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 05/12/2022

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

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/9/22 to 5/12/22. The facility was found in compliance with CFR 483.73, Emergency Preparedness. Event ID# 80Z411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/09/22 through 05/12/22. Event ID# 80Z411. The following intakes were investigated: NC00188104, NC00182641, NC00178861, NC00177734 and NC00177293. 10 of the 10 complaint allegations were not substantiated.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and record review, the facility's interdisciplinary team failed to assess and document the ability of a resident to self-administer medications for 1 of 1 resident (Resident #67) who was observed to have medications at bedside. Findings included: Resident #67 was admitted to the facility on 9/8/20 with diagnoses that included, in part, hypertension, end stage renal disease, anxiety, depression, multiple myeloma, dependence on renal dialysis, obesity, and gastroesophageal	F 554	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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.	5/31/22

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

Electronically Signed | 06/02/2022

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 05/12/2022

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

(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
F 554	Continued From page 1 reflux disease. The quarterly Minimum Data Set assessment dated 3/24/22 revealed Resident #67 was cognitively intact. Physician (MD) orders were reviewed and included an order dated 4/25/22 for Calcium Carbonate Antacid Tablet Chewable 750 milligrams. The order was to give 3 tablets by mouth with meals for and give 2 tablets by mouth at bedtime for heart burn and give 2 tablets by mouth every 8 hours as needed for heart burn. Further review of the medical record revealed no assessments were completed for the self-administration of medications. An observation and interview were conducted with Resident #67 on 5/9/22 at 11:28 AM. A medicine cup with 4 Calcium Carbonate Antacid Tablets was observed to be placed within the Resident's reach on the overbed table. During an interview with Resident #67, he stated he didn't know the nurse had left the medication in a cup at his bedside. He further stated the nurses usually stayed and watched while he took his medications. On 5/9/22 at 11:37 AM an interview was completed with Nurse #2. She stated she administered Resident #67 all his medications while physical therapy was in the room. She further stated she did not leave the antacid tablets on the overbed table. She indicated standard practice is to remain with the Resident until all meds are taken. She further indicated Resident #67 did not self-administer his medications. In an interview on 5/11/22 at 9:45 AM with Nurse #3. She stated when she administered medications to Resident #67, she stayed with him to make sure all medications were taken. She further stated she did not leave medications in a cup for him to take later as he did not have an	F 554	For resident #67 the medication was removed from bedside on 5/9/2022 by the assigned nurse and the resident was educated on the need for the nurse to administer all medications and observe that they have been taken by the resident. Assessment by the nursing team indicated that resident was a candidate for self-administration of his medications. MD notified and order given for resident to self-administer Calcium Carbonate as ordered. On 5/25/2022, the Director of Nurses and Unit Managers audited all resident rooms to assure that no medications were found at bedside that had not been assessed for resident self -administration with no other concerns identified and there were no other residents who were requesting to self-administer medications or to keep meds at bedside. No other medications were found at bedside. On 5/25/2022, the Director of Nurses began education of all Full Time, Part Time, PRN and agency nurses on facility policy related to medication safety that included resident assessment for self -administration of medication process and safely securing and storing medications. Education will be completed by 5/27/2022. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific	

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 05/12/2022

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

(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
F 554	Continued From page 2 order to self-administer medications. On 5/12/22 at 9:00 AM an interview was completed with the Medication Aide. She stated, during medication administration, she stayed with Resident #67 and observed him take his medications. She further stated she did not leave medications on the Resident's overbed table to self-administer later. On 5/12/22 at 1:05 PM a phone interview with Nurse #4 revealed he did not recall leaving medication on the overbed table for Resident #67 to self-administer. He further revealed Resident #67 had a history of asking nurses to leave the antacids in a cup for later. Nurse #4 stated the Resident did not have an order to self-administer medications. During an interview with the Director of Nursing (DON) on 5/12/22 at 12:00 PM she explained if a Resident requested medications be kept at the bedside, the facility assessed the Resident's competence to self-administer medications and obtained an order from the physician for medications to be kept at bedside. She stated the nurse who administered a medication was expected to follow the 6 Rights of Medication Administration and stay with the Resident until the medications were taken. She further stated Resident #67 did not have an order to self-administer medications before 5/9/22.	F 554	in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 5/27/2022. Beginning 5/30/2022, Quality assurance audits will be completed by the Director of Nurses or designee to assess that the medication self- administration process is in compliance and that no other meds are at bedside if the resident is not appropriate for self-administration. Audits of 5 resident rooms will be completed on various days of the week and shifts to assure compliance with the medication storage policy. Audits will be done weekly for 2 weeks, then monthly for 3 months or until resolved for compliance with facility policy on self- administration of medication process. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Unit Manager, Social Worker, Activity Director and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process.	
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561		5/31/22

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 05/12/2022

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

(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
F 561	Continued From page 3 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to ensure the resident choice was honored for preference of dining for 2 of 2 resident reviewed for choices. (Resident #67 and Resident #21) Findings included: 1) Resident #67 was readmitted to the facility on	F 561	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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	

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 05/12/2022

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

(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
F 561	Continued From page 4 4/13/22. A review of Resident #67's admission MDS (minimum data set) dated 4/20/21, revealed he was cognitively intact, and required supervision for meals. Review of Physician Orders dated 4/13/22 revealed Resident #67 was on a regular diet with no added sugar and thin consistency liquids. During the entrance conference on 5/9/22 at 9:56 AM, the Administrator revealed the facility's dining room was not in use by the residents of the facility. He stated that the dining room was available if a resident requested to eat his or her meals in the dining room. An interview on 5/9/22 at 11:28 AM revealed Resident #67 ate his meals in his room because the facility dining room was closed. He further revealed that the dining room had been closed because of COVID for a long time but had had opened back up a few months ago. He explained it had only been open a short time when it closed back down again. He said he had not been given a reason for the closure. He stated his preference was to eat in the dining room. He did not like to take all his meals on the overbed table in his room. On 5/9/22 at 12:15 PM, there were no residents observed in the dining room throughout the scheduled lunch period. During the Resident Council group meeting on 5/10/22 at 11:10 AM, Resident #67 stated the Resident Council had inquired about eating in the dining room in February 2022. The facility	F 561	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. For resident #67 and Resident #21-a corrective action was obtained on 5/10/2022 by allowing resident to eat meals in dining room. Resident□s preferences were updated in the resident□s plan of care by MDS nurse. All residents who reside in the facility have the potential to be affected by this alleged deficient practice. Beginning 5/25/2022, Nursing and Social Workers conducted resident interviews and will update dining preferences and establish updated resident care plan and resident profile to reflect preferences. This process to be completed by 5/27/2022. On 5/25/2022, the Director of Nursing began in-servicing all current full time, part time and PRN clinical staff. This in-service included the following topics: self-determination related to dining preferences and resident rights. The Director of Nursing will ensure that any staff clinical who has not received this training by 5/27/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific	

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 05/12/2022

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

(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
F 561	Continued From page 5 subsequently opened the dining room for the lunch meal only and residents ate there for three weeks before the facility closed the dining room due to new COVID-19 infections. Resident #67 said he had been told the residents had to wait fourteen days after a new COVID-19 infection before the dining room could be opened again for meal service. The Activities Director was present for the Resident Council group meeting and shared she had last asked the Infection Control Nurse about the status of the dining room in February 2022 and was told it was closed and the residents were "under the impression" that there was no meal service in the dining room. The Activities Director added there had not been any new COVID-19 infections for several weeks. In addition, during the Resident Council meeting, Resident #67 expressed he wanted to eat his meals in the dining room because it gave him more time to "have fellowship." Resident #67 further stated it was his right to eat where he wanted and that it got old "sitting in my room all the time to eat." 2) Resident #21 was admitted to the facility on 9/7/2018. Cumulative diagnoses included, in part, stroke and hemiplegia. The quarterly Minimum Data Set assessment dated 2/10/22 revealed Resident #21 had minimal cognitive decline and he required one person assist with eating. During the entrance conference on 5/9/22 at 9:56 AM, the Administrator revealed the facility's dining room was not in use by the residents of the facility. He stated that the dining room was available if a resident requested to eat his or her meals in the dining room.	F 561	in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Beginning 6/1/2022, The Administrator or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Residents Dining Preferences. The monitoring will include reviewing a sample of residents to ensure dining preferences are being followed. This will be completed weekly for 4 weeks then monthly x 2 months or until resolved to ensure their needs are met. Quality Of Life/Quality Assurance Committee Reports will be given to the Monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

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 05/12/2022

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

(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
F 561	Continued From page 6	F 561		

During an interview on 5/9/22 at 12:25 pm while Resident #21 was observed in his room eating lunch, he stated that he would prefer to eat in the dining room but that "they closed that down months ago". He also stated that he liked to eat in his room too but would like to option to go to the dining room.

During an interview on 5/10/22 at 9:43 AM with Resident #21 he stated that he did not go to the dining room for supper yesterday and no one asked him if he wanted to go.

During the Resident Council group meeting on 5/10/22 at 11:10 AM, one resident stated the Resident Council had inquired about eating in the dining room in February 2022. The facility subsequently opened the dining room for the lunch meal only and residents ate there for three weeks before the facility closed the dining room due to new COVID-19 infections. The Activities Director was present for the Resident Council group meeting and shared she had last asked the Infection Control Nurse about the status of the dining room in February 2022 and was told it was closed and the residents were "under the impression" that there was no meal service in the dining room. The Activities Director added there had not been any new COVID-19 infections for several weeks.

During an interview on 5/11/22 at 9:05 AM with Resident #21 again stated that he did not go to the dining room for lunch or supper yesterday and no one asked him if he wanted to go.

During an interview on 5/12/22 09:16 AM with Nurse #1, she stated no one ate in the dining

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 05/12/2022

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

(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
F 561	Continued From page 7 room that she was aware of for breakfast. She stated they just brought all the trays to the rooms. She added there was a list now at the nurse's station with the names of those residents who they were supposed to ask if they wanted to eat in the dining room or not. She stated Resident #21's name was not on that list. She was unable to tell me where that list came from and how long it had been there. During an interview on 5/12/22 at 2:15 PM with the Infection Preventionist (IP), she stated that the facility last positive Covid infection was in March. She stated that corporate said they had to be two weeks out from their last infection in order to reopen the dining room. They also needed to keep it closed during high transmission for their county. The IP added she was under the impression that the transmission rate was still high and that most residents didn't want to eat in the dining room.	F 561		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.	F 577		5/31/22

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 05/12/2022

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

(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
F 577	Continued From page 8 (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post the results of the most recent survey of the facility. Findings included: The Aspen Central Office database system was reviewed and revealed the most recent survey at the facility was a COVID-19 focused infection control survey completed on 10/17/21. During tours of the facility on 5/10/22 at 10:48 AM and 5/11/22 at 3:40 PM, observations were made of the facility's survey results located in a notebook in a bin attached to the wall in the front lobby area of the facility. The most recent survey results in the notebook were from a recertification survey completed 10/24/19. An interview was completed with the Administrator on 5/11/22 at 3:42 PM. He stated he printed off the survey results and placed them in the survey results notebook. He reported he only placed results from the annual survey in the notebook and was not aware he was supposed to place the most recent survey results, regardless	F 577	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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. No resident affected by alleged deficient practice. Survey results from 10/17/2021 were placed on Survey Posting Book on 5/11/2022 All residents have the potential to be affected by the alleged deficient practice. On 5/25/2022, the QA nurse consultant reeducated Administrator on policy related Survey results posting and Administrator audited survey posting book to ensure most recent survey results were in book.	

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 05/12/2022

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

(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
F 577	Continued From page 9 of the type of survey, in the notebook. On 5/11/22 at 3:54 PM the corporate Nurse Consultant was interviewed. She explained the Administrator was responsible to print out and post survey results. She added she thought survey results only applied to the annual recertification survey and was unaware the regulation required the most recent survey results from any survey were to be posted in the notebook.	F 577	On 5/25/2022, The Director of Nursing and QA Nurse Consultant began education with to all full time, part time, and as needed Administrative team members. Topics included: " Survey Results posting policies and regulations. This information has been integrated into the standard orientation training for all administrative staff and in the required in-service refresher courses for all administrative staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The Administrator will ensure that any administrative staff who has not received this training by 5/27/2022 will not be allowed to work until the training is completed. The Administrator or assigned personnel will monitor by visually inspecting the Survey Posting Book to ensure results of most recent survey are posted weekly x 4 weeks, and then monthly x 2 months using the Survey Results Posting QA Tool. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
F 636 SS=D	Comprehensive Assessments & Timing	F 636		5/31/22

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 05/12/2022

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

(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
F 636	Continued From page 10 CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) 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. (xv) Special treatments and 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	F 636		

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 05/12/2022

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

(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
F 636	Continued From page 11 include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to complete an admission Minimum Data Set (MDS) comprehensive assessment within 14 days of the assessment reference date for 2 of 7 residents (Resident #58 and Resident #2) reviewed for timeliness completion of admission MDS assessments. The findings included: 1. Resident #58 was admitted to the facility on 2/22/22 with diagnoses that included, in part, diabetes and hypertension. The admission MDS assessment with an	F 636	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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 dates indicated. Minimum Data Set (MDS) assessments for affected residents that were identified as not being completed within the required	

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 05/12/2022

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

(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
F 636	Continued From page 12 assessment reference date of 2/9/22 was reviewed and revealed the assessment was signed as completed by the MDS Nurse on 3/8/22. An interview was completed with the MDS Nurse on 5/12/22 at 11:19 AM. She verified the assessment reference date was 2/9/22 and said the admission MDS assessment should have been completed and signed by the 14th day, which was 2/22/22. The MDS Nurse explained she was the only one in the facility who completed MDS assessments. She said she had support from the corporate office in the past but the individual who helped her moved to a different role in the company and there wasn't anyone else who helped her complete the assessments. She stated she helped work as a floor nurse earlier in the year during a COVID-19 outbreak and some of the MDS assessments fell behind schedule. During an interview with the Director of Nursing (DON) on 5/12/22 at 11:28 AM she stated the MDS Nurse had performed other work duties earlier in the year which included helping on a medication cart on the floor on the weekends. The DON added the corporate support staff member who assisted with MDS assessments moved to a different role in the company. The Corporate Nurse Consultant was interviewed on 5/12/22 at 11:36 AM. She explained there was a corporate staff member available to the MDS Nurse who was able to assist with the completion of MDS assessments. She shared all the MDS assessments had been caught up and signed as completed. 2. Resident #2 was admitted to the facility on	F 636	timeframe were completed and submitted to the state database as follows: Resident #58 had a Comprehensive Admission Assessment with Assessment Reference Date (ARD) set for 02/09/22. The assessment was completed on 03/08/22 and accepted into the Quality Improvement and Evaluation (QIES) system 03/09/22 in Batch# 1660. Resident # 2 had a Comprehensive Admission Assessment with Assessment Reference Date (ARD) set for 12/6/21. The assessment was completed on 01/29/22 and accepted into the Quality Improvement and Evaluation (QIES) system 01/31/22 in Batch #1637 All residents have the potential to be affected by the alleged deficient practice. On 05/27/22, the Clinical Reimbursement Consultant conducted an audit utilizing the CMS Validation reports within the past 30 days to determine if there were late Admission Comprehensive Minimum Data Set (MDS) assessments completed with the Assessment Reference Date (ARD) not being greater than 14 days from date of admission. The results of this audit were: 15 Validation Reports were reviewed 178 Minimum Data Set (MDS) Assessments were transmitted 35 of the transmitted Minimum Data Set (MDS) Assessments were Admission Assessments 33 of the transmitted were late On 05/31/22, the Clinical Reimbursement Consultant conducted in-service training	

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 05/12/2022

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

(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
F 636	Continued From page 13 11/29/21 with diagnoses that included, in part, kidney failure and hypertension. The admission MDS assessment with an assessment reference date of 12/6/21 was reviewed and revealed the assessment was signed as completed by the MDS Nurse on 1/29/22. An interview was completed with the MDS Nurse on 5/12/22 at 11:19 AM. She verified the assessment reference date was 12/6/21 and said the admission MDS assessment should have been completed and signed by the 14th day, which was 12/19/21. The MDS Nurse explained she was the only one in the facility who completed MDS assessments. She said she had support from the corporate office in the past but the individual who helped her moved to a different role in the company and there wasn't anyone else who helped her complete the assessments. She stated she helped work as a floor nurse during a COVID-19 outbreak and some of the MDS assessments fell behind schedule. During an interview with the Director of Nursing (DON) on 5/12/22 at 11:28 AM she stated the MDS Nurse had performed other work duties earlier in the year which included helping on a medication cart on the floor on the weekends. The DON added the corporate support staff member who assisted with MDS assessments moved to a different role in the company. The Corporate Nurse Consultant was interviewed on 5/12/22 at 11:36 AM. She explained there was a corporate staff member available to the MDS Nurse who was able to assist with the completion	F 636	for the facility Minimum Data Set (MDS) Nurse on the importance of scheduling and completing an admission Minimum Data Set (MDS) assessment for all residents within the specified time frame per chapter 2 of the Resident Assessment Instrument (RAI) manual. The education emphasized that all residents must have an Admission Comprehensive completed within 14 days of the Admission date and the Care Areas Assessment (CAA) completed within 21 days. Focus was also placed on the importance of ensuring that all Minimum Data Set (MDS) assessments be completed, encoded and transmitted within the required timeframes as set forth by CMS as stated in Chapter 2 of the Resident Assessment Instrument (RAI) manual. The Director of Nursing and/or designee will review the CMS Validation reports for residents who have been admitted to the facility to validate timely completion of the Minimum Data Set (MDS) comprehensive admission assessment (A310A =01) per the Resident Assessment Instrument (RAI) manual. This report will be reviewed each week for the admissions from the previous week to ensure that admission assessments are being completed in a timely manner. This will be completed using the Quality Assurance tool entitled “Admission Assessment and Timing Audit Tool”. This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure	

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 05/12/2022

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

(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
F 636	Continued From page 14 of MDS assessments. She shared all the MDS assessments had been caught up and signed as completed.	F 636	corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator.	
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 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 observation, record review, resident and staff interviews, the facility failed to complete a SCSA (significant change in status assessment) for a functional decline in mobility for 1 of 1 resident (Resident #67) reviewed for Comprehensive Assessment After Significant Change. Findings included: Resident #67 was readmitted to the facility on 4/13/22 after a stay in the hospital. His diagnoses included, in part, hypertension, end stage renal	F 637	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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	5/31/22

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 05/12/2022

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

(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
F 637	Continued From page 15 disease, anxiety, depression, multiple myeloma, anemia in chronic kidney disease, and dependence on renal dialysis. A quarterly Minimum Data Set (MDS) assessment dated 3/24/22 revealed Resident #67 was cognitively intact and required supervision for locomotion, bed mobility, transfers, dressing and assistance of one staff with transfers. During an interview with Resident #67 on 5/9/22 at 11:28 AM he stated he has not regained his former level of functioning since his return from the hospital in April. He further stated he was working with physical therapy to try to get back some of his strength in his legs and arms. He explained he needed more assistance with most activities of daily living (ADLs) and he didn't like being so dependent on staff. A review of Resident #67's electronic medical record on 5/10/22 revealed a Significant Change in Status Assessment (SCSA) with an Assessment Reference Date (ARD, the last day of the MDS look back period) of 4/20/22 had not been completed. An interview with the Med Aide on 5/12/22 at 9:00 AM revealed Resident #67 had required more extensive assistance with ADLs since his return from the hospital. She stated that his bed mobility and ability to transfer independently had declined. On 5/12/22 at 9:57 AM an interview was conducted with a Nurse Aide (NA#3) familiar with Resident # 67. She stated the Resident had a decline in his ability to perform his ADLs since he had been readmitted from the hospital. She explained he needed one person assist with some ADLs prior to being hospitalized and had required the assistance of two staff for most ADLs and with transfers since his return. On 05/12/22 at 2:53 PM an interview was conducted with the MDS/Care Plan Nurse. She	F 637	corrected by the date or dates indicated. Minimum Data Set (MDS) assessment for affected resident that was identified as not being completed within the required timeframe has been completed and submitted to the state database as follows: Resident #67 Comprehensive Assessment after Significant change set with Assessment Reference date (ARD) 04/20/2022. The assessment was not completed within the required 14 days. The Significant Change assessment was completed 05/16/2022 and accepted into the Quality Improvement and Evaluation System (QIES) system 05/16/22 in Batch #1693. All residents have the potential to be affected by the alleged deficient practice. On 05/30/22, the Clinical Reimbursement Consultant conducted an audit for timely completion of Significant Change Assessments within the last 90 days utilizing the Centers for Medicare and Medicaid (CMS) final validation reports. The audit reviewed the Minimum Data Set (MDS) assessments for completion dates not more than 7 days from the Assessment Reference Date (ARD) and the Care Area Assessment (CAA) completion date not more than 14 days. The results of this audit were: 6 Significant Change Assessments were identified and reviewed utilizing a 90 day lookback. 2 Significant Change Assessments were completed within the specified timeframe	

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 05/12/2022

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

(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
F 637	Continued From page 16 stated since Resident #67's return from the hospital he had declined in his functional status and had not returned to baseline. She verified an SCSA should have been completed by the 14th day. She stated she helped work as a floor nurse earlier in the year during a COVID-19 outbreak and some of the MDS assessments fell behind schedule. On 5/12/22 at 11:28 AM an interview was conducted with the Director of Nursing. She indicated MDS assessments should be completed and submitted in a timely manner and that a significant change MDS should have been completed for Resident #67 within 14 days. She explained the MDS Nurse had performed other duties earlier in the year including working as a floor nurse on the weekends. On 5/12/22 at 11:36 AM an interview was conducted with the Corporate Nurse Consultant. She stated there was a corporate staff member available to the MDS Nurse who was able to assist with the completion of MDS assessments.	F 637	4 Significant Change Assessments were completed outside the specified timeframe On 05/31/22, the Clinical Reimbursement Consultant conducted in-service training for the facility Minimum Data Set (MDS) Nurse on the importance of scheduling and completing a Minimum Data Set (MDS) assessment for all residents with the specified time frame per chapter 2 page 22 of the Resident Assessment Instrument (RAI) manual. The education emphasized that all residents must have a Comprehensive Assessment after Significant Change completed within 14 days of noted significant change. A significant change is a major decline or improvement in a resident□s status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self limiting; 2. Impacts more than one area of the resident□s health status; and 3. Requires interdisciplinary review and/or revision of the care plan. Chapter 2/page 22 Resident Assessment Instrument. Focus was also placed on the importance of ensuring that all Minimum Data Set (MDS) assessments be completed, encoded and transmitted within the required timeframes as set forth by Centers for Medicare and Medicaid Services (CMS) as stated in Chapter 2 of the Resident Assessment Instrument (RAI) Manual.	

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 05/12/2022

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

(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
F 637	Continued From page 17	F 637	The Director of Nursing and/or designee will review 5 random (current) residents who have been in the facility for at least 3 months to validate whether or not they have had a Significant Change with a Minimum Data Set (MDS) assessment completed timely per the Resident Assessment Instrument (RAI) Manual, including whether or not the assessment was completed within the required timeframe. This will be completed using the Quality Assurance tool entitled Comprehensive Assessment after Significant Change. This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record	F 638	The statements made on this plan of	5/31/22

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 05/12/2022

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

(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
F 638	Continued From page 18 review, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 14 days of the assessment reference date for 1 of 9 residents (Resident #58) reviewed for timeliness completion of quarterly MDS assessments. The findings included: Resident #58 was admitted to the facility on 2/22/22 with diagnoses that included, in part, diabetes and hypertension. The quarterly MDS assessment with an assessment reference date of 3/9/22 was reviewed and revealed the assessment was signed as completed by the MDS Nurse on 4/4/22. An interview was completed with the MDS Nurse on 5/12/22 at 11:19 AM. She verified the assessment reference date was 3/9/22 and said the quarterly MDS assessment should have been completed and signed by the 14th day, which was 3/23/22. The MDS Nurse explained she was the only one in the facility who completed MDS assessments. She said she had support from the corporate office in the past but the individual who helped her moved to a different role in the company and there wasn't anyone else who helped her complete the assessments. She stated she helped work as a floor nurse earlier in the year during a COVID-19 outbreak and some of the MDS assessments fell behind schedule. During an interview with the Director of Nursing (DON) on 5/12/22 at 11:28 AM she stated the MDS Nurse had performed other work duties earlier in the year which included helping on a medication cart on the floor on the weekends.	F 638	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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. Minimum Data Set assessments for affected residents that were identified as not being completed within the required timeframe were completed and submitted to the state database as follows: Resident #58 Minimum Data Set (MDS) with Assessment Reference Date (ARD) 3/9/22 was completed on 4/4/22 and submitted to the State Database on 4/6/22 with validation of acceptance in Batch# 1660 All residents have the potential to be affected by the alleged deficient practice. On 05/27/22, the Minimum Data Set Consultant conducted an audit utilizing the CMS Validation reports within the past 30 days to determine if there were late Minimum Data Set assessments completed with the Assessment Reference Date not being greater than 92 days since prior assessment□s reference date. The results of this audit were: 15 Validation Reports were reviewed 178 Minimum Data Set Assessments were transmitted 83 of the transmitted Minimum Data Set	

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 05/12/2022

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

(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
F 638	Continued From page 19 The DON added the corporate support staff member who assisted with MDS assessments moved to a different role in the company. The Corporate Nurse Consultant was interviewed on 5/12/22 at 11:36 AM. She explained there was a corporate staff member available to the MDS Nurse who was able to assist with the completion of MDS assessments. She shared all the MDS assessments had been caught up and signed as completed.	F 638	Assessments were late On 5/31/22, the Minimum Data Set Nurse Consultant conducted in-service training for the facility Minimum Data Set (MDS) Nurse on the importance of scheduling and completing a Minimum Data Set (MDS) assessment for all residents at least every 92 days per chapter 2 of the Resident Assessment Instrument (RAI) manual. The education emphasized that all residents must have no more than 92 days between Assessment Reference Dates (ARD) of each Minimum Data Set (MDS) assessment (Admission, Annual, Quarterly, Significant Change). Focus was also placed on the importance of ensuring that all Minimum Data Set (MDS) assessments be completed, encoded and transmitted within the required timeframes as set forth by CMS as stated in Chapter 2 of the Resident Assessment Instrument (RAI) Manual. The Director of Nursing and/or designee will review 5 random (current) residents who have been in the facility for at least 6 months to validate whether or not they have had an Minimum Data Set assessment completed at least once every 92 days per the Resident Assessment Instrument (RAI) manual, including whether or not the assessment was completed within the required timeframe. This will be completed using the Quality Assurance tool entitled Quarterly Completion of Minimum Data Set Assessments. This will be done on a weekly basis for 4 weeks then monthly for	

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 05/12/2022

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

(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
F 638	Continued From page 20	F 638	2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately complete the quarterly minimum data set (MDS) for 1 of 2 sampled residents (Resident #62) reviewed for range of motion. Findings included: Resident #62 was admitted to the facility on 4/26/21 with diagnoses which included: atrial fibrillation, respiratory failure with hypoxia, dementia, diabetes mellitus, muscle weakness, and a history of falls. The significant change MDS dated 1/14/22 indicated Resident #62 was severely, cognitively impaired and had range of motion impairment of	F 641	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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. For resident # 62 corrective action was obtained on 05/27/22 by modifying and correcting the Minimum Data Set (ARD) assessment for assessment reference date (ARD) of 03/12/22. Coding of	5/31/22

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 05/12/2022

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

(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
F 641	Continued From page 21 her upper extremities. The quarterly MDS dated 3/13/22 indicated Resident #62 was severely, cognitively impaired and had no range of motion impairments. Documentation in the clinical records described Resident #62's hands as contracted. During an observation on 5/10/22 at 10:01 a.m., Resident #62 was lying on her back in bed with her head hyper-extended and the fingers of her right hand were in a tightly fisted position. On 5/10/22 at 10:05 a.m., NA#1 (nursing assistant) entered Resident #62's room. NA#1 revealed the resident was unable to open her right hand and when in bed the resident would hyper-extend her neck. An interview with the Rehabilitation Director on 5/11/22 at 11:43 a.m. revealed the nursing staff had not referred Resident #62 for evaluation of the range of motion of her upper extremities. During an interview on 5/12/22 at 10:23 a.m., the Director of Nursing stated that when completing an assessment for the MDS, her expectation was for the MDS Coordinator to observe the resident.	F 641	question G0400 (Functional Limitation in Range of Motion) was corrected to accurately reflect that resident did have limitation in one upper limb that was present during the specified lookback timeframe. Correction was completed by the Clinical Reimbursement Consultant on 05/27/22. Corrected Minimum Data Set (MDS) assessment was re-submitted to the state. All residents have the potential to be affected by the alleged deficient practice. An audit of residents with known limitations who have had a Minimum Data Set (MDS) assessment completed during the past 90 days was completed in order to identify any potential coding error is section G0400 Functional Limitations. This audit was conducted by the Clinical Reimbursement Consultant. Audit Results: 15 charts were reviewed for accuracy of coding section G0400 Functional Limitations in the past 90 days 1 chart was found to have a discrepancy Modification has been completed to the inaccurate Minimum Data Set (MDS) assessment and submitted for transmission into the Centers for Medicare and Medicaid (CMS) portal on 05/31/22. On 05/31/22, the Clinical Reimbursement Consultant completed an in-service training for the facility Minimum Data Set (MDS) nurse that included the importance of thoroughly reviewing the medical record during the assessment process and	

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 05/12/2022

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

(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
F 641	Continued From page 22	F 641	observing each resident before coding the Minimum Data Set (MDS) assessment. Special emphasis was highlighted on: It was detailed the importance of thorough review of the medical record including progress notes, nurse aide documentation, nursing notes and observing each resident during the seven day lookback for completion of Minimum Data Set (MDS) Assessment. This information is located in the Resident Assessment Instrument (RAI) manual in chapter 3 pages G-36 through G-39 and has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The Director of Nursing or designee will begin auditing the coding of MDS items utilizing the Accurate Coding of MDS Audit Tool provided. This audit will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		5/31/22

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 05/12/2022

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

(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
F 688	Continued From page 23 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to provide treatment and services to 1 of 2 sampled residents (Resident #62) who demonstrated some reduction in the range of motion of her bilateral hands and the hyper-extension of her neck. Findings included: Resident #62 was admitted to the facility on 4/26/21 with diagnoses which included: respiratory failure with hypoxia, dementia, diabetes mellitus, muscle weakness, and a history of falls. The quarterly minimum data set dated 3/13/22 indicated Resident #62 was severely, cognitively impaired; required extensive to total assistance with activities of daily living; and had no range of	F 688	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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. For Resident#62, On 5/11/2022 resident assessed by Director of Nursing for need of contracture management. MD notified and order given for OT evaluation for Splinting and positioning needs of hands. All current residents who utilize a splint for	

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 05/12/2022

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

(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
F 688	Continued From page 24 motion impairments. The Nurse's Note dated 12/23/21 read in part: "continues to work with therapy, due to contractures and weakness due to CVA (cerebral vascular accident)". The Therapy Discharge Summary dated 12/27/21 indicated Resident #62 received treatment for abnormal posture and muscle weakness with the goal of tolerating sitting up in a high back wheelchair. The Nurse's Note dated 4/20/22 documented the Resident #62 had some contracture of her left hand. During an observation on 5/10/22 at 10:01 a.m., Resident #62 was lying on her back in bed with her head hyper-extended and the fingers of her right hand were in a tightly fisted position. On 5/10/22 at 10:05 a.m., NA#1 (nursing assistant) entered Resident #62's room. When questioned, NA#1 revealed the resident was unable to open her right hand and when in bed the resident would hyper-extend her neck. During an interview on 5/11/22 at 11:33 a.m., the Rehabilitation Director revealed Resident #62 last received physical therapy on 12/27/21 for wheelchair positioning, only. She indicated residents were screened for therapy upon referrals from the nursing department and quarterly via informal discussion with the nurse. She stated that the nursing department had not made the rehabilitation department of Resident #62 having any contractures. As a result of this interview, the Rehabilitation Director scheduled a	F 688	contractures have the potential to be affected. On 5/25/2022, the Director of Nursing audited all current residents for contractures. This was completed by assessing the resident□s extremities and placing them through ROM to determine if a contracture were present. If a new or worsening contracture was noted, a therapy referral will be initiated by the Nurse Manager. This process will be completed by 5/31/2022. On 5/25/2022, the nurse managers audited all current residents to establish which residents had MD orders for devices such as a splint, brace, palm guard, or hand roll. This was accomplished by auditing orders and care plan task for those devices. Once it was determined who needed a splint, brace, palm guard, or hand roll, the nurse managers and MDS nurse ensured the device were in place, had an MD order, CNA task, and care plan. This process will be completed by 5/31/2022. On 5/25/2022, the Director of Nursing began an in-service education to all full time, part time, and as needed nurses and CNA□s. Topics included: ¿ The importance for applying splints, palm guards, hand rolls as ordered by the MD. ¿ Inspecting skin at least daily or more frequently as ordered for irritation, redness or skin breakdown. ¿ What to do if mobility issues noted or when contracture device cannot be located.	

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 05/12/2022

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

(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
F 688	Continued From page 25 therapy screening with the Occupational Therapist. On 5/12/22 at 10:04 a.m., a follow-up interview was conducted with the Rehabilitation Director. She revealed Resident #62 was evaluated by the Occupational Therapist on 5/11/22 and the findings revealed the resident did not have contractions of her hands but did have some hyper-extension of her neck which was resistive to moving her head to a more neutral position. She stated that the resident was added to the Occupational Therapist's caseload, effective 5/11/22. Treatment would include splinting devices applied to both resident's hands to prevent contractions and a wedge cushion was positioned to the resident's neck while in bed. The Rehabilitation Director concluded the interview with "It was the responsibility of the nursing staff to inform and refer residents to the rehabilitation department for therapy." During an interview on 5/12/22 at 10:23 a.m., the Director of Nursing (DON) stated it was her expectation for nursing to report any changes in a resident's range of motion and/or functioning level to therapy or her (DON). On 5/12/22 at 11:54 a.m., an interview was conducted with NA#2. She stated that for approximately six months Resident #62 was unable to use her hands (would keep them fisted) and would extend her head back while in bed. NA#2 acknowledged she did not report these observations to anyone.	F 688	The Director of Nursing will ensure that any Nurse or CNA who has not received this training will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training by 5/31/2022 will not be allowed to work until training has been completed. Beginning 6/1/2022, The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Splint and Brace use. The monitoring will include reviewing a sample of residents who require a splint or brace to ensure it is applied and removed per MD orders. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by to ensure their needs are met. Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

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 05/12/2022

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

(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
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, the facility failed to withhold a hypotensive medication when the resident's systolic blood pressure was greater than 120 as ordered by the physician for 1 of 5 sampled residents (Resident #62) reviewed for unnecessary drugs. Resident #62 was admitted to the facility on 4/26/21 with diagnoses which included: respiratory failure with hypoxia, dementia, diabetes mellitus, and orthostatic hypotension. The quarterly minimum data set dated 3/13/22	F 757	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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.	5/31/22

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 05/12/2022

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

(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
F 757	Continued From page 27 indicated Resident #62 was severely, cognitively impaired. Review of the May 2022 medication administration record (MAR) revealed the physician's order for Resident #62 to receive 2.5 mg (milligrams) of Midodrine HCl (an alpha-adrenergic agonist medication which increases blood pressure) for her diagnosis of orthostatic hypotension. The medication was to be administered two times (9:00 a.m. and 9:00 p.m.) each day unless the resident's systolic blood pressure was greater than 120. The Midodrine HCl was administered to the resident on 5/3/22 at 9:00 p.m. when the resident's systolic blood pressure reading was 138 and on 5/7/22 at 9:00 p.m. when the resident's systolic blood pressure reading was 132. Both systolic blood pressure readings were greater than 120 when the medication was administered by the nursing staff. During an observation on 5/10/22 at 10:01 a.m., Resident #62 was lying in bed. During an interview on 5/12/22 at 10:48 a.m., the Director of Nursing (DON) stated that all nurses were required to check all perimeters when administering medications. The DON further indicated as a result of this incident all nurses and medication aides in the facility were educated on medication errors and checking perimeters before administering medications.	F 757	For resident #62, on 5/12/2022 the resident was assessed by Director of Nursing. No acute distress noted. MD was notified of the deficient practice with no new orders. Staff education began on 5/12/2022 for medication errors/administering medications following the MD orders. On 5/25/2022, the Director of Nursing audited 100% of all current residents with orders for Antihypertensive medications who have orders that require monitoring to identify any administrations that should be held. This was completed on 5/25/2022. Results: No other residents identified with orders for hold parameters related to antihypertensive medications. On 5/12/2022 the Director of Nurses (DON) began educating all Licensed Nurses, RNs, Licensed Practical Nurses, full time, part time, agency staff, and PRN on the following topics: -Administering medications following MD orders to ensure that adequate monitoring of medication is provided prior to medication administration -Medication Errors This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 5/31/2022.	

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 05/12/2022

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

(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
F 757	Continued From page 28	F 757	Beginning 6/1/2022, The DON or designee will monitor compliance utilizing the F757 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON will monitor compliance to ensure medications are administered with adequate monitoring required according to the physician□s order. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		5/31/22

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 05/12/2022

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

(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
F 812	Continued From page 29 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain sanitary conditions in the kitchen and in 1 of 2 nourishment rooms by not ensuring food items were not stored on the floor; by not ensuring resealed food items were dated/labeled; by not ensuring food service equipment remained free from debris; and by not ensuring dietary staff wore hair covering while preparing meal trays on the meal trayline. Findings included: 1. During the initial tour of the kitchen on 5/9/22 at 11:15 a.m., there were 2-cases labeled dinner napkins stored on the floor of the dry storage room and 2-cases (chicken and ground beef) stored on a large sheet tray beneath a storage rack in the walk-in freezer. On 5/12/22 at 5:30 p.m., there was 1-opened case of canned foods and 1-opened case of small porcelain plates stored on the floor in the dry storage room. 2. During the tour of the kitchen on 5/9/22 at 11:15 a.m., 5-resealed bags of noodles that were not dated were stored on the storage racks in the dry storage room. On 5/12/22 at 1:09 p.m., during an observation of	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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. On 5/12/2022, Boxes of dinner napkins, canned goods, and plates noted on floor were properly stored on shelf in dry storage room. On 5/9/2022 Items noted stored on sheet tray in freezer were discarded. 5/9/2022 Bags of noodles not dated on storage racks in dry storage room were discarded. 5/12/2022 Items noted not labeled/dated or expired in nourishment room #1 and #2 were discarded. 5/9/2022 Lids for flour, breadcrumbs, and cornmeal bins were cleaned. 5/9/2022 Fryer and floor surrounding fryer were cleaned. 5/12/2022 Filter in vent hood cleaned and replaced. 5/12/2022 Dietary staff provided with hair	

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 05/12/2022

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

(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
F 812	Continued From page 30 1 of 2 nourishment room refrigerators there were 2-(8 ounce) cartons of milks that were not dated and 1-opened box of single serve teabags that was not labeled with a resident's name, room number and date. In the dry storage room of the kitchen there were 2-resealed bags of noodles that were not dated. 3. The initial tour of the kitchen on 5/9/22 at 11:15 a.m. fine white particles were observed on the top of the lids of the flour and breadcrumb bins, and brown particles on the lid and handles of the cornmeal bin in the dry storage room of the kitchen. The filters in the vents of the hood over the stove contained thick, dark gray lint. When questioned, the Dietary Manager stated the hood was professionally cleaned every six months, but she was unable to recall when the dietary staff last cleaned the filters. The outer sides of the deep fryer and the floor surrounding the fryer consisted of thick brown/black grease build-up. On 5/12/22 at 1:09 p.m., the observation of 1 of 2 nourishment room refrigerators revealed a spilled brown liquid had frozen in the freezer compartment. The filters in the vents of the hood over the stove continued to be covered in thick, dark gray lint. The outer sides of the deep fryer and the floor surrounding the fryer remained dirty with thick brown/black grease build-up. 4. During the meal trayline service observation in the kitchen on 5/12/22 at 5:25 p.m., the two dietary aides were not wearing hair coverings while assisting the cooking with the meal tray preparation at the steamtable.	F 812	net and verbally educated r/t dress code policy related to meal preparation and service All current residents have the potential to be affected by the alleged deficient practice. On 5/25/2022 the unit support staff completed 100% inspection of all nourishment rooms to check for expired or unlabeled/undated items and any noted were discarded. On 5/25/2022, the Dietary Manager completed inspection of all walk-in coolers and dry storage area and all food items were properly stored and labeled. Any food items noted without a date or not stored properly were removed and discarded. On 5/25/2022, the Administrator and Director of Nursing began In-service education to all full time, part time, and as needed dietary staff on checking for and discarding expired food items and all food items must be stored, dated and discarded per NC State Regulations and Food Safety, Food Storage Policy reviewed, dress code, debraded/ stained serviceware and cleaning of food service equipment. The Administrator will ensure that any staff who has not received this training will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not	

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 05/12/2022

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

(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
F 812	Continued From page 31	F 812	receive scheduled in-service training by 5/31/2022 will not be allowed to work until training has been completed. The Dietary Manager will monitor food storage weekly x 4 weeks then monthly x2 months using the Dietary QA Audit Tool. Monitoring will include auditing all nourishment rooms, dry storage areas, walk-in coolers in which food is stored. Monitoring food service equipment floors, and storage bins for cleanliness, Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Performance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, Maintenance Director, Environmental Services Director, and the Dietary Manager	