

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>345309</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE:  <b>10/9/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CAROLINE AVENUE WELDON, NC</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<b>F 623</b>	<p>Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)</p> <p>§483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-</p> <ul style="list-style-type: none"> <li>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</li> <li>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</li> <li>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</li> </ul> <p>§483.15(c)(4) Timing of the notice.</p> <ul style="list-style-type: none"> <li>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</li> <li>(ii) Notice must be made as soon as practicable before transfer or discharge when- <ul style="list-style-type: none"> <li>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</li> <li>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</li> <li>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</li> <li>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</li> <li>(E) A resident has not resided in the facility for 30 days.</li> </ul> </li> </ul> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <ul style="list-style-type: none"> <li>(i) The reason for transfer or discharge;</li> <li>(ii) The effective date of transfer or discharge;</li> <li>(iii) The location to which the resident is transferred or discharged;</li> <li>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</li> <li>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</li> <li>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</li> <li>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with</li> </ul>
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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

The above isolated deficiencies pose no actual harm to the residents

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<b>F 623</b>	<p>Continued From Page 1</p> <p>a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide written notice of reason for discharge to hospital to the resident and resident representative for 1 of 1 resident (Resident #4) reviewed for hospitalization.</p> <p>The findings included:</p> <p>Resident #4 was originally admitted to the facility on 5/27/16.</p> <p>Review of a Situation Background Assessment Recommendation (SBAR) communication form dated 5/20/24 revealed Resident #4 was sent to the emergency department due to shortness of breath.</p> <p>Resident #4 was readmitted to the facility on 5/27/24 with a diagnosis that included acute respiratory failure with hypoxia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 9/3/24 revealed Resident #4 had moderate cognitive impairment.</p> <p>There was no evidence in the electronic medical record that written notification of transfer to the hospital was provided to the resident or resident representative.</p> <p>An interview was conducted with the Administrator on 10/9/24 at 3:22 PM. The Administrator stated she was responsible for written discharge notification and Resident #4 transferred to the emergency department prior to her starting at the facility. The previous Administrator was not available for interview. The Administrator stated it was her expectation that a written discharge transfer notification would be sent to the resident and/or resident representative.</p> <p><b>F 842</b></p> <p>Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)</p>
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<b>F 842</b>	<p>Continued From Page 2</p> <p>§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized</p> <p>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p>
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<b>F 842</b>	<p>Continued From Page 3</p> <p>Based on record review and staff interview the facility failed to maintain an accurate medical record regarding transfer to hospital for 1 of 2 residents reviewed for hospitalizations.</p> <p>The findings included:</p> <p>Resident #4 was originally admitted to the facility on 5/27/2016 and discharged with return anticipated on 5/20/24.</p> <p>Review of a nursing note dated 5/20/24 written by Nurse #1 revealed Resident #4 was sent to the emergency room at 1:15 PM.</p> <p>Review of a discharge summary from the local hospital dated 5/27/24 revealed Resident #4 was assessed and admitted for metabolic encephalopathy, acute respiratory failure with hypoxia along with other diagnoses.</p> <p>Resident #4 was readmitted to the facility on 5/27/24 with a diagnosis that included acute respiratory failure with hypoxia.</p> <p>Review of Resident #4's medical record revealed no order for transfer to hospital.</p> <p>Nurse #1 was interviewed on 10/08/24 at 02:20 PM and confirmed that she was working the day Resident #4 was sent to the hospital on 5/20/24. She stated that Resident #4 had a change in condition that morning during medication pass. Nurse #1 stated she notified the healthcare provider and was instructed to send Resident #4 out to the emergency room for evaluation and treatment. Nurse #1 stated another nurse assisted her with getting the paperwork ready for Resident #4 to be sent out to the hospital. Nurse #1 stated she was the nurse caring for Resident #4 and was responsible for putting in the physician order for transfer. Nurse #1 reviewed the physician's orders for Resident #4 and confirmed there was no transfer order.</p> <p>An interview was conducted with the Director of Nursing (DON) on 10/8/24 at 3:16 PM. The DON reviewed the physician's orders for Resident #4 and confirmed there was no transfer order documented. The DON stated the nurse should have documented the order in the electronic medical record once she received the verbal order to send Resident #4 to the emergency room for evaluation and treatment.</p> <p>An interview was conducted with the Administrator on 10/9/24 at 3:22 PM. The Administrator stated the nurse should have documented an order for Resident #4 to be transferred to the emergency department once she received the verbal order for transfer.</p>
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