STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 07/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY	4412 SOUTH MAIN STREET SALISBURY, NC 28147

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 7/6-10/2020. Event # BJN711 Two complaint allegations investigated were not substantiated.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		7/24/20

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

Electronically Signed | 07/24/2020

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F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, nurse practitioner and physician interviews, the facility failed to communicate that a resident was experiencing leg numbness for1 of 3 residents reviewed for changes in physical condition (Resident #1). Findings included: Resident #1 was admitted to the facility on 1/9/2015 with diagnoses to include heart disease, vascular dementia and heart failure. Resident #1 was discharged from the facility on 6/9/2020. A physical therapy note dated 4/16/2020 written by Physical Therapist (PT) #1 was reviewed. The note documented that Resident #1 refused physical therapy services because Resident #1 was afraid of falling and reported to PT #1 that her legs were numb. The physical therapy note	F 580	On 4/16/2020 Resident #1 was assessed by the Licensed Practical Nurse(LPN) and was given Tylenol at 1700. Pain medication assessed as effective with a pain score of 0. On 5/3 resident complained of numbness in LLE to nursing staff and the doctor was notified .with new orders received for a Venous Doppler test. 5/5 Doppler performed , the finding were negative. On 5/12 second Doppler performed because resident□s pulse was difficult to auscultate and a knot was now noted on LLE. Results of the Doppler were negative. 5/19 first vascular appointment was made Resident refused. 6/9 was the next available appointment d/t resident refusal of first, was educated on the importance of the test and decided to go. Resident was directly admitted to	

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F 580	Continued From page 2 documented that PT #1 had communicated the report of leg numbness to the nursing staff. A nursing note dated 4/16/2020 at 2:33 PM written by Nurse #1 documented Resident #1 had a therapy evaluation and Resident #1 had refused to cooperate. The report of leg numbness was not documented. The medication administration record was reviewed, and it was documented on 4/16/2020 for 2nd shift (3:00 PM to 11:00 PM) that Resident #1 had reported knee pain "9" (1-10 scale) and she had received a scheduled analgesic at 5:00 PM that was effective. There was no nursing documentation on 4/16/2020 regarding nurse practitioner or physician notification in Resident #1 ' s medical record regarding the report of leg numbness. The NP was interviewed by phone on 7/7/2020 at 8:13 AM. The NP reported she had not been notified that Resident #1 had reported leg numbness to PT #1 on 4/16/2020. The NP reported Resident #1 had not complained of numbness of her legs to her, only knee pain. PT #1 was interviewed by phone on 7/7/2020 at 9:21 AM. PT #1 reported she had evaluated Resident #1 on 4/16/2020 after she had a change in status due to a fractured left arm. PT #1 reported that Resident #1 had refused physical therapy services and had said that she was afraid of falling because her legs were numb. PT #1 reported she had informed Nurse #1 of Resident #1 ' s report that her legs were numb. A phone interview was conducted with Nurse #1 on 7/7/2020 at 11:16 AM. Nurse #1 reported that	F 580	acute care for surgery. Resident didn□t not return to the facility. On 7/14/2020 Director of Nursing (DON) and Minimum Data Set (MDS) coordinator completed audit of 100% of resident□s progress notes review and E interact tool SBAR change of condition assessment for 73 residents. No other changes of condition or complaints of leg numbness were identified with the audit. On 7/14/2020 DON and Staff development co coordinator (SDC) began education on documentation and notification of a change in condition and professional standards with all Nursing staff. All (60) Fulltime, Part -time, and as needed nursing staff received training. Training will be incorporated into the facility general orientation program On 7/27/2020 the Director of Nursing/designee will begin a weekly QA monitoring audit of 5 resident charts, monitoring for completion of E interact SBAR tool and progress notes for change of changes in condition, decline, or injury. Monitoring tool will be completed weekly x4 then monthly x 3 and will be reviewed the facility QA meeting weekly for follow up. The QA meeting attended by the Administrator, Director of Nursing, Unit mangers, Dietary Manager, Minimum Data Set Registered Nurse, Environmental/Housekeeping Director, and Health information Manager.	

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F 580	Continued From page 3 she was not able to recall PT #1 reporting Resident #1 ' s complaint that her legs were numb. Nurse #1 went on to say she may have gotten busy and forgot to document the report or notify the NP. The facility physician (MD) was interviewed by phone on 7/7/2020 at 12:36 PM. The MD reported she had been notified of Resident #1 ' s leg numbness in May 2020, but was not previously notified of Resident #1 ' s numbness in her leg. The MD reported she expected the NP or MD to be notified if a resident experienced a change in condition. The Director of Nursing (DON) was interviewed by phone on 7/8/2020 at 12:02 PM. The DON reported that Resident #1 was inconsistent with reports to staff and she had reported leg pain not numbness to nursing on 4/16/2020 and she had been medicated for the pain. The DON reported that when nursing staff were notified of a concern or complaint that was new for a resident, the nurse would perform an assessment on the resident and address the issue, including notifying the NP or MD.	F 580		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical	F 637		7/24/20

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F 637	Continued From page 4 interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and nurse practitioner interviews, the facility failed to complete a significant change of status Minimum Data Set (MDS) assessment after a fall on 3/28/2020 that resulted in a fractured humerus (long bone in the arm that runs from the shoulder to the wrist) with a decline in 4 areas of activities of daily living (ADL) as well as increased fecal and urinary incontinence for 1 of 3 residents reviewed for a significant change in status (Resident #1). Findings included: Resident #1 was admitted to the facility on 1/9/2015 with diagnoses to include heart disease, vascular dementia and heart failure. The quarterly MDS dated 2/25/2020 assessed Resident #1 to require no assistance with bed mobility, no assistance with transfers, no assistance with toileting, no assistance with eating, supervision for walking in her room, limited assistance with dressing, personal hygiene and extensive assistance with bathing. The MDS assessed Resident #1 to be always continent of bowel and bladder. An incident report dated 3/28/2020 written by Nurse #2 documented Resident #1 had an unwitnessed fall in the bathroom. The report documented Resident #1 reported she lost her balance and hit her left arm and reported left arm pain.	F 637	All current residents with either two or more areas of decline or two or more areas of improvement ;this may include two changes within a particular domain (e.g., two areas of ADL decline or improvement) in a resident□s condition from his/her baseline has occurred as indicated by comparison of the resident□s current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and The resident□s condition is not expected to return to baseline within two weeks have the potential to be affected by the alleged practice. On 7/21/2020 through 7/23/2020 an audit was completed by the Director of Nursing to ensure that the facility had conducted a significant change comprehensive, accurate, standardized reproducible assessment of each resident□s functional capacity. Out of the 73 current residents, 3 residents required a significant change of status comprehensive assessment. The significant change of status comprehensive assessment, assessment reference date for all 3 residents is 7/14/2020. This assessments are due to be completed by 7/28/2020. This audit was complete on 7/23/2020. On 7/21/2020 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator,	

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F 637	Continued From page 5 A physician ' s order dated 3/28/2020 ordered a portable x-ray of the left arm. An x-ray report dated 3/28/2020 noted Resident #1 had a fractured humerus. A care plan was in place (no date) that addressed the fall with risk for further falls and interventions included "my arm is immobilized, and I am not longer attempting my own care, staff will assist as needed." The quarterly MDS dated 5/20/2020 assessed Resident #1 to require extensive two-person assistance with bed mobility, transfers, and toileting and extensive one-person assistance with eating. The MDS documented Resident #1 was always incontinent of bowel and bladder. An interview was conducted with a nursing assistant (NA) #1 on 7/6/2020 at 1:34 PM. NA #1 reported she had provided care to Resident #1 before and after 3/28/2020. NA #1 reported that prior to 3/28/2020, Resident #1 was independent for all ADLs and toileted herself without assistance. NA #1 reported after 3/28/2020 Resident #1 was dependent on staff for all ADLs because of the arm fracture and fear of getting out of bed. NA #1 reported that Resident #1 had become incontinent of bowel and bladder after 3/28/2020. NA #2 was interviewed on 7/6/2020 at 1:45 PM. NA #2 reported that she had provided care to Resident #1 before and after 3/28/2020 and Resident #1 had been independent with her ADLs before 3/28/2020 and required total staff assistance after 3/28/2020. NA #2 reported that	F 637	Licensed Practical Nurse (LPN) Support nurses any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the Director of Nursing. . The education focused on: The facility must ; Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:(i) Identification and demographic information(ii) Customary routine.(iii) Cognitive patterns.(iv) Communication.(v) Vision.(vi) Mood and behavior patterns.(vii) Psychological well-being.(viii) Physical functioning and structural problems.(ix) Continence.(x) Disease diagnosis and health conditions.(xi) Dental and nutritional status.(xii) Skin Conditions.(xiii) Activity pursuit.(xiv) Medications. Special treatments and	

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F 637	Continued From page 6	F 637		

before 3/28/2020 Resident #1 toileted herself without assistance and after 3/28/2020 she was incontinent of both bowel and bladder.

An interview was conducted with NA #3 on 7/6/2020 at 1:54 PM. NA #3 reported she had provided care to Resident #1 before 3/28/2020 and Resident #1 had been independent for her ADLs, but after 3/28/2020 Resident #1 required total assistance from staff for hygiene, eating, and toileting.

Nurse #1 was interviewed on 7/6/2020 at 2:32 PM. Nurse #1 reported before 3/28/2020 Resident #1 was independent to perform ADLs and after Resident #1 fell on 3/28/2020 she became dependent on staff because of the arm fracture. Nurse #1 reported that Resident #1 was afraid to get out of bed and would call staff for help.

Medication tech (MT) #1 was interviewed on 7/6/2020 at 3:26 PM. MT #1 reported Resident #1 had a decline after the fall on 3/28/2020 and required total assistance with all ADLs after the fall and arm fracture and was incontinent of bowel and bladder after the fall.

The nurse practitioner (NP) was interviewed by phone on 7/7/2020. The NP reported Resident #1 had changes after the fall and arm fracture on 3/28/2020 and the changes affected her ability to get out of bed without assistance and perform ADLs. The NP reported Resident #1 experienced anxiety and changes were made to her medications.

Nurse #2 was interviewed by phone on 7/7/2020 at 8:58 AM. Nurse #2 reported Resident #1 had

procedures.(xvi) Discharge planning.(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non licensed direct care staff members on all shifts.
This in service was completed by 7/22/2020. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

To ensure compliance, The Director of Nursing and/or Mini Data Set (MDS) Coordinators will review weekly, 5 residents electronic records with either two or more areas of decline or two or more areas of improvement ;this may include two changes within a particular domain (e.g., two areas of ADL decline or improvement) in a resident□s condition from his/her baseline has occurred as indicated by comparison of the resident□s current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and

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F 637	Continued From page 7 been independent with all ADLs before she fell on 3/28/2020, but after the fall she was dependent on staff to help with bed mobility, transfers, eating, toileting due to the arm fracture. Nurse #2 reported Resident #1 became incontinent after the fall as well. The MDS nurse was interviewed by phone on 7/7/2020 at 9:32 AM. The MDS nurse reported the interdisciplinary team (IDT) discussed resident changes and decline and the IDT had discussed Resident #1 in April and focused on her anxiety level and refusal to get out of bed. The MDS nurse reported Resident #1 should have been a significant change in April 2020 after her fall and arm fracture. MDS nurse reported a significant change MDS had been initiated after the quarterly MDS dated 5/20/2020 but was struck out after Resident #1 was discharged from the facility on 6/9/2020. The Director of Nursing (DON) was interviewed by phone on 7/8/2020 at 12:02 PM. The DON reported Resident #1 had not experienced a true change of condition because she was refusing care after the fall and the IDT did not feel that was a true change. The DON reported that Resident #1 had a medication adjustment for anxiety and when the MDS was completed on 5/20/2020 it reflected a true change in Resident #1's ability to perform ADLs and that was when the significant change in condition was noted. The DON reported a significant change MDS had been initiated but struck out when Resident #1 was discharged from the facility on 6/9/2020. The DON reported she expected significant change MDS assessments to be completed when a resident displayed a true decline.	F 637	The resident□s condition is not expected to return to baseline within two weeks to ensure that a Significant Change in Status Assessment are completed timely. This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse.	