. An Electrocardiogram (EKG), (a recording of the electrical activity in the heart) was unchanged from an EKG done on 3/30/14. Labs were drawn and were within normal limits, and vital signs were done every thirty minutes, and were within normal limits. The ER physician wrote that the resident would be observed for 4 hours and discharged if there were no changes. Resident # 135 was discharged at 1:47 PM on 8/2/14.<br>A review of the statement by Nurse #6 revealed that when the medication error was discovered, a co-nurse was notified, the on call nurse was notified and the physician and administrator were called. It was noted in his statement that the physician gave an order for Res. # 135 to be sent to the Emergency Room (ER), and to start oxygen at 2 liters per minute by way of nasal cannula. Nurse #6 was not available for interview. | F 333 | and oriented.<br><br>Quality Assurance<br><br>The DON reviews all medication errors for identification of facility trends and opportunities to improve performance. Additionally, all medication errors are reviewed during Quarterly QA for recommendations and tracking trends for improvement. | |

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| F 333 | Continued From page 18<br>In an interview on 9/4/14 at 4:00 PM, the Nurse Manager for the facility stated that she was the on call nurse for the facility on 8/2/14 and was called by Nurse #6 in regard to the wrong medication being given to Res. #135. The Nurse Manager stated that she instructed Nurse #6 to call the physician and fill out a Medication Error Form.<br>In an interview on 9/4/14 at 4:10 PM, the Administrator stated that she was aware that statements were taken and root cause analysis was done, as well as a sequence of events that gave instructions to Nurse # 6, but that the facility felt that this was an isolated incident. A review of the sequence of event sheet noted that Nurse # 6 did not follow policy to identify the resident. | F 333 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must | F 441 | | 9/18/14 |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| F 441 | Continued From page 19<br>isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to provide an isolation sign on the door of 1 of 1 resident ' s (Resident #100) room who was on Contact Precautions; and failed to follow infection control procedures for hand washing/hand hygiene between residents (Resident #53 and Resident #49; Resident #57 and Resident #166) for 4 of 8 residents observed during the medication administration pass.<br><br>The findings included:<br><br>1) Resident # 100 was admitted to the facility on 10//9/13 with diagnoses that included significant history of chronic diarrhea. A review of the medical record revealed Physician's Notes dated 8/22/15 in which Resident # 100 was seen for follow up of diarrhea. Two stool cultures were ordered to be sent to rule out / confirm clostridium | F 441 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>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.<br>Corrective Action for Resident Affected<br>On 9/4/2014 for resident #100 the RN staff development coordinator posted the correct isolation sign.<br><br>On 9/4/2014 for resident #53, #49, #57 the nursing staff involved was in-serviced by the RN staff development coordinator | |

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| F 441 | Continued From page 20<br>difficile (or c-diff, an infectious diarrhea caused by a spore-forming bacteria).<br>A review of the laboratory results for the stool cultures revealed two stool specimens were collected on 8/21/14, no collection time given. Two laboratory reports were faxed to the facility on 8/22/14 8:22:04 AM, one reporting the stool culture was positive for c-diff, the other reporting the stool culture was negative for c-diff. A third laboratory report faxed to the facility on 8/22/14 12:04:22 PM reported the stool culture was negative for c-diff.<br>On 9/2/14 at 2:15 PM, Resident # 100 was observed sitting in her room. An isolation cart with isolation supplies was observed outside the door of the room in the hall. There was no sign posted indicating what type of isolation was being implemented or what the guidelines were. During an interview on 9/2/14 at 2:15 PM, Nurse # 3 stated, "(Resident # 100) is on Contact Precautions. I will get a sign for the door." (Contact Precautions indicate what may be needed to prevent the spreading of germs by touching).<br>On 9/2/14 at 3:15 PM, a Contact Precautions sign was observed on Resident # 100's door. During an interview on 9/2/14 at 3:20 PM, Nurse # 3 stated, "(Resident # 100) came from the 100 hall over the weekend (August 24, 2014) because she needed to be on Contact Precautions. In reference to the lab reports indicating the stool cultures were negative for c-diff, Nurse # 3 stated, "She is still on Contact Precautions because she had more loose stools on Friday 8/29/14 and is getting an antibiotic for c-diff. The sign should have been up. That was a mistake."<br>During an interview on 9/4/14 at 4:14 PM, the Administrator stated, "(Resident # 100) was in a room with someone else. The hall nurse called | F 441 | on proper hand washing techniques between resident medication administrations.<br><br>Corrective Action for Resident Potentially Affected<br>No other residents were on isolation to be affected by this deficient practice.<br><br>We have isolation signs for each type of isolation available on the isolation carts.<br>An in-service was conducted on 9/11/2014, 9/12/2014 and 9/18/2014 by the staff development coordinator. Those who attended were all RNs, LPNs, and 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. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. 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 included:<br>Location of isolation carts, proper storage of isolation carts, precaution signs in the top drawer of isolation carts, reminder to tape precaution sign to door and above isolation cart, reminder to put precaution signs back in drawer when removing patient from isolation, make SDC or other nurse manager aware if sign is needed. Additionally, reminder to wash hands between all residents care and medication | |

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| F 441 | Continued From page 21<br>the oncall nurse who called m. The oncall nurse said (Resident # 100) was incontinent and having diarrhea and asked if they could move her to a private room. This was on Sunday 8/24/14."<br>Nurse # 1 was also present during the interview. Nurse # 1 stated, "The resident had a positive culture for c-diff and she was put on isolation, Contact Precautions. If we have a room available, we move the resident to a private room or to a room with no other resident in it. We set up the isolation supplies outside the door and post the isolation sign outside the door. This one happened on a weekend, and the resident's nurse got the supplies set up. I should have followed up when I came in on the following Monday. I was at the end of the hall and I saw the isolation cart outside her room, but I did not walk to the end of the hall."<br>During an interview on 9/5/14, the Administrator stated it was her expectation that an isolation sign would be posted on a resident's door when the resident was placed on isolation.<br><br>2) A review of the facility ' s Hand Washing Policy dated 10/1/2001 included a section titled, General Instructions, which read:<br>" --Wash hands before and after resident contact.<br>--Wash hands when soiled "<br><br>On 9/3/14 at 5:07 AM, Nurse #5 was observed preparing and administering medications to Resident #53. A continuous observation was made of Nurse #5 as she completed medication administration for Resident #53 and began medication administration for the next resident (Resident #49). On 9/3/14 at 5:15 AM, Nurse #5 was observed preparing and administering medications to Resident #49. The nurse did not | F 441 | administration to prevent the spread of infection and proper hand washing techniques.<br><br>Systemic Changes<br>We have isolation signs for each type of isolation available on the isolation carts.<br>The RN Unit Manager or designee will review all physician orders Monday □ Friday for isolation orders. The review will include ensuring compliance with the proper isolation sign and posting on the residents door and above the isolation cart.<br>An in-service was conducted on 9/11/2014, 9/12/2014 and 9/18/2014 by the staff development coordinator. Those who attended were all RNs, LPNs, and 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.<br>Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. 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 included:<br>Location of isolation carts, proper storage of isolation carts, precaution signs in the top drawer of isolation carts, reminder to tape precaution sign to door and above isolation cart, reminder to put precaution signs back in drawer when removing patient from isolation, make SDC or other | |

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| F 441 | Continued From page 22<br>wash her hands nor did she use a hand sanitizer between residents.<br><br>On 9/3/14 at 5:40 AM, Nurse #5 was observed preparing and administering medications to Resident #57. A continuous observation was made of Nurse #5 as she completed medication administration for Resident #57 and began medication administration for the next resident (Resident #166). On 9/3/14 at 5:47 AM, Nurse #5 was observed preparing and administering medications to Resident #166. The nurse did not wash her hands nor did she use a hand sanitizer between residents.<br><br>An interview was conducted with Nurse #5 on 9/3/14 at 6:10 AM. Upon inquiry as to why she did not wash or sanitize her hands between medication administrations for the residents, Nurse #5 stated that normally hand sanitizer was kept on the medication cart and that there wasn ' t any there this morning.<br><br>An interview was conducted with Nurse #1 on 9/4/14 at 2:06 PM. Nurse #1 was identified by the facility's Administrator as the nursing staff contact person (in the absence of the Director of Nursing). Nurse #1 also assumed the duties associated with Infection Control for the facility. During the interview, Nurse #1 indicated the expectation would be that everyone wash their hands or use alcohol-based hand sanitizer (when appropriate) between patients. | F 441 | nurse manager aware a sign is needed. Additionally, reminder to wash hands between all residents care and medication administration to prevent the spread of infection and proper hand washing techniques.<br><br>Quality Assurance<br>The infection control nurse will monitor any resident identified to be on isolation monthly for the next 3 months to ensure quality assurance practices are followed. Any concerns will be reported to the QOL  QA committee for recommendations as appropriate. The RN unit manager will observe the staff nurses on their medication pass for proper hand washing techniques<br>while administering medications. These observations will be completed 2 per week for the first 4 weeks. After 4 weeks these observations will be completed 2 per month for a minimum of 3 months. Each of these weekly observations will be completed on an equally distributed number of nursing shifts (7A-7P, 7P-7A). | |