STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	06/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete an accurate nursing assessment by not obtaining required vital signs to aid in the assessment of a resident after a fall for 1 of 1 residents (Resident #1) observed. Findings included: Resident #1 was admitted to the facility on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. The Minimum (MDS) data set [DATE] quarterly assessment revealed the resident was severely cognitively impaired. Resident #1 required limited assistance with one staff physical assistance with bed mobility, transfers, personal hygiene and dressing and supervision with set up only with walking in the room and corridor, locomotion on / off unit, and extensive assistance with one staff physical assistance with toileting. Resident #1 moved from seated to standing position and was not steady but able to stabilize without staff assistance. Resident #1 had no impairments and used a walker and wheelchair. Resident #1 had two or more falls with no injury since admission. A review of the care plan updated on 01/23/20 revealed a plan of care for falls; at risk for falls related to confusion with an intervention to include: monitor for and document for 72 hours post fall for signs and symptoms of pain, bruising, mental status change or new onset of confusion, sleepiness, inability to maintain posture and agitation. A review of the initial fall review note on 02/05/20 at 6:52 PM by Nurse #1 revealed Resident #1 was observed on the floor in the resident ' s room as an unwitnessed fall. Resident #1 was unable to communicate what happened due to baseline confusion, there were no injuries noted at this time. This form included neurological (neuro) checks which consisted of assessing the level of consciousness, pupil response, and range of motion, pain response, vital signs, and observations. The note reported the resident was alert and had normal pupil response, equal hand grasps and was able to move all extremities. Pain was documented as hurts a little bit. Vital Signs (VS) were recorded at 6:55 PM. The resident ' s blood pressure (BP) was 168/74, temperature 98.2, heartrate (HR) 69 beats per minutes (bpm) and regular, respiration rate (RR) was 20 breaths per minutes (bpm), oxygen saturation (02 sats) was 97 % on room air (R/A). A review of the follow up fall review assessment recorded on 02/05/20 at 7:52 PM by Nurse #2 revealed under the observation of resident ' s current status, there were no changes. The neuro checks revealed an alert resident with normal pupil response, had equal hand grasps and was able to move all extremities. The assessment indicated the resident had no pain and the VS recorded were the same resulted VS from 02/05/20 at 6:55 PM: BP was 168/74, temperature 98.2, HR 69 (bpm) and regular, RR was 20 (bpm), 02 sats was 97 % on R/A. The time stamp and date for the vital signs was recorded as 02/05/20 at 6:55 PM. A review of the follow up fall review assessment recorded on 02/05/20 at 8:52 PM by Nurse #2 revealed under the observation of resident ' s current status, there were no changes. The neuro checks revealed an alert resident with normal pupil response, had equal hand grasps and was able to move all extremities. The assessment indicated the resident had no pain and the VS recorded were the same resulted VS from 02/05/20 at 6:55 PM: BP was 168/74, temperature 98.2, HR 69 (bpm) and regular, RR was 20 (bpm), 02 sats was 97 % on R/A. The time stamp and date for the vital signs was recorded as 02/05/20 at 6:55 PM. A review of the follow up fall review assessment recorded on 02/06/20 at 11:06 AM revealed under the observation of resident ' s current status, the resident had new or worsening pain. The neuro checks revealed an alert resident with normal pupil response, had equal hand grasps and was able to move all extremities. The assessment indicated the resident had pain rated with a face pain scale indicating hurts even more. The VS recorded were the same resulted VS from 02/05/20 at 6:55 PM: BP was 168/74, temperature 98.2, HR 69 (bpm) and regular, RR was 20 (bpm), 02 sats was 97 % on R/A. The time stamp and date for the vital signs was recorded as 02/05/20 at 6:55 PM. An interview was conducted with Nurse #1 on 06/18/20 at 1:40 PM. Nurse #1 reported she observed Resident #1 on the floor in her room on 02/05/20 at 6:55 PM. Nurse #1 stated the resident was sitting up on the floor with her head against the wheelchair. Nurse #1 stated when a resident had a fall, nurses are to complete a head to toe assessment to check for any injury, assess for pain, and get a full set of vital signs. Nurse #1 stated, if a resident had any complaint of pain while on the floor, she would not move the resident, but instead would notify the physician. Nurse #1 stated the resident complained of pain after she had moved her from the floor and was already in her bed. Nurse #1 stated Resident #1 reported she was a little sore. Nurse #1 stated she completed the neuro checks at this time and notified the doctor. Nurse #1 stated she reassessed the resident for pain about 15 minutes later and the resident reported she did not have any. Nurse #1 stated she reported off to the oncoming Medication Aide (Med Aide), the resident had a fall. Nurse #1 stated when a resident had a fall, the training for nurses was to complete an initial fall review assessment with neuro checks and vital signs. Nurse #1 stated the neuro checks should be conducted every hour for 4 hours and then every shift for 72 hours. Nurse #1 stated a new set of vital signs should be obtained with every new assessment. Nurse #1 stated vital signs can be an indicator of pain or something else going on that a resident cannot verbally express. An interview was conducted with the Medication Aide (Med Aide) on 06/18/20 at 2:15 PM. The Med Aide reported she was the oncoming staff to replace Nurse #1 on 02/05/20 at 7:00 PM. The Med Aide reported she was present when Nurse #1 was assessing the resident post fall and assisted with the transfer of the resident back to her bed. The Med Aide reported she and Nurse #1 checked on Resident #1 shortly after 7:00 PM when doing walking rounds and the resident had no complaints of pain. The Med Aide reported it was not within her scope of practice to assess a resident post fall which included neuro checks and that the nurse on duty (Nurse #2) had to complete the assessment. The Med Aide stated she could not recall if anything was communicated to Nurse #2 to complete the fall assessment and neuro checks for Resident #1. An interview was conducted with Nurse #2 via phone on 06/19/20 at 9:00 AM. Nurse #2 reported if a resident had a fall witnessed or unwitnessed, the protocol was to complete neuro checks every 15 minutes for the first 2 hours and then every 30 minutes for 4 hours and then hourly. Nurse #2 reported it was more than 72 hours that a nurse had to complete neuro checks and get VS, but she was not sure of how long. Nurse #2 reported neuro checks included determining if the resident was alert, had normal pupil response, equal hand grasps and normal range of motion, pain, and a new set of vital signs with each assessment. Nurse #2 stated she was not aware Resident #1 had a fall and was instructed to complete the fall review assessments by management the next day. Nurse #2 stated she put the date and time 02/05/20 at 7:52 PM and 8:52 PM in but that was not the actual time the assessment was completed. Nurse #2 stated she received a note indicating she had to complete her assessments for Resident #1 the next day. Nurse #2 stated she never laid eyes on the resident. Nurse #2 stated she never reported off to the 11-7 Nurse on 02/05/20 (Nurse #4) that Resident #1 had a fall because she was not aware the resident had a fall. An interview was conducted with Nurse #4 via phone on 06/19/20 at 9:15 AM. Nurse #4 reported she could not recall if she was made aware Resident #1 had a fall on 02/05/20 when she came in for her shift from 11:00 PM 7:00 AM. Nurse #4 reported she would have been the nurse to complete the neuro checks on Resident #1 since the Med Aide was unable to do so, but she believed she had no knowledge of Resident #1 ever having a fall. Nurse #4 stated she was not sure of the process to check vital signs and neuro checks, but believed you needed an order from the physician. Nurse #4 stated she believed once a fall review assessment was initiated, the computer system would indicate that an assessment was due. Nurse #4 stated she could not remember the process. An interview was conducted with the Assistant Director of Nursing (ADON) via phone on 06/19/20 at 9:30 AM. The ADON reported if a resident had a fall, the protocol for nursing staff was to complete a fall review assessment which included neuro checks and vital signs every

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) hour for 4 hours and then every 4 hours for 24 hours. The ADON reported she would expect the nursing staff to obtain a new set of vital signs with each new assessment. An interview was conducted with the Director of Nursing (DON) via phone on 06/19/20 at 10:08 AM. The DON reported if a resident had a fall witnessed or unwitnessed the protocol was to complete a fall assessment every hour for 4 hours and then every 4 hours for first 24 hours. The DON reported along with assessing the neurological checks, the vital signs should be retaken every time. The DON reported VS are key to changes in a patient ' s condition along with the rest of the fall assessment and stated that was why they used this form.