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

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

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with [DIAGNOSES REDACTED]. 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 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 [REDACTED]. 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 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 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] 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. A physician's order [REDACTED]. 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 [DATE] 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 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 [DATE] 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 been independent with all ADLs before she fell on [DATE], 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 [DATE] 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

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 0637 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 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.