PRINTED: 10/03/2011 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SU COMPLET		
		345520	B. WING	4017	1	C !2/2011	
	ROVIDER OR SUPPLIER WOOD NURSING CEN	TER	STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360				
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SS=C	RIGHTS, RULES, and in writing in a launderstands of his regulations governing responsibilities during facility must also promotice (if any) of the \$1919(e)(6) of the made prior to or up resident's stay. Reany amendments to writing. The facility must intentitled to Medicaid of admission to the resident becomes exitems and services facility services und which the resident other items and service and for which the resident to the items and service (i)(A) and (B) of this The facility must infat the time of admist the resident's stay, facility and of chargincluding any chargunder Medicare or informed in the items and service (i) (A) and (B) of this the resident's stay, facility and of chargincluding any chargunder Medicare or informed in the items and service (i) (A) and (B) of this the resident's stay, facility and of chargincluding any chargunder Medicare or including any chargunder Medic	form each resident before, or sion, and periodically during of services available in the es for those services, es for services not covered by the facility's per diem rate.	poster works had p poster applied and u refund. B. A facility currer inform Shift 2011 the in October 1. The notice Assurate to the or admirequire (2) A. Reswas no resider covera applica	con becoming aware during the direct notice, the administrator important the post the notice of rights and reviously been posted. The fad the notice of rights and rule cants for admission informationse Medicare and Medicaid beds for previous payments cover the time of admission and attraction with the location mation. The services will be himforming all staff to report and after superior and the services will be himforming all staff to report and administration board to their superior all staff to report and administration and the services and administrate monthly to ensure the notice in posted in a visible location posting site. The Quality Assurance Committee members will presence of the notice and to ministrator if a committee member will presence of the notice and to ministrator if a committee member will presence of the notice and to ministrator if a committee member will presence of the notice and to ministrator if a committee member will presence of the notice and to ministrator if a committee member will presence of the notice and to ministrator if a committee member will presence of the notice and to ministrator if a committee member will presence of the notice and to ministrator if a committee member will presence of the notice and to ministrator if a committee member will presence of the notice and to ministrator if a committee members will presence of the notice and to ministrator if a committee members will presence of the notice and to ministrator if a committee members will presence of the notice and to ministrator if a committee members will presence of the notice and to ministrator if a committee members will presence of the notice and to ministrator if a committee members will presence of the notice and to ministrator if a committee members will presence of the notice and to ministrator if a committee members will present the notice and to ministrator if a committee members will present the notice and to ministrator if a committee members will present the notice and to ministrator if a commit	mediately had the rules in the loc icility social works providing resident about how to mefits, and howered by such bear a least annually, and/or remind ear of the posted led beginning Only removed item rator will monitorice of rights and and not removed inform the social maniposted. Quality inform the social maniposted inform the social maniposted. We will be instructed to inform the social maniposted. We will be instructed to inform the social maniposted. We will be instructed to inform the social maniposted. We will be instructed to inform the social maniposted. We will be instructed to inform the social maniposted. We will be instructed to inform the social maniposted. We will be instructed to inform the social maniposted.	ne social ation it ker lents and apply for to receive nefits. the ch ctober 21, s from ion date or weekly rules ed from med the ality o be alert il worker ware a sident at	

Any deficiency statement ending with an asterisk (1) 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.

	S FOR MEDICARE & OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPI	E CONSTRUCTION	(X3) DATE SUR	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUII			COMPLETE	:D
			B. WIN			0	·
		345520	B. WIIN			09/22	//2011
NAME OF PR	OVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTYM	VOOD NURSING CENTE				28 BLAIR STREET		
LIDERTIT				T	HOMASVILLE, NC 27360	701	
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 156	Continued From pag A description of the r personal funds, under section; A description of the r for establishing eligible the right to request a 1924(c) which detern non-exempt resource institutionalization ar spouse an equitable cannot be considere toward the cost of the medical care in his of down to Medicaid el A posting of names, numbers of all pertir groups such as the agency, the State lic ombudsman prograt advocacy network, a unit; and a statemer complaint with the S agency concerning misappropriation of facility, and non-cor directives requirement The facility must co specified in subpart related to maintainin procedures regardin requirements include	e 1 manner of protecting er paragraph (c) of this requirements and procedures polity for Medicaid, including an assessment under section mines the extent of a couple's rese at the time of and attributes to the community share of resources which available for payment re institutionalized spouse's re her process of spending rigibility levels. addresses, and telephone rent State client advocacy State survey and certification rensure office, the State rent, the protection and and the Medicaid fraud control and the Medicaid fraud control at that the resident may file a resident abuse, neglect, and resident property in the repliance with the advance rents. I of part 489 of this chapter rent written policies and reg advance directives. These rele provisions to inform and	B re re no do no do C. rec Me no to the	ceiviviewotific ocum tific ne ad anag tific cum The cord edica tifica the r resi Aud	e medical and billing records for earing Medicare coverage for skilled and to ensure the chart contained contained provided to the resident and tentation regarding provision of the ation was contained within the charministrator has informed by the Ber (or Designee) of responsibilities ation of Medicare non-coverage leenting the issuance in the medical Administrator or designee will awand billing record for each resident are coverage for skilled services mation of Medicare non-coverage leesident and issuance of the letter is dent's chart. It of the required letter of notificat verage will be monitored by the Quittee quarterly.	services was opy of letter appropriate e liability art. Business Offi for issuing tters and record. dit the medic tt receiving onthly to en- tters are provised documente	of cal sure vided d in
	provide written inforcement on concerning the righ or surgical treatment	rmation to all adult residents t to accept or refuse medical nt and, at the individual's n advance directive. This		•			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
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		345520			09.	22/2011
	ROVIDER OR SUPPLIER VOOD NURSING CENTI	ER .	10	EET ADDRESS, CITY, STATE, ZIP CODE 128 BLAIR STREET HOMASVILLE, NC 27360	:	
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F 156	policies to implement applicable State law. The facility must informame, specialty, and physician responsible. The facility must prowritten information, a applicants for admissinformation about he Medicare and Medicare and Medicare refunds for psuch benefits. This REQUIREMENT by: Based on observation facility failed to (1) ditto apply for and use benefits and (2) failed two days in advance Medicare benefits for (Resident #29). The 1. On 09/20/11 at 3:: 7:55 AM, general observation of the medicare was about how to apply for Medicaid benefits of On 09/21/11 at 8:35	scription of the facility's tadvance directives and the advance directives and the advance directives and the way of contacting the se for his or her care. Ininently display in the facility and provide to residents and sion oral and written who apply for and use aid benefits, and how to revious payments covered by the splay information about how Medicare and Medicaid do to provide a written notice of discontinuation of the facility of the servation of the building was as no posting of information or and use Medicare and served in the facility. AM, the social worker was ked around and stated that	F 156			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A BUIL	(X2) MULTIPLE CONSTRUCTION A BUILDING			S S	
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F 156	interviewed. He stat Medicaid information social worker but not not know when they	e 3 AM, the administrator was ed that Medicare and had been posted by the withey were missing. He did started missing. He stated social worker to post them	F	156			
	Business Office Mar Resident #29 receiv 7/6/11 - 8/5/11. The Administrative Nurse	w on 9/21/11 at 4:30 PM, the nager (BOM) indicated that ed Medicare benefits from BOM indicated that e #2 was responsible for if Medicare non-coverage			•		
F 221	Administrative Nurs aware that Residen had terminated whe however, she had n was her responsibil non-coverage letter said that no notifica #29 or the responsi coverage was endir 483.13(a) RIGHT T	O BE FREE FROM	1	= 221			
SS=C	The resident has the physical restraints in	AINTS e right to be free from any mposed for purposes of nience, and not required to	(1)	appr restr	n finding during survey that rest coaches listed in goal number to aint reduction program) the can ad that approaches for restraint	vo for (partic re plan was re	ipates in a eviewed and
	treat the resident's	medical symptoms.	74.7				
	This REQUIREME	NT is not met as evidenced	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				

PRINTED: 10/03/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С B. WING 345520 09/22/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1028 BLAIR STREET** LIBERTYWOOD NURSING CENTER THOMASVILLE, NC 27360 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 221 Continued From page 4 F 221 by: in goal number one. (see attached careplan) careplan will be Based on observation, record review, staff updated to include outcomes for goal #2. interview and policy review the facility failed to (1b) Upon finding during survey that resident #51, her restraint provide a specific medical symptom for the use of order dated 1/31/2011, had not been reviewed. The physician a restraining device, and to provide a gradual was notified and will review and update order upon screening by process in reducing the restraining device for one the physical therapist. PT notified and conducted screen on (1) of one (1) sampled residents using a resident #51 with recommendations to change wheel chair and restraining device. (Resident #51) cushion for positioning. (1c) Upon finding during survey that resident #51 was not coded Findings Include: as having a restraint, physical therapy was asked to do a screen for possible restraint reduction. It was recommended by PT to Review of the facility policy titled "Policy: change wheel chair related to sagging and to add new profile Restraints - Physical" (undated) read: "It is the cushion for positioning. Physician order on 10/11/2011 to policy of this facility that restraints only be used for the safety and well being of the residents and discharge lap buddy and anti-thrust cushion. only after other alternatives have been tried (1d) Upon finding during survey that resident #51 was found to unsuccessfully." The Procedures for the policy be unable to remove her lap buddy upon command. Resident had included the following: been previously coded as being able to remove lap buddy but "Restraints will only be used after other had not recently been assessed. It was recommended by PT to alternatives have been tried unsuccessfully change wheel chair related to sagging and to add new profile and/or only with informed consent." cushion for positioning. Physician order on 10/11/2011 to "Orders indicate the specific reason, type, and discharge lap buddy and anti-thrust cushion. Resident care plan period of time for the use of restraints. Restraints has been changed to reflect this change. must be used only as a last resort, and the 2) An audit of all residents requiring lap buddy's was conducted with medical record must indicate the events leading the Carolina Center for Medical Excellence representative (Maria up to the necessity of the restraint." Fisher) and staff. Residents identified will be assessed for possible "Orders for restraints must be reviewed and restraint reduction. renewed on a routine basis (i.e., with each routine 3) All residents whose restraints are reduced will be followed by risk visit by the attending physician)." program x 4 weeks for further possible reduction of restraints. In "A resident placed in restraint will be checked at addition, all restraints will be addressed on a weekly basis for least every thirty (30) minutes by nursing personnel." possible restraint reduction x 4 weeks. All residents on restraint "The opportunity for motion and exercise is monitoring will be added to the restorative program to ensure provided for a period of at least ten (10) minutes approaches including release and exercises every 2 hours. A shift by

FORM CMS-2567(02-99) Previous Versions Obsolete

during each (2) hours in which restraints are

Resident # 51 was admitted 4/1/2006 and

employed, except at night,"

Event ID: RUDI11

shift in-service will be conducted to all nursing staff on the facilities

4) All restraint reductions were added to the monthly Quality

Assurance meeting to monitor compliance. All restraints will be addressed at the quarterly QA which is attended by the Medical

Director. As directed by DHHS, CCME was contacted and facility met with Maria Fisher for guidance for the POC concerning restraints. Copies of questionnaires and checklist were given to the

policy and procedure with regards to constraints.

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD	TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	
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F 221	Review of the active Care Plan problem w that read, in part "req	011 with diagnoses ion, hyperlipidemia, s disease and depression. medical record revealed a ith an onset date of 9/5/2011 uries use of lap buddy as	given to restraint quarter	of Nursing to aide in restrain aint reduction for monitoring and DON. The facility will incorreduction plan and will addrest QA meetings to determine coil compliance will be completed.	along with audit to porate their sugges as progress in mon	ools were stions into ou nthly and
	least restrictive restrato history of falls with forward in wheelchair The goal for this probwill be maintained in from injury." The application of the problem of the prob	aint when in wheelchair due significant injury, leans r and has poor trunk control." olem read "(Resident #51) proper position and kept free proaches for this goal erapy/Occupational Therapy entervention and to ensure aint" to restraint use and use e possible" mfort at least every ½ hour		11/2	21/11	
	revealed a physician "may be oob (out of tanti-thrust cushion and positioning per PT/O documentation in the	al record for Resident #51 order dated 1/31/11 for ped) in w/c (wheelchair) with and lap buddy for safety and T." There was no a medical record of this order newed after this date.				
		cant Change Minimum Data ant dated 2/9/11 revealed				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		. 345520	B. WING	<u></u>		1	C 2/2011
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F 221	Review of the most re Data Set (MDS) asserevealed that the resic cognitively impaired a requiring the assistant and toileting. She als assistance of one per off the unit but could eset up. The MDS indinot have functional linextremities but that shonly stabilize with assistanted to a standing mot coded as having a assessment. Review of the Nursing pm read "res (residen assisted to floor by Clinjury noted VS (vital and Doctor) aware" Review of the Falls In (dated 9/21/11) for the fall revealed, in part, to statement of witnesses below lap buddy so stoyert injury noted." The Tor chair evaluation Falls Investigation World Further review of the fall reverse of the statement of witnesses and the statement of witnesses are statement of witnesses	ecent quarterly Minimum sement dated 7/8/11 dent was moderately and was totally dependent ce of two staff for transfer or required limited son for locomotion on and eat with encouragement and located that Resident #51 did nitation in her upper or lower ne was unsteady and could istance when moving from a position. Resident #51 was a physical restraint on this and total process of the process o	F2	221			
	observation of Reside	ent #51 on 9/19/11at 12:30					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 221	being assisted with lu wheelchair and had a Observation of Resid	lent was in the dinning area nch. She was seated in her	F 221				
	lap buddy in place. Release or remove he to attempt to remove. Interview with Nurse revealed that she had ever remove her lab be	tesident #51 was unable to r lap buddy when requested it. #3 on 9/22/11 at 2:41 PM I not seen Resident #51 buddy. She further stated the resident was capable of					
F 278 SS=D	On 9/22/11 at 2:42 Pl Administrative Nurse #51 had been assess rails but that the use of restrictive device had asked what the medic was, Administrative N the resident's fall risk. 483.20(g) - (j) ASSES	Interview with the #1 revealed that Resident ed for the use of her side of the lap buddy as the least not been assessed. When tal indication for the restraint turse #1 stated that it was	F 278				
	resident's status. A registered nurse mu each assessment with participation of health A registered nurse mu assessment is complete.	professionals. ust sign and certify that the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.) MULTIP BUILDING	LE CONSTRUCTION	(X3) DATE SUR COMPLET	
		345520		MNG		09/2:	2/2011
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	1D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 278	Continued From page assessment must sign that portion of the ass	n and certify the accuracy of		F 278			
Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.		 Upon finding during survey that resident #51 was not coded as having a restraint, physical therapy was asked to do a screen for possible restraint reduction. It was recommended by PT to change wheel chair related to sagging and to add new profile cushion for positioning. Physician order on 10/11/2011 to discharge lap buddy and anti-thrust cushion. An audit of all residents requiring use of a lap buddy, was conducted on all residents with lap buddy's to ensure proper coding. 					
			3) DON/ designee along with interdisciplinary team, will conduct weekly meetings to discuss issues involving restraints. Any significant changes requiring coding changes will be addressed and corrected at that meeting.				
:	by: Based on record revi interviews, the facility	is not met as evidenced iew, observations and staff failed to code the use of a	4) All month	reside ily QA	nts requiring a coding change will and quarterly QA meetings.	be monitore	ed at the
		the Minimum Data Set for npled residents for physical #51)			11/2	.1/4	
	Findings include:						
	Resident # 51 was ac readmitted on 1/15/20 including: hypertensi dementia, Parkinson'	011 with diagnoses					
	revealed a physician' "may be oob (out of b	al record for Resident #51 s order dated 1/31/11 for ped) in w/c (wheelchair) with nd lap buddy for safety and r."			-		

ENTERS FOR MEDIC	ARE & MEDICAID SERVICES		LTIPLE CONSTRUCTION	(X3) DATE S	URVEY		
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ME OF PROVIDER OR SUPF	LIER		STREET ADDRESS, CITY, STATE, ZIP C 1028 BLAIR STREET	, ODL			
IBERTYWOOD NURSIN	G CENTER .		THOMASVILLE, NC 27360	or conduction	(X5)		
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F 278 Continued F	rom page 9	F	278				
Cat (MDS)	le Significant Change Minimum Data Issessment dated 2/9/11 revealed 1 was not coded as having a physical						
Data Set (A revealed the cognitively requiring the and toileting assistance off the unit set up. The not have freezer mittee only stabilities seated to not coded assessment.	ne most recent quarterly Minimum (IDS) assessment dated 7/8/11 at the resident was moderately impaired and was totally dependent e assistance of two staff for transfer g. She also required limited of one person for locomotion on and but could eat with encouragement and e MDS indicated that Resident #51 did inctional limitation in her upper or lower to but that she was unsteady and could ze with assistance when moving from a a standing position. Resident #51 was as having a physical restraint on this int.						
Observat PM revea lap budd release o to attemp	ir and had a lap buddy in place. ion of Resident #51 on 9/22/11 at 2:40 illed she was up in her wheelchair with a y in place. Resident #51 was unable to ir remove her lab buddy when requested but to remove it. with Nurse #3 on 9/22/11 at 2:41 PM that she had not seen Resident #51 hove her lap buddy. She further stated did not think the resident was capable of			* • • • • • • • • • • • • • • • • • • •			

	TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
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F 278	#51 had been asses rails but that the use restrictive device had asked what the med	M interview with the #1 revealed that Resident sed for the use of her side of the lap buddy as the least d not been assessed. When ical indication for the restraint	F	278	,		×
F 279 SS=D	the resident's fall ri 483.20(d), 483.20(k) COMPREHENSIVE A facility must use the develop, review a comprehensive plan. The facility must deplan for each reside objectives and time medical, nursing, an needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any side to the resident's §483.10, including under §483.10(b)(4)	care plans the results of the assessment and revise the resident's a of care. velop a comprehensive care and that includes measurable tables to meet a resident's and mental and psychosocial diffied in the comprehensive describe the services that are a ttain or maintain the resident's physical, mental, and using as required under ervices that would otherwise services that would otherwise services of rights under the right to refuse treatment services.	F	1.	B. Resident #24 has been reasse updated to include management for possible side effects of anti-	ventions to /22/11 ssed and c of anxiety anxiety me /22/11 ssed and c siving hem	o prevent are plan has been and monitoring dications. are plan has been odialysis and to care for a resider
	by:	NT is not met as evidenced tion, staff interview and record failed to develop		.,	·		

PRINTED: 10/03/2011 FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С R WING 345520 09/22/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1028 BLAIR STREET** LIBERTYWOOD NURSING CENTER THOMASVILLE, NC 27360 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 279 Continued From page 11 F 279 comprehensive care plans for 2 of 20 sampled Each resident with contractures, receiving anti-anxiety residents (Residents #24 and #89). medications or receiving dialysis will be reassessed and care plans will be developed or updated with specific goals and The findings included: interventions necessary to meet each resident's individual 1. Resident #89 was admitted to the facility on needs. 4/24/09. Diagnoses included quadriplegia, dvsarthria, and aphasia. The annual Minimum A. The Interdisciplinary Care Planning Team involved in Data Set (MDS) dated 4/12/11 and the quarterly the assessment or care planning process will be in-serviced MDS dated 7/12/11 indicated that the resident regarding developing and updating comprehensive care had limitation of range of motion in all extremities. plans to establish goals and determine interventions to address each resident's individual needs. Resident #89's care plan dated 9/14/11 listed a problem of requiring assistance with activities of B. Residents #89 and #24will be monitored by the daily living due to quadriplegia and contractures. assessment nurse on a weekly basis x 4 for changes in The goal included, "Will maintain current level of condition related to contractures, side effects of functional abilities" for the next 90 days. The medications, and issues related to dialysis. If these 2 approaches lacked any intervention to prevent residents are stable, they will then be monitored monthly by worsening of contractures. the assessment nurse. Observation of Resident #89 on 9/19/11 at 3:16 PM revealed bilateral wrist and finger C. The Director of Nursing and/or designee will monitor the contractures. No interventions or devices were assessments and care plans of Residents #89 and #24 on a observed to prevent worsening of the monthly basis x 3 months to ensure assessments are contractures. accurate and care plans are updated in a timely manner to prevent complications and prevent worsening of condition. During an interview on 9/22/11 at 11:50 AM, Administrative Nurse #2 acknowledged that A. The Director of Nursing and/or designee will audit MDS Resident #89 should have been care planned for Assessments and Care Plans on a quarterly basis to ensure contractures/range of motion and she would do accuracy of the MDS and care plans that address each so now. B. The Quality Assurance committee will monitor audit 2a. Resident #24 was admitted to the facility on system on quarterly basis to ensure effectiveness 7/6/11. Cumulative diagnoses included anxiety. The admission Minimum Data Set (MDS) dated 7/19/11 revealed that the resident received C. Concerns identified by Quality Assurance Committee

antianxiety medication.

needed.

related to assessment and care planning process will be revised by the Director of Nursing and Administrator as

11/21/4

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F 282	Review of Resider Medication Adminirevealed that Resi antianxiety medica needed. The MAR requested and reciday. During an interview Administrative Nutley 4 should have to management of all of his medication 2b. Resident #24 7/6/11. Cumulative renal disease and orders included he The admission Mi 7/19/11 revealed dialysis. Review of Resident musing care plan received hemodia to provide care for During an interview Administrative Nucare plan should #24 to address his would do so now.	at #24's care plan revealed no eatment of anxiety. It #24's September 2011 stration Record (MAR) dent #24 was on Ativan (an ation) three times a day as indicated that the resident eived the Ativan 1 - 3 times a If w on 9/21/11 at 11:05 AM, are #2 indicated that Resident eiven care planned for exiety and possible side effects and would do so now. If was admitted to the facility on endialysis 3 times a week. In the resident received that the resident on hemodialysis. If w on 9/21/11 at 11:48 AM, are #2 acknowledged a nursing that been done for Resident seeds related to dialysis and ERVICES BY QUALIFIED	F 2	282		
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	FOR MEDICARE & DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIP	LE CONSTRUCTION	(X3) DATE SUR' COMPLETE	
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F 282	Continued From page The services provided by accordance with ear care. This REQUIREMENT by: Based on record reinterview, the facility resident's care plan and catheter care versidents with an infindings include: 1. Resident #80 woo6/13/08 with multiple reention. The quay (MDS) assessment Resident #80 had and had an indwell the care plan date. One of the care plan fection due to the goal was "cathete will be free from upon days". The apleg strap, cathete tubing to avoid te on 06/24/11, these	ge 13 get or arranged by the facility of qualified persons in the resident's written plan of the resident to ensure that the resident to ensure that the resident to the leg strap were implemented for 3 as \$\pi\$ 33 \$\pi\$ \$\pi\$ 31) of 3 sampled and welling urinary catheter. The resident will be resident that severe cognitive impairment the resident was "at risk for the presence of catheter". The resident will remain patent and resident urinary tract infection x (times) represences included the use of a reare every shift and to position	F			entions to pro	plan has been omote proper
	dressing daily.	ecord for September, 2011 was					
	THE HEADINGING	Social tot a chickman to the control of the control					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SUF COMPLET	
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F 282	reviewed. There were days (09/19, 09/20 & the tube site was cle On 09/21/11 at 8:15 observed in bed. The the bed and the cathe wheelchair seat. The and the catheter site site had a small amound it. On 09/21/11 at 8:30 NA #2 did not know also stated that it was assistant who hung the wheelchair seat. On 09/21/11 at 8:45 interviewed. She state were responsible to with indwelling cathetes trap was only used bed. On 09/21/11 at 8:50 was interviewed. She at all times. She also (nurses and nursing to check if the reside on 09/22/11 at 9:05 interviewed. She state were very search of the state of the reside on 09/22/11 at 9:05 interviewed. She state were search of the reside on 09/22/11 at 9:05 interviewed. She state were very search of the reside on 09/22/11 at 9:05 interviewed. She state was clearly the state was clear the was clear to the catheter was clear the was clear	re no nurse's initials for 3 k 09/21/11) to indicate that aned and dressed. AM, the resident was ere was a wheelchair beside eter bag was hung under the re was no leg strap observed had no dressing on it. The unt of fresh and old blood AM, NA #2 was interviewed. What a leg strap was. She is the night shift nursing he catheter bag under the he catheter bag under the he catheter bag under the he when a resident was out of when a resident was out of a stated that all residents with er should have a leg strap on to stated that everybody assistants) was responsible in thad a leg strap or not. AM, the treatment nurse was used that the nurse who works naible for the care of the	3. 4. A is s	upda and C. R upda infector treatment of the assessment of the ass	ated to include specific interventions in the case of a leg strap at the control of the case of a leg strap at the case of a leg	and care plans to prevent and care plans to prevent and cathet ary catheter as have been als and intervidual needs application dered by phyentions based ocumentate onducted. Viced regarding application will be in the hensive care and position and position application criveness.	on has been intercare. and leg in reventions is. In proper in of hysician, is dupontion of his direction o

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F 282	F 282 Continued From page 15 interviewed. She stated that she did not clean and dress the tube site on 09/19, 09/20 and 09/21/11 because she could not find a drain gauze to dress the tube site.		annl	ed to indwelling urinary cat ication process will be revis sing and Administrator as no	ed by the Direc	тар ctor of
	O5/02/10 and was remultiple diagnoses in The admission MDS indicated that Residucognitive impairment urinary catheter. The care plan dated One of the care plan infection due to the goal was "catheter will be free from urin 90 days". The apprileg strap and cathete On 08/31/11, there clean the tube site vapply a clean drain afternoon. The Treatment recoveries was cleaned at On 09/21/11 at 8:30 observed in bed. The observed and the conserved and the conserved in section of the conserved and the conserved in section of the conserved and the conserved in section in the conserved and the conserved in section of the conserved and the conserved in section in the conserved in section of the conserved in section in the conserved	was a telephone order to with NS (normal saline) and to sponge everyday in the ord for September, 2011 was ere no nurse's initials for 2 (1/11) to indicate that the tube and dressed. O AM, the resident was mere was no leg strap eatheter site dressing had a need blood on it. There was no		,	21/11	

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С B. WING 345520 09/22/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1028 BLAIR STREET** LIBERTYWOOD NURSING CENTER THOMASVILLE, NC 27360 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 282 | Continued From page 16 F 282 On 09/21/11 at 8:30 AM, NA #2 was interviewed. NA #2 did not know what a leg strap was. On 09/21/11 at 8:45 AM, Nurse #1 was interviewed. She stated that nursing assistants were responsible to put the leg strap on residents with indwelling catheters. She also stated that leg strap was only used when a resident was out of On 09/21/11 at 8:50 AM, administrative nurse #1 was interviewed. She stated that all residents with an indwelling catheter should have a leg strap on at all times. She also stated that everybody (nurses and nursing assistants) was responsible to check if the resident had a leg strap or not. On 09/22/11 at 9:05 AM, the treatment nurse was interviewed. She stated that the nurse who works 3-11 shift was responsible for the care of the indwelling catheters. On 09/22/11 at 3:47 PM, Nurse # 2 was interviewed. She stated that she did not clean and dress the tube site on 09/20 and 09/21/11 because she could not find a drain gauze to dress the tube site. 3. Resident #31 was admitted to the facility on 12/21/08 with multiple diagnoses including neurogenic bladder. The admission MDS assessment dated 08/16/11 indicated that Resident #31 had moderate cognitive impairment and had an indwelling urinary catheter.

The care plan was reviewed. One of the care plan problems was "at risk for infection due to the PRINTED: 10/03/2011

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F 282	remain patent and resurinary tract infection approaches included catheter care every signature. On 09/21/11 at 8:20 A observed in bed. He is and there was no leg the catheter. On 09/21/11 at 8:30 A NA #2 did not know with the control of the catheter. On 09/21/11 at 8:45 A interviewed. She stat were responsible to p with indwelling cathet	The goal was "catheter will sident will be free from x (times) 90 days". The the use of a leg strap and hift. AM, Resident #31 was nad an indwelling catheter strap observed to anchor AM, NA #2 was interviewed.	F 282			
	was interviewed. She an indwelling catheter at all times. She also (nurses and nursing a to check if the resident 483.25(d) NO CATHE RESTORE BLADDER Based on the resident assessment, the facility resident who enters the indwelling catheter is resident's clinical concatheterization was now ho is incontinent of the statement of the statement and the stat	t's comprehensive ty must ensure that a	F 315			

PRINTED: 10/03/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 345520 09/22/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1028 BLAIR STREET** LIBERTYWOOD NURSING CENTER THOMASVILLE, NC 27360 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL). PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY** F 315 Continued From page 18 F 315 infections and to restore as much normal bladder A. Resident #80 has been reassessed and care plan has been function as possible. updated to include specific interventions to promote proper use of a leg strap and catheter care. This REQUIREMENT is not met as evidenced B. Resident #83 has been reassessed and care plan has been updated to include specific interventions related to catheter Based on record review, observation and staff and skin care interview, the facility failed to secure the indwelling urinary catheter to prevent excessive C. Resident #31 has been reassessed and care plan has been tension which can lead to dislodging the catheter for 3 (Residents #80, #83 & #31) of 3 sampled updated to include specific interventions to prevent residents with an indwelling urinary catheter. The infection with proper use of a leg strap and catheter care. facility also failed to clean and dress the urinary catheter site as ordered for 2 (Resident #80 & Each resident with an indwelling urinary catheter and leg #83) of 3 sampled residents. The findings strap has been reassessed and care plans have been include: developed or updated with specific goals and interventions necessary to meet each resident's individual needs. 1a. Resident #80 was admitted to the facility on A. All licensed nurses will be in-serviced regarding proper 06/13/08 with multiple diagnoses including urinary indwelling urinary catheter care, usage application of retention. The quarterly Minimum Data Set catheters and leg straps, treatments ordered by physician, (MDS) assessment dated 07/15/11 indicated that properly implementing care plan interventions based upon Resident #80 had severe cognitive impairment routine standards of care and accurate documentation of and had an indwelling urinary catheter. treatments provided and assessments conducted. The care plan dated 06/14/11 was reviewed. One of the care plan problems was "at risk for B. All nursing assistants will be in-serviced regarding infection due to the presence of catheter". The proper indwelling urinary catheter care, usage application goal was "catheter will remain patent and resident of catheters and leg straps. will be free from urinary tract infection x (times)

90 days". The approaches included the use of a leg strap, catheter care every shift and to position

Review of the urology consult notes revealed that on 08/29/11, Resident #72 was sent for a urology

tubing to avoid tension/pulling.

consult due to leakage from penis and no drainage from the suprapubic tube. The urology C. The Policy and Procedure regarding Urinary

Incontinence and Indwelling Urinary Catheter will be revised and updated as needed. All direct care staff will be inserviced regarding the updated policy and procedure.

D. Each resident with a catheter will be monitored by the Director of Nursing and/or designee for correct usage of catheter, pericare, proper application of leg strap and

NAME OF PROVIDER OR SUPPLIER LIBERTYWOOD NURSING CENTER LIPENTX CENTER AND FOR CENTER OF CONSISTENCE OF THE MEREY LIPENTX CENTER AND FOR CENTER OF THE MEREY LIPENTX CHOOSENER PRECEDED BY FULL PREFIX TAG PREFIX TAG PROMISERS PLAN OF CORRECTIVE ACTORS SHOULD BE CROSS-REFERENCEGO TO THE APPROPRIATE PREFIX TAG PROMISERY EAPL OF CORRECTIVE ACTORS SHOULD BE CROSS-REFERENCEGO TO THE APPROPRIATE LIPENTX CROSS-REFERENCEGO TO THE APPROPRIATE PREFIX TAG PREFIX TAG PREFIX TAG PROMISERY EAPL OF CORRECTIVE ACTORS SHOULD BE CROSS-REFERENCEGO TO THE APPROPRIATE LIPENTX TAG F 315 POSITIONING F 315 POSI	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 315 Continued From page 19 notes revealed that the suprapuble tube was not in correct position. On 09/21/11 at 8:15 AM, the resident was observed in bed. There was a wheelchair beside the bed and the catheter bay was hung under the wheelchair seat. There was no leg strap observed and the catheter site had no dressing on it. The site had a small amount of fresh and old blood around it. On 09/21/11 at 8:30 AM, NA #2 was interviewed. NA #2 did not know what a leg strap was. On 09/21/11 at 8:45 AM, Nurse #1 was interviewed. She stated that hursing assistants were responsible to put the leg strap or at all times to secure the catheter. She also stated that all residents with an indwelling catheters. She stated that all residents with an indwelling catheter should have a leg strap on at all times to secure the catheter. She also stated that everybody was responsible to check if the resident had a leg strap or not. 1b. Resident # 80 was admitted to the facility on 06/13/08 with multiple diagnoses including urinary retention. The quarterly Minimum Data Set			R		1	028 BLAIR STREET		
notes revealed that the suprapubic tube was not in correct position. On 09/21/11 at 8:15 AM, the resident was observed in bed. There was a wheelchair beside the bed and the catheter bag was hung under the wheelchair seat. There was no leg strap observed and the catheter site had no dressing on it. The site had a small amount of fresh and old blood around it. On 09/21/11 at 8:30 AM, NA #2 was interviewed. NA #2 did not know what a leg strap was. On 09/21/11 at 8:45 AM, Nurse #1 was interviewed. She stated that nursing assistants were responsible to put the leg strap on residents with an indwelling catheters. She also stated that leg strap on at all times to secure the catheter. She also stated that everybody was responsible to check if the resident had a leg strap or not. 1b. Resident # 80 was admitted to the facility on 06/13/08 with multiple diagnoses including urinary retention. The quarterly Minimum Data Set	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	ΙX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
Resident #80 had severe cognitive impairment and had an indwelling urinary catheter. The care plan dated 06/14/11 was reviewed. One of the care plan problems was "at risk for infection due to the presence of catheter". The	F 315	notes revealed that the in correct position. On 09/21/11 at 8:15 A observed in bed. The the bed and the cathet wheelchair seat. Then and the catheter site is site had a small amount around it. On 09/21/11 at 8:30 A NA #2 did not know where the catheter site is site had a small amount around it. On 09/21/11 at 8:45 A interviewed. She state were responsible to p with indwelling catheter strap was only used where the catheter at all times to secure at all times at all times to secure at all times at all	MM, the resident was are was a wheelchair beside ther bag was hung under the ewas no leg strap observed and no dressing on it. The ant of fresh and old blood MM, NA #2 was interviewed. That a leg strap was. MM, Nurse #1 was ed that nursing assistants at the leg strap on residents ers. She also stated that leg when a resident was out of the catheter. She also was responsible to check if strap or not. MM, administrative nurse #1 stated that all residents with a should have a leg strap on the catheter. She also was responsible to check if strap or not. MM, administrative nurse #1 stated that all residents with a should have a leg strap on the catheter. She also was responsible to check if strap or not. MM, administrative nurse #1 stated that all residents with a should have a leg strap on the catheter. MM, administrative nurse #1 stated that all residents with a should have a leg strap on the catheter. MM, administrative nurse #1 stated that all residents with a should have a leg strap on the catheter. MM, administrative nurse #1 stated that all residents with a should have a leg strap on the catheter. MM, administrative nurse #1 stated that leg catheter. MM, administrative nurse #1 stated that leg catheter. MM, administrative nurse #1 stated that leg with a stated that leg catheter. MM, administrative nurse #1 stated that leg with a stated that leg with a stated that leg catheter. MM, administrative nurse #1 stated that leg with a state	4. A ii s	oosit A. T ndw yste b. Co elate pplie	ioning of catheter tubing, weekly x he Quality Assurance committee welling urinary catheter and leg strapm on quarterly basis to ensure effect oncerns identified by Quality Assured to indwelling urinary catheter catheter in the cation process will be revised by the ng and Administrator as needed.	vill monitor o application ctiveness. rance Comm	n audit

CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 315	goal was "catheter wi will be free from urina 90 days". The approaleg strap, catheter car tubing to avoid tension. On 06/24/11, there was clean the tube site and dressing daily. The Treatment record reviewed. There were days (09/19, 09/20 & the tube site was clean. On 09/21/11 at 8:15 A observed in bed. The dressing on it. The siftensh and old blood at 0n 09/22/11 at 9:05 A interviewed. She stat 3-11 shift was resport indwelling catheters. On 09/22/11 at 3:47 Finterviewed. She stat and dress the tube sit 09/21/11 because she gauze to dress the tube 2 a. Resident #83 was 05/02/10 and was resmultiple diagnoses income the site of the s	Il remain patent and resident ry tract infection x (times) aches included the use of a re every shift and to position in/pulling. as a telephone order to d to apply new gauze If for September, 2011 was a no nurse's initials for 3 09/21/11) to indicate that ined and dressed. MM, the resident was a catheter site had no te had a small amount of round it. MM, the treatment nurse was and that the nurse who works insible for the care of the could not find a drain one site. BM, Nurse # 2 was and that she did not clean a could not find a drain one site. BM admitted to the facility on admitted on 08/02/11 with cluding neurogenic bladder. The assessment dated 08/16/11 in the site including neurogenic bladder.	F	315				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
	ROVIDER OR SUPPLIER	345520 ER	STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360				
(X4) ID PREFIX TAG	(FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION		
F 315	The care plan dated One of the care plan infection due to the goal was "catheter will be free from uring the goal was." The apprileg strap and for care on 09/21/11 at 8:30 observed in bed. The observed and the commall amount of dring the goal of	in problems was "at risk for presence of catheter". The will remain patent and resident mary tract infection x (times) roaches included the use of a theter care every shift. O AM, the resident was here was no leg strap atheter site dressing had a ed blood on it O AM, NA #2 was interviewed. What a leg strap was. S AM, Nurse #1 was tated that nursing assistants or put the leg strap on residents heters. She also stated that leg d when a resident was out of O AM, administrative nurse #1 the stated that all residents with ever should have a leg strap on re the catheter. She also body was responsible to check if	F 315				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	· · · · · · · · · · · · · · · · · · ·		
		345520	B. WNG		09/2	2/2011
	OVIDER OR SUPPLIER VOOD NURSING CENTE	R	1	REET ADDRESS, CITY, STATE, ZIP CODE 028 BLAIR STREET THOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X6) COMPLETION DATE
F 315	Continued From page	22	F 315			
	One of the care plan infection due to the progoal was "catheter wiwill be free from urina	06/14/11 was reviewed. problems was "at risk for resence of catheter". The Il remain patent and resident rry tract infection x (times) aches included the use of a				
	On 08/31/11, there we clean the tube site with	as a telephone order to th NS (normal saline) and to conge everyday in the			;	·
	reviewed. There were	for September, 2011 was e no nurse's initials for 2 '11) to indicate that the tube dressed.				
	interviewed. She stat	AM, the treatment nurse was led that the nurse on floor ne care of the indwelling				
	and dress the tube si	PM, Nurse # 2 was ted that she did not clean te on 09/20 and 09/21/11 ot find a drain gauze to dress				
	12/21/08 with multiple neurogenic bladder. assessment dated 08	The admission MDS /16/11 indicated that derate cognitive impairment	·			
_	The care plan was re	viewed. One of the care				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345520	B, WNG		09	C /22/2011	
	COVIDER OR SUPPLIER	ER	102	ET ADDRESS, CITY, STATE, ZIP CODE 8 BLAIR STREET DMASVILLE, NC 27360			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 315	plan problems was presence of cathete remain patent and a urinary tract infection approaches include for catheter care even on 09/21/11 at 8:20 observed in bed. He and there was no let the catheter. On 09/21/11 at 8:30 NA #2 did not know on 09/21/11 at 8:40 interviewed. She swere responsible to with indwelling catheters.	"at risk for infection due to the er". The goal was "catheter will resident will be free from on x (times) 90 days". The ad the use of a leg strap and	F 315				
F 318 SS=D	was interviewed. S an indwelling cathe at all times to secu stated that everybo assistants) was res resident had a leg 483.25(e)(2) INCR IN RANGE OF MO Based on the compresident, the facilit with a limited rang appropriate treatm	EASE/PREVENT DECREASE PTION prehensive assessment of a symust ensure that a resident e of motion receives ent and services to increase ad/or to prevent further	F 318				

PRINTED: 10/03/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A, BUILDING C B, WING 09/22/2011 345520 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1028 BLAIR STREET** LIBERTYWOOD NURSING CENTER THOMASVILLE, NC 27360 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY F 318 F 318 | Continued From page 24 A. Resident #89 has been reassessed and care plan has been updated to include specific interventions to prevent This REQUIREMENT is not met as evidenced worsening of contractures. Based on observation, staff interview and record B. Based upon Physical Therapy recommendations, review, the facility failed to provide services to resident #89 will receive restorative nursing services for prevent worsening of contractures for 1 of 3 range of motion and splinting to prevent decline in range of sampled residents (Resident #89). motion or worsening of contractures. The findings included: A. Each resident with contractures will be reassessed and care plans will be developed or updated with specific goals Resident #89 was admitted to the facility on and interventions necessary to meet each resident's 4/24/09. Diagnoses included quadriplegia, individual needs related to preventing decline in range of dysarthria, and aphasia. The annual Minimum Data Set (MDS), dated 4/12/11 and the quarterly motion or worsening contractures. MDS dated 7/12/11 indicated that the resident had limitation of range of motion in all extremities. B. Each resident with decline in range of motion or

worsening of contractures.
3. A. Resident # 89 will be monitored by the assessment nurse on a weekly basis x 4 for changes in condition related to contractures. If resident is stable, will then be monitored monthly by the assessment nurse.

contractures will be evaluated for potential restorative

services to prevent further decline in range of motion or

B. The Director of Nursing or designee will monitor the restorative services provided to Resident #89 on a monthly basis x 3 months to ensure services are provided to prevent complications and prevent worsening of contractures.

The care plan, last reviewed 9/14/11, listed a

functional abilities" for the next 90 days. The

worsening of contractures.

approaches lacked any intervention to prevent

Review of restorative nursing form dated April

2011 revealed that passive range of motion and splinting to upper extremities were discontinued.

Observation of Resident #89 on 9/19/11 at 3:16

PM revealed bilateral wrist and finger

problem of requiring assistance with activities of

daily living due to quadriplegia and contractures.

The goal included, "Will maintain current level of

contractures.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		С
		345520	B. WING		09/22/2011
	ROVIDER OR SUPPLIER WOOD NURSING CENTE	R	1	REET ADDRESS, CITY, STATE, ZIP CODE 028 BLAIR STREET 'HOMASVILLE, NC 27360	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 318	Physical Therapist (P services for range of be beneficial in preve motion or worsening #89. 483.25(I) DRUG REG UNNECESSARY DR Each resident's drug unnecessary drugs. drug when used in ex duplicate therapy); or without adequate mo indications for its use adverse consequences hould be reduced or combinations of the r Based on a compreheresident, the facility in who have not used a given these drugs un therapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral interventices.	any progress. In 9/22/11 at 2:00 PM, the PT) indicated that restorative motion and splinting would enting a decline in range of of contractures for Resident GIMEN IS FREE FROM UGS regimen must be free from An unnecessary drug is any accessive dose (including for excessive duration; or nitoring; or without adequate ; or in the presence of es which indicate the dose of discontinued; or any easons above. ensive assessment of a must ensure that residents intipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic drug and dose reductions, and	ra ba fiu con qua B. (The Director of Nursing or design storative services provided to each nge or motion or worsening contracts x 3 months to ensure services and ther decline in range of motion and natractures. The Quality Assurance committee stracture and restorative services and reterly basis to ensure effectiveness. Concerns identified by Quality Assured to restorative services and preve of motion or worsening of contracte of motion or worsening and Administracture.	resident with decline in ctures on a monthly re provided to prevent I prevent worsening of will monitor dit system on arance Committee ention of decline in
	This REQUIREMENT	is not met as evidenced			

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03							
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY	
		345520	B. WING			C 2/2011	
	ROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP COD 1028 BLAIR STREET THOMASVILLE, NC 27360		.2.2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 329	by: Based on record revifacility failed to monitor level as ordered for 1 sampled residents. The Resident #72 was addressed of the sampled residents. The Resident #72 was addressed of the sampled residents and The quarterly MDS as indicated that Resider decision making problem. Review of the physicial 2011 revealed that Refor Hypertension. On serum Potassium lever (milliequivalent)/L (lite 3.5 meq/L - 5.3 meq/L) The package insert from Zestril indicated that the Hyperkalemia (high Potacommended to check frequently. On 06/03/11, the pharm high serum Potassium recommended to repermetabolic panel) which There was no evidence upon this recommended. On 09/01/11, Resident physician. The progre	ew and staff interview, the or the serum Potassium (Resident #72) of 10 he finding includes: nitted to the facility on diagnoses including ry Artery Disease (CAD), d Fibromyalgia. sessment dated 07/20/11 ht #72 had no memory and ems. In's order for September, sident #72 was on Zestril 05/03/11, the resident's I was high, 5.9 meq r). The normal range was of the drug can cause obtassium level) and k serum Potassium level macist had addressed the level to nursing and at the BMP (basic in included Potassium level, e that the facility acted ation.	B. folional staff obtar phys communications are communicated as the contract of the contract o	esident #72's physician orders, armacy consultant reviews and ll be audited and laboratory terformed as ordered. Medical records for all residents ordered will be audited to enformed as ordered Pharmacy recommendations who will be prosecuted in the processing staff regarding policy and follow up of laboratory tests be the process and pharmacy recommendation of laboratory request follow up of laboratory request follow up of laboratory request follow in the process of the process o	or Pharmacy will audit medicate performed as or exitle laboratory to the procedure for obtained upon physications, accurate forms, and accurate forms, and accurate forms and accurate forms are performed as or the all licensed nurse of the all licensed nurse or the all licensed	y blood ests are ensure end taining the and end end end end end end end end end e	

		MEDICAID SERVICES	(X2) ML	JLTIPLE C	CONSTRUCTION	(X3) DATE SURVI	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL				
,410 24101		•	B. WIN			09/22/	2011
•		345520	B. Will			USIZZI	2011
	OVIDER OR SUPPLIER			1028	ADDRESS, CITY, STATE, ZIP CODE BLAIR STREET		
LIBERTYV	WOOD NURSING CENTE			THO	MASVILLE, NC 27360 PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(CACU DESIGNATION)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	COMPLETION DATE
F 37	Continued From page 27 the BMP. As of 09/21/11, there was no BMP drawn. On 09/21/11 at 4:32 PM, the administrative nurse #1 was interviewed. She stated that she did not know where the pharmacist recommendations were kept and who was responsible. She also stated that there was no policy when to draw the labs (laboratory) as ordered. She indicated that when labs were ordered the nurse who carried out the order had to fill out the request form and had to enter it in the lab book to be drawn. She stated that there was no lab request filled out and it was not entered in the lab book to be drawn. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to discard outdated food in the kitchen refrigerator/dry storage room, failed to date open food in the freezer and failed to monitor the freezer temperature in 2 (100 & 200 hall)of 2 nourishment refrigerators. The findings include:		D. Director of Nursing, Administrator and Medical Director will ensure Policy and Procedure regarding laboratory tests has been reviewed and will be revised and updated as needed 4. Quality Assurance Committee will review Policy and Procedure regarding laboratory tests and will recommend to Administrator if the policy needs to be revised and updated				
			B. Dated open food in the freezer if it had not exceeded appropriate time frame C. Checked freezer temperature in nourishment refrigerators D. On 9/21/11, a new policy on Nourishment rooms/Refrigerators was provided to the survey team whice indicates nursing will check the temperatures in the nourishment refrigerator and freezer in a.m. and p.m. and housekeeping will be responsible for cleaning/defrosting the freezer.				
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CENTER	10 LOK MEDICAKE &	MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED		
		345520	8. W	MNG		C 09/22/2011		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE			
! IRERTY	WOOD NURSING CENTE	D		1028 BLAIR STREET	,			
CIDENTI	HOOD HOROMO CLIVIE	in.		THOMASVILLE, NC 27	360			
(X4) ID		ATEMENT OF DEFICIENCIES	1	D PROVIDER'S	S PLAN OF CORRECT	ION (X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		EFIX (EACH CORRE AG CROSS-REFERE	CTIVE ACTION SHOU NCED TO THE APPRO	LD BE COMPLETION		
	,		1	The following have been	DEELOJENOVO	7,10,112		
			2.	The following have been	i implemented.	-		
F 371	Continued From page	e 28		A. Food in kitchen refrig	gerator/storage r	room will be		
	1. The facility's policie	es on leftover food (undated)		discarded as dates expire				
		e dated 05/27/09 were	Ì	•				
		on leftovers read in part		B. Open food in the free	zer will be date	d when opened		
		within 48 hours (by next ble)". The policy on cold				•		
		part "food item/example		C. Freezer temperature i		efrigerators will be		
		nd cooked items such as		checked twice daily by n	iursing staff			
		o use in 3 days after placing		D. Policies have been w	ndated regardin	a laftarray food sald		
in refrigerator and 30 days after placing in			D. Policies have been updated regarding leftover food, cold food storage; and bulk food storage					
	freezer".		1	room ototugo, und outk r	ood storage			
	On 09/19/11 at 10:40	AM, an initial tour of the		E. Dietary manager is re-	sponsible for ch	ecking the		
		d. There was a package of		expiration dates of all for				
	mini marshmallow wit	h expiration date of				- '		
		observed in the dry storage		F. Inservice has been pro	ovided to dietary	manager and		
		efrigerator, there was an that was not dated or	dietary staff regarding expiration dates					
	sealed.	anat was not dated of		G. Buildup of ice on top	of from the land	nam a1aa1		
				Maintenance will be resp				
	On 09/19/11 at 10:45	AM, the dietary manager		and ensuring ice is remov				
	was interviewed. She	e stated that she was ing the expiration dates of		freezer.	· ·	, , , , , , , , , , , , , , , , , , ,		
	all food items in the s	torage room. She further						
		t think that marshmallow		H. Nursing staff will che				
		e, so she did not check it.	(clean the nourishment re	frigerators week	dy		
		he dietary aide should have	1	I. Housekeeping will elea	on the freezer se	notion of the		
	putting it in the refrige	pack of lettuce before		nourishment refrigerator				
	pateng it in the tenige	idoi.	•		on a weekly ou	ois of as needed.		
	2. On 09/21/11 at 10:	30 AM, a kitchen tour was	3.	A. Inservice education w	ill be provided	to all dietary and		
		ip lock bag of chicken		nursing staff regarding th		ĺ		
		k bag of chopped nuggets	_					
were observed in the refrigerator dated 09/17/11. On 09/21/11 at 10:38 AM, the dietary manager		J	B. Monitoring of dietary	action steps ide	ntified above will			
			be conducted by the admi	mistrator or des	ignee on a monthly			
	was interviewed. She	stated that leftover foods	· ·	70010				
		and she discarded both	4. 7	The administrator will rep	port to Onality	Assurance on a		
	bags.		1 0	quarterly basis regarding	the dietary and	nourishment		
DRM CMS-256	7(02-99) Previous Versions Obs	olete Event ID; RUDI	11 0	compliance issues identif	ied above.			
200	, top to make the series of the	EYEIL ID, KUDI	• •	+ aciasy 10. 20020000	If cor	ntinuation sheet Page 29 of 34		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	•	345520	B. WING		C 09/22/2011
	OVIDER OR SUPPLIER	R	10	EET ADDRESS, CITY, STATE, ZIP CODE 028 BLAIR STREET HOMASVILLE, NC 27360	03/22/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
	refrigerators on 100 & Inside the freezer of ton the 200 hall, there stored and the ice creathere was a big build freezer. On 09/21/11 at 10:55 nurse #1 was intervie facility staff was check fridge but not the free On 09/21/11 at 11:00 Dietician was intervies staff should check the in the nourishment re "right now nobody was the temperature of the cleaning/defrosting the On 09/21/11 at 4:30 fon Nourishment room provided. The policy check the temperature freezer in AM and PM responsible for cleaning.	45 AM, the nourishment a 200 halls were observed. The nourishment refrigerator were several ice cream are were noted to be soft. The property of the administrative wed. She stated that the king the temperature of the zer. AM, the Registered wed. She stated that the atemperature of the freezer frigerators. She added that is responsible for checking a freezer and in a freezer. PM, a copy of the new policy as/Refrigerators was indicated that nursing will see on the refrigerator and and housekeeping will be ing/defrosting the freezer. GIMEN REVIEW, REPORT	F 371	DEFICIENCY	
	reviewed at least onc pharmacist. The pharmacist must the attending physicia	each resident must be e a month by a licensed report any irregularities to an, and the director of ports must be acted upon.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		The state of the s	A. BUILDI	NG			
		345520	B. WING_		1	2/2011	
NAME OF PROVIDER OR SUPPLIER LIBERTYWOOD NURSING CENTER			REET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360	1 00/2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	(X5) COMPLETION DATE	
F 428	Continued From page	∋ 30	1.	boratory re harmacy co have now l	onsultations been		
	This DEGLIDENSENT	Lo not most an ovidence d	2.	A. Medical records for all residents with laboratory blood teats ordered will be audited to ensure laboratory tests are performed as ordered			
	by: Based on record revipharmacist failed to rephysician and/or direct repeat serum Potassi by the pharmacist and #72) of 10 sampled resincludes: Resident #72 was add 03/29/11 with multiple Hypertension, Coron Pernicious Anemia are The quarterly MDS as indicated that Resided decision making probect Review of the physicia 2011 revealed that Refor Hypertension. On serum Potassium leve (milliequivalent)/L (lite 3.5 meq/L - 5.3 meq/L The package insert for Zestril indicated that the Hyperkalemia (high Potassian and procession and	mitted to the facility on e diagnoses including ary Artery Disease (CAD), and Fibromyalgia. seessment dated 07/20/11 ant #72 had no memory and lems. an's order for September, esident #72 was on Zestril 05/03/11, the resident's el was high, 5.9 meq ar). The normal range was form the manufacturer of the drug can cause	3.	B. Pharmacy recommendations will follow up on each recommendation C. Inservice education will be provuling staff regarding policy and pland follow up of laboratory tests based orders and pharmacy recommendation of laboratory request for timely documentation of laboratory D. Policy and Procedure regarding payorates and Procedure regarding payorates and will be revised. A. Director of Nursing or designed varieties monthly for all residents with ordered to ensure laboratory tests are second monthly for all residents with ordered to ensure laboratory tests are recommendation monthly to ensure the staff regarding compliance with policibatining and follow up of laboratory onlysician orders and pharmacy recommendation of laboratory request for timely documentation of laboratory simely documentation of laboratory s	ided to all I rocedure for sed upon plons, accurates, and accurates amples obtained and update vill audit mand all licensed by and procedures, and accurate procedures, and accurate procedures, and accurate procedures.	icensed or obtaining nysician te curate and tained onsultation ed as needed edical y blood teats I as ordered n each nursing edure for d upon ns, accurate	
		rmacist had addressed the		Quality Assurance Committee will re			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	COMPLETI	ED
		`. 345520	B. WIN			1	2/2011
	OVIDER OR SUPPLIER			10	EET ADDRESS, CITY, STATE, ZIP CODE 128 BLAIR STREET HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	high serum Potassiu recommended to rep metabolic panel) whi There was no evider	Continued From page 31 high serum Potassium level to nursing and recommended to repeat the BMP (basic metabolic panel) which included Potassium level. There was no evidence that the facility acted upon this recommendation.		Procedure regarding laboratory tests and will recommend Administrator if the policy needs to be reviewed and updated			
	pharmacist had revidence of the DRR (drug reginal address the high K+result as recommen 06/03/11. The note mention the missing the physician on 09/07/11. Resid	11 and 09/05/11, the ewed the resident's records. men review) notes did not level and the missing BMP ded by the pharmacist on s dated 09/05/11 also did not g BMP result as ordered by //01/11. Tent #72 was seen by the gress notes had addressed			(u/ w	(11	
	the high Potassium the BMP. As of 09/drawn. On 09/21/11 at 4:33 #1 was interviewed know where the ph were kept and who	level and ordered to check (21/11, there was no BMP) 2 PM, the administrative nurse I. She stated that she did not armacist recommendations was responsible. She also				·	
	labs (laboratory) as when labs were order that the order had to had to enter it in the stated that there we it was not entered On 09/27/11 at 10/2 interviewed. He stated the missing BMP reserved.	as no policy when to draw the sordered. She indicated that dered the nurse who carried of fill out the request form and the lab book to be drawn. She has no lab request filled out and in the lab book to be drawn. 26 AM, the pharmacist was tated that he did not address result ordered on 09/01/11 ht the result had not been faxed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTIO A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345520	B. WIN	IG_		l .	C 2/2014
NAME OF PROVIDER OR SUPPLIER LIBERTYWOOD NURSING CENTER			09/22/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428 F 461 SS=C	to the facility yet. He aware that the ordered 483.70(d)(1)(vi)-(vii), (WINDOW/FLOOR, BE Bedrooms must have outside; and have a flet The facility must provide (ii) A separate bed of puthe convenience of the convenience of the (iii) A clean, comfortabe (iii) Bedding, appropriate; and (iv) Functional furnesident's needs, and the resident's bedroomshelves accessible to CMS, or in the case of survey agency, may prequirements specified (ii) of this section relationses when the facility that the variationseign and	stated that he was not di BMP was not drawn. d)(2) BEDROOMS - ED/FURNITURE/CLOSET at least one window to the por at or above grade level. de each resident with- proper size and height for a resident; le mattress; periate to the weather and liture appropriate to the dindividual closet space in m with clothes racks and the resident.	F 1. If it is selected as a s	pace All Placeside his romporage The mpl	dent # 99's single closet which she and/roommate has been remodeled at for each resident. Il resident closets have been evaluate ans have been developed for remodernt rooms to separate resident belong remodeling project will take several lete, but when completed, will provide space for each resident. The maintenance supervisor will oversation project to ensure completion. The administrator will monitor to ensure the closet separator project definitions and the closet separator project definitions. The density of the closet separator project definitions are supervisor to Quality And the progress of the closet separator rely basis.	ted. eling all clangings in the limonths to ride separate see the closure timely	osets in e closets. e clothes
	This REQUIREMENT by: Based on observation interview, the facility fa resident with individual	iled to provide each					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
			B. WING	·	(;
		345520	b. m.io_		09/22	2/2011
	OVIDER OR SUPPLIER VOOD NURSING CENTE	R	1	REET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET HOMASVILLE, NC 27360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.DBE	(X5) COMPLETION DATE
F 461	200 hall) of 2 halls. TI Resident #99 was add 03/25/10 with multiple Vein Thrombosis (DV (PE). The quarterly M 07/18/11 indicated the memory or decision in On 09/19/11 at 4:03 Finterviewed. She starthusband were sharing was only one small of one shelf. She further space was too small of On 09/21/11 at 4:30 F AM, observation of reconducted. There were residents in the room 200 halls were observed stored on to clothes and personal floor in the closet. The hanging on the door I space. When shared with add 09/22/11 at 4:30 PM, that all residents were stated that he would the started that he started that he would the started that he would	cks and shelves on 2 (100 & ne findings include: mitted to the facility on a diagnoses including Deep T) and Pulmonary Embolus MDS assessment dated at Resident #99 had no naking problems. PM, Resident #99 was led that she and her go the same room and there oset space in the room with a stated that the closet for 2 people in the room. PM and on 09/22/11 at 8:30 sidents' rooms was are rooms with 2, 3 or 4. All residents in 100 and wed sharing a closet space, in each closet which was not tes. Disposable briefs were op of the shelf. Resident's items were noted on the lare were clothes observed knobs and outside the closet ministrative staff on he stated that he was aware a sharing a closet space. He figure it out to ensure that lividual closet space with	F 461			

PRINTED: 10/16/2011 OCT 3 7011 EPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO, 0938-0391 ENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND FLAN OF CORRECTION A. BUILDING 01 - BUILDING O1 B. WING 10/11/2011 345520 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP GODE 1028 BLAIR STREET LIBERTYWOOD NURSING CENTER THOMASVILLE, NC 27360 PROVIDER'S PLAN OF CORRECTION (X6) NOITBLEMOD BYNG SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY Upon becoming aware during the survey of the K 025 K 025 I NFPA 101 LIFE SAFETY CODE STANDARD deficient practice, the smoke barrier was \$\$¤D repaired on 10/24/2011, by the maintenance Smoke barriers are constructed to provide at director, with coment to maintain the rating of least a one half hour fire resistance rating in said smoke barrier. accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are. B. An audit has been conducted of all smoke protected by fire-rated glazing or by wired glass barriers to ensure that no holes are present, and any panels and steel frames. A minimum of two repairs necessary to maintain the fire resistance separate compartments are provided on each rating have been completed, 11/21/2011 floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted C. The maintenance director, or designee will heating, ventilating, and air conditioning systems. complete monitor tool weekly x 4 weeks then 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 monthly to ensure no penetration or holes are in the fire walls. All staff in-serviced by the Staff Development Coordinator(SDC) by 11/21/2011 D. The Quality Assurance Committee will review This STANDARD is not met as evidenced by: the audits x 3 months to determine compliance with Based on observation on Tuesday 10/11/2011 regards to the smoke barriers (Q.A. committee between 9:30 AM and 2:00 PM the following was members are: Administrator, Director of Nursing, noted: Dietary, Housekeeping, Maintenance, Admissions, 1) The smoke wall in 200 Hall has holes and Staff Development, MDS Nurse, Business Office penetrations that were not sealed in order to Manager) maintain the required fire resistance rating of the smoke barrier, 42 CFR 483,70(a) K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 SS≃F One hour fire rated construction (with % hour 1) fire-rated doors) or an approved automatic fire A) Upon becoming aware during the survey of the extinguishing system in accordance with 8.4.1 deficient practice, the kitchen ceiling has been repaired with 5/8th's fireguard sheetrock. and/or 19,3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system Completion Date: 11/1/2011 option is used, the areas are separated from B. An audit has been conducted of all ceilings to other spaces by smoke resisting partitions and ensure that no wood has been used to repair doors. Doors are self-closing and non-rated or ceilings,, and any repairs necessary to maintain the field-applied protective plates that do not exceed fire resistance rating have been completed. 48 inches from the bottom of the door are 11/21/2011 permitted. 19.3,2,1 (X8) DATE LABORATORY DIRECTOR'S OR PROVIDENCE REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an astolisk of 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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	PLAN OF CORRECTION NUMBER; A BUILDING 01 - BUILDING 01					COMPLETED	
		345520	B, Wil	NG.		10/1	1/2011
	ROVIDER OR SUPPLIER WOOD NURSING CE	NYER]	REET ADDRESS, CITY, STATE ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27380		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
K 029	Continued From pa	age 1	K	02!	9		
K 062 SS=D	Based on observa between 9:30 AM a noted: 1) The ceiling in the of plywood covering does not meet the rated ceiling. 2) The stock room ceiling by PVC plose UL: approved fire rated in the ceiling order to maintain the stock of the dried to the dried t	is not met as evidenced by; tion on Tuesday 10/11/2011 and 2:00 PM the following was Extitchen has a 1/8 inch piece g a large hole. The plywood requirements for a one hour celling have penetration of the es that are not equipped with ated assembly. The are also that have not been sealed in the required rating of the ceiling. Ition in the ceiling above the rs in the laundry room. AFETY CODE STANDARD c sprinkler systems are alined in reliable operating aspected and tested 1.6, 4.6.12, NFPA 13, NFPA	de	n/ 2	A) Upon becoming aware during the control of the sprinkler system we 4/2011 by High Point Sprinkler Comterly inspection. At this time Liberty	he survey of as tested on pany at 2PM	the as a
	This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/11/2011 between 9:30 AM and 2:00 PM the following was noted: 1) Based on record review and staff interview, the facility sprinkler system was not being tested in accordance with NFPA 25 - Standard for the Inspection, Testing and Maintenance of		W	rith	HPSC to due the quarterly, somi-annections. (see attached contract please) B. This is the only sprinkler syst C. The facility now has a contract Sprinkler Co. to maintain facility NFPA requirements. 10/25/2011 D. The Quality Assurance Committee contract x 3 months to determine	oual and annu om in the fact ot with High y compliance see will revie	eility. Point with

06/10

K 029

- C. The maintenance director, and or designce will complete monitor tool weekly x 4 then monthly to ensure no wood has been used for repairs to ceilings. All staff in-serviced by the SDC by 11/21/2011
- D. The Quality Assurance Committee will review the audits x 3 months to determine compliance with regards to any ceiling repairs.
- A) Upon becoming awars during the survey of the deficient practice, the stock room ceiling has been repaired with fire rated caulk, and a UL approved fire rated assembly has been installed to maintain the rating of said smoke barrier. 11/1/2011
 - B. An audit has been conducted of all ceilings to ensure that no holes are present, and any repairs necessary to maintain the fire resistance rating have been completed. 11/21/2011
 - C. The maintenance director, or designee will complete monitor tool weekly x 4 then monthly to ensure no holes are in the ceilings. All staff inserviced by the SDC by 11/21/2011
 - D. The Quality Assurance Committee will review the audits x 3 months to determine compliance with regards to the ceilings.
 - A) Upon becoming aware during the survey of the deficient practice, the laundry room ceiling has been repaired with fire rated caulk to maintain the rating of the ceiling. 10/28/2011
 - B. An audit has been conducted of all ceilings to ensure that no holes are present, and any repairs necessary to maintain the fire resistance rating have been completed.
 - C. The maintenance director, and or designee will complete monitor tool weekly x 4 then monthly to ensure no holes are in the ceilings. All staff inserviced by SDC by 11/21/2011
 - D. The Quality Assurance Committee will review the audits x 3 months to determine compliance with regards to the ceilings

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTI LDIN	PLE CONSTRUCTION G 01 - BUILDING 01	(X3) DATE SURVEY COMPLETED	
		345520	B, WIN	IG	4,144	10/1	1/2011
NAME OF PROVIDER OR SUPPLIER LIBERTYWOOD NURSING CENTER				1	REET AODRESS, CITY, STATE, ZIP CODE 028 BLAIR STREET HOMASVILLE, NC . 27360		
(X4) ID PREFIX TAG	(EACH DEFIGIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULO BE	(X5) COMPLETION OATE
	edition). Interview with facili sprinkler inspection annual inspection a documentation of q inspection. 42 CFR 483,70(a)	ge 2 Protection Systems (1999 ity staff confirmed the fire contractor is performing ind testing only. There was not uarterly or semi annual FETY CODE STANDARD	Ko		14ear ? avertily ?	,	
SS=E	Heating, ventilating with the provisions in accordance with specifications. 19.5.2.2 This STANDARD is Based on observat between 9:30 AM a noted: 1) In the water close sprinkler closet roor removed and not op 2) in the laundry root outside the drier en high and low combine.	and air conditioning comply of section 9.2 and are installed the manufacturer's 9.5.2.1, 9.2, NFPA 90A, s not met as evidenced by: lon on Tuesday 10/11/2011 and 2:00 PM the following was let in room 207 and in the manufacture the exhaust fans were perational.		1.	A. Upon becoming aware during the deficient practice, new exhaust fans in the water and sprinkler rooms by Company on 10/24/2011 at 11:00 A. B. An audit has been conducted of water/sprinkler closets to ensur fans/lights are functional. There room and 1 sprinkler room. C. The maintenance director, and or complete monitor tool weekly x 4 then sure compliance. All staff in-serve 11/21/2011 D. The Quality Assurance Committee the audits x 3 months to determine or regards to the ceilings	s were fustally Hill's Elect MM, fall c that exhause is only 1 w r designed when monthly riced by SDC	ed ric st ater rill to C by
	Electrical wiring and	FETY CODE STANDARD I equipment is in accordance lonal Electrical Code. 9.1.2	K 1				

KOBT.

- 2. A. Upon becoming aware during the survey of the deficient practice, the drier was moved into the drier enclosure on 10/20/2011, and the gas inlets capped by Hills Etonic Company. 2011/1/S PLANSING.

 B. An audit has been conducted of the other gas
 - B. An audit has been conducted of the other gas fixed drier to ensure it is in the proper enclosure, and is equipped with high and low combustion inlets. This is the only drier enclosure in the facility.
 - C. The maintenance director, and or designee will complete monitor tool weekly x 4 then monthly to ensure compliance. Staff in-serviced by SDC by 11/21/2011
 - D. The Quality Assurance Committee will review

the audits x 3 months to determine continued compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTI LDIN	PLE CONSTRUCTION G 01 - BUILDING 01	(X3) DATE SURVEY COMPLETED	
		346520	B. WIL	≀G		10/1	1/2011
NAME OF PROVIDER OR SUPPLIER LIBERTYWOOD NURSING CENTER			1	REET ADDRESS, CITY, STATE, ZIP CODE 028 BLAIR STREET HOMASVILLE, NC 27380			
(X4) ID PREFIX TAG	EPIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	Based on observal between 9:30 AM a noted: 1) In resident room protector/multi outle be in use for lights:	s not met as evidenced by: tion on Tuesday 10/11/2011 and 2:00 PM the following was as 218 and 121 surge at power strips were found to and other equipment. in housekeeping closet Wing		ae ti	A. Upon becoming aware during the deficient practice, the power strips verification from rooms 218 and 1218. An audit has been conducted of a that all rooms are void of power strips C. The maintenance director, and or complete monitor tool weekly x 4 the ensure continued compliance. Staff is SDC by 11/21/2011 D. The Quality Assurance Committed audits x 3 months to determine compliance	vere remove l. ll rooms to designee w en monthly in-serviced l tee will revi	d on ill to by