STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	01/20/2017

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LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record review, the facility failed to offer showers as scheduled for 2 of 3 (Resident #59 and Resident #26) reviewed for choices. Findings included: 1. Resident #59 was admitted 2/9/16 with cumulative diagnoses of rheumatoid arthritis, atrial fibrillation and coronary artery disease. The annual Minimum Data Set (MDS) dated 11/18/16 indicated Resident #59 was cognitively intact with no behaviors. She was coded as requiring extensive assistance for her hygiene and bathing. The MDS was coded that a choice between a shower or bed bath was very important to her. The Care Area Assessment Worksheet (CAA) dated 11/18/16 indicated Resident #59 was cognitively intact and no refusal of her activities of daily living (ADLs) were mentioned. Resident #59 most recent care plan revised 11/11/16 indicated	F 242	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F242 SS=D 483.10(f)(1)-(3) SELF DETERMINATION □ RIGHT TO MAKE CHOICES Corrective Action for Resident Affected:	2/10/17

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

Electronically Signed | 02/10/2017

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F 242	Continued From page 1 she required assistance with her ADLs and no refusal of showers or other ADLs. A review of Resident #59 Bedside Kardex Report initiated on admission dated 2/9/16 and no date of last reviewed of revised indicated she required staff of assistance of one person for bathing. In an interview on 1/17/17 at 11:51 AM, Resident #59 stated she was not offered showers on her scheduled shower days of Wednesdays and Saturdays. Resident #59 stated having showers was important to her. In an interview on 1/19/17 at 7:55 AM, Nursing Assistant (NA) #1 stated she was assigned on 1/18/17. Na #1 stated Resident #59 refused showers in in the winter time stating the shower room was too cold. NA #1 stated Resident #59 was scheduled to have her showers on first shift on Wednesdays and Saturdays. She stated she did not document Resident #59 ' s refusals but rather just offered Resident #59 a bed bath instead. NA #1 stated Resident #59 received a bed bath yesterday rather than a shower but she did not recall if she offered Resident #59 a shower yesterday. NA #1 stated she was supposed to report any refusals to the nurse. In an interview on 1/19/17 at 8:10 AM, NA #2 stated she documented when Resident #59 refused her shower on shower schedule sheet and reported refusal to the nurse. A review of the shower schedule for Resident #59 from 10/1/16 to present indicated no refusals but only receiving showers on the following days: 10/1/16-Shower 10/5/16-Shower	F 242	Resident # 59 was immediately offered a shower on 1/18/2017 by Certified Nursing Assistant (C.N.A.) and refused. Resident was offered another shower by the Certified Nursing Assistant (C.N.A.) on 1/21/2017 and accepted. On 1/27/17 resident #59 was interviewed by the Minimum Data Set (MDS) Nurse and she stated she preferred whirpool baths on Wednesdays and Saturday mornings. Residents care plan and kardex was updated on 2/3/17 by the Minimum Data Set (MDS) Nurse. Resident # 26 was immediately offered a shower on 1/20/2017 by the C.N.A and accepted. Resident was interviewed on 1/24/17 by the MDS Nurse and stated that she prefers a whirlpool or shower on Tuesdays and Fridays between the time of 3 PM to□ 11 PM. The care plan was revised on 2/6/2017 by the Minimum Data Set (MDS) Nurse to indicate these preferences stated above. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this practice. All residents and/or responsible party were interviewed between 1/23/2017 through 1/27/2017 for bathing preferences (Whirlpool, Shower, or Bed Bath or bath of choice) and preferences relating to date and time by the administrative staff to include the Social Worker, the Medical Records or Health Information Manager (HIM), The	

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F 242	Continued From page 2 10/8/16-Shower 10/9/16-Shower 12/14/16-Shower 1/14/17-Shower In another interview on 1/19/17 at 10:10 AM, Resident #59 she was not offered a shower yesterday. In another interview on 1/19/17 at 11:40 AM, NA #2 stated she did not know why she failed to document Resident #59 ' s shower refusal but she knew she reported the refusals to the nurse. In an interview on 1/19/17 at 2:55 PM, the MDS nurse stated she often also worked as a floor nurse and she had never known Resident #59 to refuse her showers. The MDS stated if Resident #59 was refusing her showers, she stated she would have care planned Resident #59 for the refusal. In an interview on 1/20/17at 8:20 AM Nurse #2 who worked with Resident #59 on Wednesday 1/18/17 stated no staff reported to her that Resident #59 refused her shower. Nurse #2 stated if she was made aware of Resident #59 refusing a shower or any of her ADLs or treatments, she would have documented it in her nursing notes. A review of the nursing notes from 10/16/16 to present made no mention of Resident #59 refusing her showers. In an interview on 1/20/17 at 9:00 AM, the Director of Nursing (DON) stated it was her expectation that Resident #59 receive her showers as scheduled and if she refused, the staff should attempt to address the reason why. The DON stated she also expected the aides to	F 242	Rehabilitation Director (RD), the Certified Dietary Manager, the Director of Nursing (DoN), the Minimum Data Set (MDS) Nurse, and the Business Office Manager (BOM). 64 updates were made to care plans and Karedex□s have been updated to reflect changes in resident preferences conducted between 1/23/2017-1/27/2017 as of 2/9/2017 by the MDS Nurse, and the Director of Nursing. Systemic Changes: Nursing Staff to include full time, part time and prn, licensed and unlicensed staff (Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nursing Assistants (C.N.A.)) were in-serviced 1/20/17 by the Director of Nursing through 2/10/2017 regarding Activities of Daily Living (ADL) Care (Showers) giving showers according to the care plan, honoring choices/preferences, documenting refusal(s) of care and alerting the nurse of changes/refusals of care. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance (QA) Process to verify that the change has been sustained. Quality Assurance: The Director of Nursing (DoN) will monitor the Certified Nursing Assistant (C.N.A.) documentation of Activities of Daily Living	

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F 242	Continued From page 3 report refusals to the nurses and the nurses and aide document the refusal. 2. Resident #26 was admitted to the facility on 1/16/16 with multiple diagnoses that included chronic kidney disease and dementia without behavioral disturbance. The admission Minimum Data Set (MDS) assessment dated 1/23/16 indicated Resident #26 was cognitively intact and she participated in the assessment. In the Preferences for Routine and Activities section, Section F, Resident #26 indicated it was very important for her to choose between a tub bath, shower, bed bath, or sponge bath. The comprehensive plan of care, initiated on 1/28/16, indicated Resident #26 had an Activities of Daily Living (ADLs) self-care performance deficit related to impaired balance and weakness. The plan of care for Resident #26 had not identified any issues with refusals of care. The quarterly MDS dated 10/24/16 indicated Resident #26 had significantly impaired cognition. She was assessed with no behaviors and no rejection of care. Resident #26 required the physical help of one person with bathing. A review of the medical record revealed Resident #26 was scheduled for showers twice per week. The shower documentation from 10/1/16 through 1/17/17 was reviewed and revealed Resident #26 received 16 of 31 scheduled showers during the 109 day timeframe. Resident #26 had received bed baths regularly, but had not received showers as scheduled.	F 242	(ADL) Care to include baths/showers weekly using the Quality Assurance (QA) Tool for Monitoring Showers. This will be completed on a minimum of 3 residents during weekly Quality of Life (QoL) Meeting x 4 weeks. Then this audit will be completed monthly x 3 months or until resolved by the Quality Assurance (QA) Committee. Any concerns identified will be immediately addressed with/by the Nursing Home Administrator (NHA)/Director of Nursing (DON). Reports will be presented to the weekly Quality Assurance (QA) committee by the Nursing Home Administrator (NHA), the Director of Nursing (DoN) or the authorized Designee to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance (QA) Meeting. The weekly Quality Assurance (QA) Meeting is attended by the Director of Nursing (DON), Wound Nurse, Minimum Data Set (MDS) Coordinator/Nurse, Support Nurse, Rehabilitation Director (RD) or Therapy Designee, Health Information Manager (HIM), Certified Dietary Manager and the Administrator. Compliance date: 2/10/2017	

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F 242	Continued From page 4	F 242		

A family interview was conducted for Resident #26 on 1/17/17 at 3:40 PM. The interview revealed Resident #26 had not received showers as scheduled.

An interview was conducted with the Director of Nursing (DON) on 1/18/17. She indicated showers were documented in the Electronic Medical Record (EMR) by Nursing Assistants (NAs). She reported that the facility utilized hard copy shower schedules for the NAs to identify which residents were scheduled for showers. The DON stated that the EMR was the primary source of documentation for showers, bed baths, and refusals of showers.

An interview was conducted with NA #2 on 1/19/17 at 1:51 PM. She indicated she was familiar with Resident #26. She reported that sometimes Resident #26 refused her shower and she was provided with a bed bath as an alternative. She stated that she was not sure of the correct process for documenting refusals of showers. NA #2 reported that the EMR required staff to pick one option for bathing and she had selected bed bath rather than refusal if a resident accepted the bed bath. She revealed that if you looked in the EMR there was no way to identify if a bed bath was provided because the resident refused a shower.

An interview was conducted with NA #3 on 1/19/17 at 2:27 PM. She indicated she was familiar with Resident #26. She reported that is Resident #26 refused her shower that she provided her with a bed bath as an alternative. NA #3 reported that the EMR required staff to pick one option for bathing and she had selected bed bath rather than refusal if Resident #26 had

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	345532	A. BUILDING _____ B. WING _____	01/20/2017

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F 242	Continued From page 5 accepted the bed bath. An interview was conducted with NA #4 on 1/19/17 at 3:45 PM. She reported that if a resident refused a shower she offered a bed bath as an alternative. NA #4 reported that the EMR required staff to pick one option for bathing and she had selected bed bath rather than refusal if a resident had accepted a bed bath. An interview was conducted with the Director of Nursing (DON) on 1/20/17 at 9:42 AM. She indicated her expectation was for showers to be offered and provided to residents as scheduled. She additionally stated that if there was a pattern of shower refusals she expected it to be addressed in the resident's plan of care.	F 242		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification	F 278		2/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 6 (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) for pressure ulcers (Resident #40), hospice, life expectancy (Resident # 81), falls (Resident #26), and diagnosis (Resident #81). Coding errors were discovered in the MDS assessments for four of the eighteen sampled residents. The findings included: 1. Resident #40 was admitted on 12/9/16 with multiple diagnoses that included peripheral vascular disease, pressure ulcers, diabetes mellitus, chronic kidney disease, and right below the knee amputation. A wound report dated 12/10/16 indicated that Resident #40 had two pressure ulcers. A review of the admission nursing assessment dated 12/10/16 indicated that Resident #40 was admitted with two stage III pressure ulcers to the left heel. Review of the wound progress notes for Resident #40 dated 12/14/16, as documented by the facility	F 278	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F278 Corrective Action for Resident Affected: On 1/18/17, the following Minimum Data Set (MDS) Assessments that were in the surveyor sample list were corrected via	

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	345532	A. BUILDING _____ B. WING _____	01/20/2017

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F 278	Continued From page 7 wound physician, revealed that Resident #40 had two independent stage III pressure ulcers. One ulcer was to the rear surface of the left heel and the other was to the bottom surface of the left heel. The admission comprehensive Minimum Data Set (MDS) assessment dated 12/16/16 indicated Resident #40 had one stage III pressure ulcer coded in section M of the assessment. A review of the medical record of Resident #40 revealed wound reports for two independent stage III pressure ulcers to the left heel, each dated 12/16/16. Each report documented that Resident #40 had been admitted with two independent stage III pressure ulcers. An interview that was conducted with the facility wound physician, on 1/18/17 at 11:03 AM, revealed that Resident #40 was admitted with two stage III pressure ulcers to the left heel that were not conjoined. An interview that was conducted with the MDS Nurse on 1/19/17 at 2:49 PM revealed that she was responsible for coding Section M of the MDS assessments. She indicated she coded the assessment for Resident #40 after she had received and reviewed the wound report. The wound nurse stated that there must have been only one stage III pressure ulcer on the wound report. The wound nurse obtained a copy of the wound report. The wound nurse reviewed the wound report and acknowledged that the wound report had documented that Resident #40 had two stage III pressure ulcers and that the error in coding one stage III pressure ulcer instead of two stage III pressure ulcers in Section M of the MDS dated 12/16/16 for Resident #40 must have been an oversight. An interview was conducted with the DON on 1/20/17 at 9:00 AM revealed that her expectation	F 278	modifications to reflect accurate resident issues that had been inaccurately coded on the MDS Assessments. Those in the resident sample included; Pressure ulcers (resident # 40), hospice, life expectancy (resident # 81), falls (resident # 26) and diagnosis to reflect depression (resident # 23). These MDS assessments modifications were completed by the MDS Coordinator/Nurse on 2/10/17 and transmitted. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this practice. On 1/18/17 through 2/10/17, Six residents who had pressure ulcers, 52 who had fallen in past 3 months, two hospice residents that had been diagnosed with life expectancy of 6 months of less to live, and 51 residents who were on psychoactive medications were reassessed and their most recent Omnibus Budget Reconciliation Act (OBRA)/Minimum Data Set (MDS) assessments reviewed for accurate coding by the Registered Nurse/Minimum Data Set (MDS) Coordinator and the Minimum Data Set (MDS) Nurse Consultant. Three residents that were found to have coding errors were corrected via modifications by 2/10/17 by the MDS Coordinator. Systemic Changes:	

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	345532	A. BUILDING _____ B. WING _____	01/20/2017

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LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 278	Continued From page 8 was that MDS be coded accurately. 2. Resident #81 was initially admitted to the facility on 10/30/14 with multiple diagnoses that included lung cancer. The comprehensive plan of care for Resident #81 indicated the focus area of hospice care was initiated on 11/4/14. A review of the medical record indicated Resident #81 was recertified for hospice services on 10/2/16 with a certification period that extended through 11/30/16. 2a. The annual Minimum Data Set (MDS) assessment dated 11/2/16 indicated Resident #81 was cognitively intact. Section J, the Health Conditions section, had not indicated Resident #81 had a life expectancy of six months or less (Question J1400). An interview was conducted with the MDS Nurse on 1/19/17 at 2:40 PM. She stated she was responsible for coding Section J of the MDS assessments. Section J of the MDS dated 10/24/16 for Resident #81 that indicated there was no prognosis of 6 months or less was reviewed with the MDS Nurse. The medical record documentation that indicated Resident #81 was on hospice care at the time of the 10/24/16 MDS was reviewed with the MDS Nurse. She revealed the MDS was inaccurate. She indicated this was an oversight and a modification was going to be completed. An interview was conducted with the Director of	F 278	On 1/20/17 through 2/10/17, the facility licensed nurses (both Registered Nurses (RN) and Licensed Practical Nurses (LPN) to include fulltime, part time, and PRN Nurses were in-serviced on the importance of notifying the Registered Nurse/Minimum Data Set (MDS) Coordinator and the facility Director of Nursing (DoN) on any new resident changes/incidents/new orders /behaviors including any refusals for care or treatment(s). This in-service was provided by the Director of Nursing (DoN). On 2/7/17 the Registered Nurse (RN)/Minimum Data Set (MDS) Coordinator and the facility Director of Nursing (DoN) were both provided with re-education on accurate MDS coding by the facility nurse consultant and Minimum Data Set (MDS) Nurse Consultant. The in-service included areas to assess, documentation that needs to be reviewed, communication required between the facility staff (Certified Nurse Assistants (CNA), Registered Nurses (RN), Licensed Practical Nurses (LPN)and the administrative staff) as well as the Medical Director (MD)/Physician so to ensure accurate Minimum Data Set (MDS) coding which should be maintained at all times. Minimum Data Set (MDS) Coordinator will ensure that questions relating to a resident□s life expectancy and hospice status, all falls, presence of pressure ulcers and diagnosis are accurately coded on the Omnibus Budget Reconciliation Act	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 9	F 278		

Nursing (DON) on 1/20/17 at 9:00 AM. She indicated she expected the MDS to be coded accurately.

2b. The annual MDS dated 10/24/16 indicated Resident #81 was cognitively intact. Section O, the Special Treatments, Procedures, and Programs section, indicated Resident #81 had not received hospice care while a resident at the facility (Question O0100K2).

An interview was conducted with the MDS Nurse on 1/19/17 at 2:40 PM. She stated she was responsible for coding Section O of the MDS assessments. Section O of the MDS dated 10/24/16 for Resident #81 that indicated he had not received hospice care while a resident at the facility was reviewed with the MDS Nurse. The medical record documentation that indicated Resident #81 was on hospice care at the time of the 10/24/16 MDS was reviewed with the MDS Nurse. She revealed MDS was inaccurate. She indicated this was an oversight and a modification was going to be completed.

An interview was conducted with the DON on 1/20/17 at 9:00 AM. She indicated she expected the MDS to be coded accurately.

3. Resident #26 was admitted on 1/16/16 with multiple diagnoses that included a history of falling and dementia without behavioral disturbance.

The quarterly Minimum Data Set (MDS) assessment dated 10/24/16 indicated Resident #26's cognition was significantly impaired. Section J, the Health Conditions Section,

(OBRA)/Minimum Data Set (MDS) assessments as appropriate and the resident Care Plan accurately updated within 24 to 48 hours of change.

This information has been integrated into the routine in service(s) for Registered Nurse (RN) Minimum Data Set (MDS) Coordinator/MDS support nurse and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance (QA)Process to verify that the change is maintained.

Quality Assurance:

The facility Director of Nursing (DON) will audit a minimum of two residents Minimum Data Set (MDS) comprehensive assessments for accuracy of the various identified areas per week for 4 weeks, then monthly for 3 months or until resolved by Quality Assurance (QA) Committee. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing (DoN) to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly Quality Assurance (QA) Meeting. The monthly Quality Assurance (QA) Meeting is attended by the Director of Nursing (DoN), Minimum Data Set (MDS) Coordinator, Support Nurse, Rehabilitation Director (RD) or Therapy designee, Health Information Manager (HIM), Certified Dietary Manager and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 278	Continued From page 10 indicated Resident #26 had no falls since the previous MDS assessment (7/24/16 quarterly MDS). A review of the medical record indicated Resident #26 had a fall with minor injury on 8/10/16. The plan of care for Resident #26 was updated on 8/11/16 with the new focus area of an actual fall with risk for further falls. An interview was conducted with the MDS Nurse on 1/19/17 at 2:40 PM. She stated she was responsible for coding Section J of the MDS assessments. She indicated she reviewed the incident log in the electronic medical record to code the MDS for falls. Section J of the MDS dated 10/24/16 for Resident #26 that indicated she had no falls since her previous MDS assessment (7/24/16 quarterly assessment) was reviewed with the MDS Nurse. The medical record documentation of Resident #26's fall with a minor injury on 8/10/16 was reviewed with the MDS Nurse. She revealed the MDS was coded inaccurately. She stated it was an oversight. An interview was conducted with the DON on 1/20/17 at 9:00 AM. She indicated she expected the MDS to be coded accurately. 4. Resident #23 was admitted to the facility on 12/16/16 with multiple diagnoses including Depression. The admission Minimum Data Set (MDS) assessment dated 12/23/16 indicated that Resident #23 had received an antidepressant medication during the assessment period. The assessment further indicated that Resident #23 did not have diagnoses of Depression.	F 278	Administrator. Compliance date: 2/10/2017	

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	345532	A. BUILDING _____ B. WING _____	01/20/2017

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F 278	Continued From page 11 Resident #23's physician's orders were reviewed. The orders included Zoloft (antidepressant drug) 50 milligrams (mgs.) daily for Depression. On 1/19/17 at 2:48 PM, the MDS Nurse was interviewed. The MDS Nurse acknowledged that she missed to code Depression under diagnoses on the quarterly MDS assessment. On 1/20/17 at 9:00 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS to be accurate.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 279		2/10/17

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F 279	Continued From page 12 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately develop a care plan for one of eighteen sampled residents for pressure	F 279	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the	

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F 279	Continued From page 13 ulcers (Resident #40). Findings included: Resident #40 was admitted on 12/9/16 with multiple diagnoses that included peripheral vascular disease, pressure ulcers, diabetes mellitus, chronic kidney disease, and right below the knee amputation. A review of the admission nursing assessment dated 12/10/16 indicated that Resident #40 was admitted with two stage III pressure ulcers to the left heel. Review of Resident #40's care plan that was initiated on 12/14/2016 revealed that Resident #40 had the following focus areas: renal insufficiency related to chronic kidney disease, hypertension, diabetes, peripheral artery disease, right below the knee amputation, and a stage III pressure ulcer to the left heel. The goal for the pressure ulcer was that the pressure would show signs of healing and remain free from infection by/through the next 90 days. There was only information in the care plan regarding one pressure ulcer. Review of the wound progress notes for Resident #40 dated 12/14/16, as documented by the facility wound physician, revealed that Resident #40 had two independent stage III pressure ulcers. One ulcer was to the rear surface of the left heel and the other was to the bottom surface of the left heel. There were additional wound progress notes from Resident #40 ' s wound physician detailing two separate pressure ulcers on the left heel on 12/21/16, 12/28/16, and on 1/4/16. A review of the wound report from 12/10/16 indicated that resident #40 had two pressure ulcers. A further review of the wound reports revealed that Resident #40 had two independent stage III pressure ulcer reports for the left heel, each dated 12/16/16. Each report documented	F 279	alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F279 Corrective Action for Resident Affected: On 1/18/17, Resident # 40□s care plan was reviewed and updated to include current pressure ulcers and interventions. This was completed by the Minimum Data Set (MDS) Coordinator. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this practice. On 1/18/17 through 2/10/17 Six residents who had pressure ulcers were reassessed and their care plans were reviewed for accuracy of wounds and wound care interventions by the Registered Nurse (RN) Minimum Data Set (MDS) Coordinator and the Minimum Data Set (MDS) Nurse Consultant. All six identified care plans were accurate and included pressure ulcer interventions. This Care Plan review completed by MDS	

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F 279	Continued From page 14 that Resident #40 had been admitted with two independent stage III pressure ulcers. A dressing change and wound care observation was completed of the pressure areas on left the foot of Resident #40 on 01/18/17 at 10:41 AM. The dressing to the left heel and foot was removed by Nurse #1 in front of the wound care physician. There were two pressure ulcers on the resident ' s left foot. The wound was cleansed by the wound nurse. The wound care physician measured one pressure ulcer on the left foot to be 2.4 centimeters by 1.7 centimeters and 0.1 centimeter depth. The other was measured to be 3.3 centimeters by 2.5 centimeters and the depth was not measured due to the condition of the skin. An interview that was conducted with the facility wound physician, on 1/18/17 at 11:03 AM, revealed that Resident #40 was admitted with two stage III pressure ulcers to the left heal that were not conjoined. An interview that was conducted with the MDS Nurse on 1/19/17 at 2:49 PM revealed that she was responsible for initiating and updating the care plans in regards to pressure ulcers. She indicated she had initiated the care plan for Resident #40 with one pressure ulcer and that the care plan had been incorrect. The wound nurse acknowledged that Resident #40 had two stage III pressure ulcers and that she would correct the care plan so that both pressure ulcers would be addressed in the care plan. An interview conducted with the DON on 1/20/17 at 9:00 AM revealed that her expectation was that care plans needed to be accurate when developed and initiated.	F 279	Coordinator on 2/10/2017. Systemic Changes: On 1/18/17,the facility licensed nurses (both Registered Nurses (RN) and Licensed Practical Nurses (LPN)), to include full time, part time, and PRN nurses were in-serviced on the importance of notifying the Registered Nurse (RN)/Minimum Data Set (MDS) Coordinator and the facility Director of Nursing (DoN) on any new resident changes / new wounds/incidents / new orders /behaviors including any refusals for care or treatment(s) by the DON. On 2/7/17 the Registered Nurse (RN)/MDS Coordinator and the facility Director of Nursing (DoN) were both provided with re-education on accurate Minimum Data Set (MDS) coding/updating care plans by the Minimum Data Set (MDS) Nurse Consultant. The in service included areas to assess, documentation that needs to be reviewed, communication required between the facility staff (Certified Nursing Assistants (CNA), nurses (both Registered Nurses (RN) and Licensed Practical Nurses (LPN)) and the administrative staff) as well as the Medical Director (MD) so to ensure accurate Minimum Data Set (MDS) coding and updating care plans which should be maintained at all times. Minimum Data Set (MDS) Coordinator will	

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F 279	Continued From page 15	F 279		

ensure that questions relating to a resident□s life expectancy and hospice status, all falls, presence of pressure ulcers and diagnosis are accurately coded on the Omnibus Budget Reconciliation Act (OBRA)/Minimum Data Set (MDS) assessments as appropriate and the resident Care Plan accurately updated within 24 to 48 hours of change.

This information has been integrated into the routine in service(s) for Registered Nurse (RN) Minimum Data Set (MDS) Coordinator/MDS support nurse and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance (QA) Process to verify that the change is maintained.

Quality Assurance:

The facility Director of Nursing (DoN) will audit a minimum of two residents MDS comprehensive assessments and Care Plans for accuracy of the various identified areas. This will be done weekly for four weeks, then monthly for three months or until resolved by Quality Assurance (QA) Committee. Reports will be presented to the weekly Quality Assurance (QA) committee by the Nursing Home Administrator (NHA) or Director of Nursing (DoN) to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly Quality Assurance (QA) Meeting. The monthly QA Meeting is attended by the Director of

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F 279	Continued From page 16	F 279	Nursing (DoN), Minimum Data Set (MDS) Coordinator, Support Nurse, Rehabilitation Director (RD) or Therapy designee, Health Information Manager (HIM), Certified Dietary Manager and the Nursing Home Administrator (NHA). Compliance date: 2/10/2017	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and	F 280		2/10/17

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F 280	Continued From page 17 shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 280		

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F 280	Continued From page 18 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and record review, the facility failed to revise a care for refusal of wearing a right hand splint (Resident #72) for 1 of 3 residents reviewed for range of motion (ROM). Findings included: Resident #72 was admitted 12/9/15 with cumulative diagnoses of cerebral vascular accident (CVA) hemiplegia (paralysis of one side of the body), anxiety and depression. The quarterly Minimum Data Set (MDS) dated 12/19/16 indicated severe cognitive impairment and no behaviors. Resident #72 was coded for extensive assistance with her activities of daily living (ADLs) and as having impairment on one side of her body. Resident #72 last care plan revision was 4/18/16 where she was to wear a right hand splint 2 hours daily for her right hand contracture. A review of the physician orders indicated the following was ordered on 9/16/16 with no orders to discontinue: Restorative nursing: Resident's right hand splint is to be worn 2 hours daily. Check skin integrity daily before applying splint.	F 280	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F280 Corrective Action for Resident Affected: On 1/23/17, Resident # 72□s care plan was revised and updated to reflect the resident□s right to choices and refusal of splints. Resident□s care plan was updated by the Minimum Data Set (MDS) nurse.	

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F 280	Continued From page 19 On 1/17/17 at 9:20 AM, Resident #72 was observed sitting in her recliner not wearing a right hand splint. Her right hand was resting in her lap with her fingers contracted over to her palm. Resident #72 was able to take her left hand and perform ROM to her right hand but she was not able to fully extend her fingers. She stated it was painful. When asked about her right hand splint, she stated she once had a splint but she did not use it anymore. In a second observation on 1/17/17 at 2:00 PM, Resident #72 was observed sitting in her doorway without a right hand splint. Her right hand was resting in her lap with her fingers contracted over to her palm. In an observation on 1/18/17 at 9:30 AM, Resident #72 was sitting up in her recliner not wearing a right hand splint. Her right hand was resting in her lap with her fingers contracted over to her palm. Nursing assistant (NA) #1 was in the room. She stated she was not aware Resident #72 had a right hand splint but she was able to use her other hand to perform ROM to her right hand. In an interview on 1/18/17 at 12:20 PM, the Rehabilitation Director stated Resident #72 was turned over to restorative nursing for right hand splinting 10/13/15. He stated Resident #72 was assessed quarterly for worsening of her right hand contracture but she had not experienced any changes. He stated he was not aware that Resident #72 was refusing her right hand splint. In another review of the care plan on 1/18/17 2:00 PM, it was updated to include Resident #72 could	F 280	Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this practice. On 1/19/17 and 2/7/17, education was provided by the Director of Nursing (DoN) to the nursing staff full time, part time, and prn, licensed and unlicensed staff (Certified Nursing Assistants (CNA), Licensed Practical Nurses (LPN), and Registered Nurses (RN)) to ensure that they communicate with the Minimum Data Set (MDS) Coordinator and facility Director of Nursing (DON) and other administrative staff about any residents on those who have portrayed any behaviors of refusals, resistance to care in-terms of Activities of Daily Living (ADL), refusal for care including showers or splints as identified. They also need to make sure those incidents such as falls, current pressure ulcers, diagnosis and diagnosis of short life expectancy r/t hospice care are reported. Sixty-one residents identified to have these issues. Twenty out of the Sixty-one Care Plans reviewed were updated accordingly. The twenty updates included two residents refusals of showers at times and eighteen residents preference related to showers. The Care Plans and Cardexes were updated for these identified twenty residents on 2/10/2017 by the MDS Nurse. The care plans were also updated immediately following the completion of the comprehensive assessment(s). All current residents were re-assessed by the	

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F 280	Continued From page 20 make her choice to refuse her right hand splint and Resident #72 to wear her right hand splint for 2 hours daily had been removed from the care plan. A review of Resident #72 ' s Kardex documentation report from 10/1/16 to 1/18/17 when the care plan was last revised indicated staff were to initial off on day shift that the Resident #72 wore her right hand splint for 1-2 hours daily each morning after her morning medications and that Resident #72 could remove it independently. There were no initials indicating any attempt to apply the right hand splint or documented refusals. In an interview on 1/18/17 at 2:10 PM, the MDS nurse stated she reviewed the care plan with the last quarterly MDS assessment 12/19/16 and she did not care plan Resident #72 ' s refusal of her right hand splint because she was not aware she was not wearing the right hand splint as ordered. The MDS nurse stated she must not have reviewed the Kardex documentation because she would have noted the aides were not applying the splint as ordered. The MDS nurse stated the Director of Nursing (DON) may have revised the care plan earlier today to include Resident #72 ' s chose to refuse the right hand splint. In an interview on 1/18/17 at 2:20 PM, the DON stated she revised Resident #72 ' s care plan today to include her refusals of the splint. The DON stated she planned to have therapy reassess Resident #72 for her splinting needs. The DON stated it was her expectation the care plan would have been revised to address her refusals at the last quarterly MDS assessment	F 280	Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Registered Nurse (RN) Director of Nursing (DON) and Minimum Data Set (MDS) Corporate Nurse Consultant for Care Plan appropriate updates to ensure that proper focus/ problem, goals and interventions were identified and appropriately documented on the Care Plans. Twenty resident Care Plans that were found out of compliance were corrected by 2/10/17 by the MDS Nurse. Systemic Changes: On 2/7/17, the Minimum Data Set (MDS) Coordinator and facility Director of Nursing (DON) were both provided with education that addressed appropriate care planning and updating of the care plan as appropriate to reflect the resident(s) current medical status. Education was provided by the Minimum Data Set (MDS) Corporate Registered Nurse (RN) Consultant. All full time, part time, and prn nursing to include both unlicensed and licensed staff (Certified Nursing Assistants (CNA), Licensed Practical Nurses (LPN), and Registered Nurses (RN) were in serviced to adequately communicate with the Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, the facility Director of Nursing (DON) and other administrative staff including the Nursing Home Administrator (NHA) on any current incidents such as falls, new pressure	

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F 280	Continued From page 21 done 12/19/16.	F 280	ulcers, refusal of wearing splints/Activities of Daily Living (ADL) care and offering different approaches/redirecting residents. Minimum Data Set (MDS) Coordinator will ensure that Care Plans are appropriately updated each and every time new interventions are determined on daily basis by the inter-disciplinary team. The said interventions will be transferred to the resident(s) Care Plan within 24 to 48 hours of said meeting. This would include any intervention for falls, any resident resistant to care which includes shower refusals, refusals for splints, current hospice status / life expectancy, current pressure ulcers, that may enhance a resident□s quality of life or prevent further decline based upon an incident, change in condition or direct observation. This information has been integrated into the routine in service(s) for Registered Nurse (RN) Minimum Data Set (MDS) Coordinator / Minimum Data Set (MDS) support nurse and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change is maintained. Quality Assurance: The Director of Nursing (DON) will audit a minimum of two residents□ care plans for accuracy and current updates to ensure that the care plans are updated with every current incident occurrence and also with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 280	Continued From page 22	F 280	completion of the comprehensive Omnibus Budget Reconciliation Act (OBRA) Minimum Data Set (MDS) Assessment(s) as appropriate. This will be done weekly for four weeks, then monthly for three months or until resolved by Quality Assurance (QA) Committee. Reports will be presented to the weekly Quality Assurance (QA) committee by the Nursing Home Administrator (NHA) or Director of Nursing (DON) to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly Quality Assurance (QA) Meeting. The monthly Quality Assurance (QA) Meeting is attended by the Director of Nursing (DON), Minimum Data Set (MDS) Coordinator, Support Nurse, Rehabilitation Director (RD) or Therapy designee, Health Information Manager (HIM), Certified Dietary Manager and the Nursing Home Administrator. Compliance date: 2/10/17	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		2/13/17

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F 282	Continued From page 23 by: Based on record review, observation and staff interview, the facility failed to consistently follow the care plan for splinting for 1 (Resident #83) of 3 sampled residents reviewed and for falls for 1 (Resident #26) of 3 sampled residents reviewed. Findings included: 1. Resident #83 was originally admitted to the facility on 4/25/16 with multiple diagnoses including hypertension and cerebral infarction. The quarterly Minimum Data Set (MDS) assessment dated 11/1/16 indicated that Resident #83 had memory and decision making problems and had impairment in range of motion (ROM) on one side. Resident #83's care plan initiated on 8/4/16 and was last reviewed on 1/11/17 was reviewed. One of the care plan problems was " I am on restorative nursing for left upper extremity splinting/brace application. " The goal was " I will wear splint/brace to my left extremity for 2 hours per day in order to minimize risk for further decline in ROM to my left extremity x (times) 90 days. " The approaches included " assist me with application of brace according to schedule, observe my skin underneath splint/brace for redness, irritation, etc. (etcetera), and restorative nurse to review my progress periodically. " On 1/18/17 at 11:10 AM and 3:45 PM and on 1/19/17 at 8:45 AM, Resident #83 was observed. His left hand was contracted and there was no splint or brace observed. On 1/19/17 at 9:30 AM, NA (nursing assistant) #6 was interviewed. NA #1 stated that she was assigned to Resident #83. She stated that the splint for Resident #83 had been discontinued due to the sore on his wrist. She indicated that	F 282	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F282 Corrective Action for Resident Affected: On 1/19/17, Resident # 83□s left hand splint was applied per Physician/MD orders and Residents # 26□s reacher was placed in resident□s room. Resident # 83 and # 26 care plans were reviewed and no issues were identified. The splint and reacher were issued for residents # 83 and # 26 by the Director of Nursing. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this practice. On 1/19/17 and 2/7/17, education by the DON was provided to full time, part time, and prn nursing staff on all shifts (Certified Nursing Assistants (CNA), Licensed	

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F 282	Continued From page 24 the nurses did not inform her to start applying the splint so she had not been applying it. On 1/19/17 at 10:05 AM, the Director of Nursing (DON) was interviewed. The DON indicated that the facility had no restorative NAs or restorative nurse. The NAs working on the floor were responsible for applying the splints. She stated that splint application was documented on the activity of daily living (ADL) flow sheets. Resident #83's ADL flow sheets were reviewed. The September 2016 flow sheet indicated that the splint was not applied on 9/1, 9/2, 9/3, 9/4, 9/5, 9/6, 9/7, 9/9, 9/14 and 9/15/16. There was no flow sheet for October 2016 to indicate that the splint was applied. The November 2016 flow sheet indicated that the splint was not applied on 11/1, 11/2, 11/3, 11/4, 11/5, 11/6, 11/7, 11/8, 11/12, 11/25, 11/26 and 11/3016. The January 2017 flow sheet indicated that the splint was not applied on 1/4, 1/5, 1/6 and 1/17/17. On 1/19/17 at 2:35 PM, NA #3 was interviewed. She stated that she had been assigned to Resident #83. She stated that Resident #83 was not wearing his splints for a long time now. His splint was stopped due to the sore on his wrist and she was not informed by the nurses to resume applying the splint. On 1/20/17 at 9:00 AM, the DON was interviewed. The DON stated that she expected the splint to be applied consistently as care planned. She indicated that the facility had no restorative nurse who will monitor the splint application and who will evaluate the progress of the residents on splints. 2. Resident #26 was admitted to the facility on 1/16/16 with multiple diagnoses that included a history of falling and dementia without behavioral	F 282	Practical Nurses both licensed and unlicensed (LPN, and Registered Nurses (RN) to ensure that they are aware of the residents care plan to ensure all resident needs including adaptive equipment, splints, reachers, etc. Also to report on those who have portrayed any behaviors of refusals, resistance to care in-terms of Activities of Daily Living (ADL), refusal for care including showers or splints as identified. Two out of Three residents identified to have these issues have had their care plans reviewed and updated accordingly by the MDS Nurse on 2/10/2017. All current residents were re-assessed by the Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Registered Nurse Director of Nursing (DON) and Minimum Data Set (MDS) Corporate Nurse Consultant for Care Plan appropriate updates to ensure that proper focus/ problem, goals and interventions were identified and appropriately documented on the Care Plans. Two Resident Care Plans that were found out of compliance were corrected by 2/10/17 by the MDS Nurse. Systemic Changes: On 2/7/17, the Minimum Data Set (MDS) Coordinator and facility Director of Nursing (DON) were both provided with education that addressed appropriate care planning and updating of the care plan as appropriate to reflect the resident(s) current medical status to	

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	345532	A. BUILDING _____ B. WING _____	01/20/2017

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LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 282	Continued From page 25 disturbance. The comprehensive plan of care for Resident #26 included the focus area of the risk for falls initiated on 1/28/16. The quarterly MDS dated 10/24/16 indicated Resident #26's cognition was significantly impaired. She required extensive assistance with bed mobility. Resident #26 required limited assistance with transfers, dressing, toileting and personal hygiene. She required supervision with walking in room, walking in corridor, locomotion on unit, and locomotion off unit. Resident #26 utilized a walker. A review of the medical record revealed Resident #26 had a fall on 1/6/17. The fall report indicated Resident #26 had tried to pick up something from the floor and had slid off the side of her bed. The fall investigation indicated the fall was due to Resident #26 reaching to pick up an object from the floor. The fall interventions indicated a "reacher" was to be provided for Resident #26 to assist with the retrieval of items that were not in her reach. The plan of care related to falls for Resident #26 was updated on 1/6/17 with an addition of the intervention, "Provide me with a reacher to pick up objects". An observation of Resident #26's room was conducted on 1/19/17 at 9:50 AM. There was no reacher observed in Resident #26 ' s room. An interview was conducted with Nursing Assistant (NA) #3 on 1/29/17 at 2:27 PM. She indicated she was familiar with Resident #26.	F 282	include the possession of a device such as a reacher. This education was provided by the Minimim Data Set (MDS) Corporate Nurse Consultant. All nursing staff were in-serviced between 1/20/17-2/10/2017 by the Director of Nursing to adequately communicate with the Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, the facility Director of Nursing (DON) and other administrative staff including the Nursing Home Administrator (NHA) on any current incidents such as falls, new pressure ulcers, adaptive equipment, splints, reachers, etc. Staff was additionally educated on the use of the Electronic Kardex/Bedside Kardex, where information pertaining to the utilization of resident specific devices can be found and is integrated with new hire orientation. This information has been integrated into the routine in service(s) for Registered Nurse (RN) Minimum Data Set (MDS) Coordinator/MDS support nurse and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance (QA) Process to verify that the change is maintained. Quality Assurance: The Director of Nursing will audit a minimum of two residents kardex for accuracy and current updates to ensure that the care plans for devices/adaptive	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 282	Continued From page 26 She reported Resident #26 was a fall risk. NA #3 indicated Resident #26 had no intervention of a reacher to minimize the risk of falls. An observation of Resident #26 was conducted on 1/19/17 at 3:00 PM. Resident #26 was sleeping in her bed. There was no reacher observed in Resident #26's room. An interview was conducted with NA #4 on 1/19/17 at 3:45 PM. She indicated she was familiar with Resident #26. She reported Resident #26 was a fall risk. NA #4 revealed Resident #26 had no intervention of a reacher to minimize the risk of falls. She stated if a resident had a reacher it was kept near their bed so the resident was able to access it easily. An interview was conducted with NA #5 on 1/19/17 at 4:05 PM. She indicated she was familiar with Resident #26 and she was assigned to her on 1/19/17. She reported Resident #26 was a fall risk. NA #5 revealed Resident #26 had no intervention of a reacher to minimize the risk of falls. She stated if Resident #26 had a reacher it would have been kept in her room. NA #5 indicated there was no reacher in Resident #26's room on 1/19/17. An interview was conducted with the Director of Nursing (DON) on 1/20/17 at 9:42 AM. She indicated her expectation was for the plan of care to be followed.	F 282	equipment to include splints and reachers are being carried out for accuracy as indicated on the resident kardex. This will be done weekly for one month then monthly for three months or until resolved by Quality Assurance Committee. The Support nurse, the Supervisory Registered Nurse or the Licensed Practical Nurse Lead will conduct three random audits (one per shift and one must be on a weekend) for the first four weeks, then monthly for three months or until resolved by the Quality Assurance Committee beginning the week of 2/13/2017. Reports will be presented to the weekly Quality Assurance (QA) committee by the Nursing Home Administrator (NHA) or Director of Nursing (DON) to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly Quality Assurance (QA) Meeting. The monthly Quality Assurance (QA) Meeting is attended by the Director of Nursing (DON), Minimum Data Set (MDS) Coordinator, Support Nurse, Rehabilitation Director (RD) or Therapy designee, Health Information Manager (HIM), Certified Dietary Manager and the Nursing Home Administrator. Compliance date: 2/13/17	
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		2/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	01/20/2017

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LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 318	Continued From page 27 (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to apply the prescribed splinting device as ordered for 2 of 3 sampled residents (Resident #72 and Resident #83) reviewed for range of motion (ROM). Findings included: 1. Resident #72 was admitted 12/9/15 with cumulative diagnoses of cerebral vascular accident (CVA) hemiplegia (paralysis of one side of the body), anxiety and depression. The quarterly Minimum Data Set (MDS) dated 12/19/16 indicated severe cognitive impairment and no behaviors. Resident #72 was coded for extensive assistance with her activities of daily living (ADLs) and as having impairment on one side of her body. Resident #72 ' s care plan, which was last reviewed on 4/18/16 specified she was to wear a right hand splint 2 hours daily for her right hand contracture. A review of the physician orders indicated the following was ordered on 9/16/16 with no orders to discontinue: Restorative nursing: Resident's right hand splint	F 318	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F318 SS=D 483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Corrective Action: Resident Number # 72 was ordered a splint on 9/16/16, the care plan was revised on 1/23/17 by the MDS Coordinator to include Passive Range of Motion (ROM) to be provided daily. 2 sets	

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	345532	A. BUILDING _____ B. WING _____	01/20/2017

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F 318	Continued From page 28 is to be worn 2 hours daily. Check skin integrity daily before applying splint. On 1/17/17 at 9:20 AM, Resident #72 was observed sitting in her recliner not wearing a right hand splint. Her right hand was resting in her lap with her fingers contracted over to her palm. Resident #72 was able to take her left hand and perform ROM to her right hand but she was not able to fully extend her fingers. She stated it was painful. When asked about her right hand splint, she stated she once had a splint but she did not use it anymore. In a second observation on 1/17/17 at 2:00 PM, Resident #72 was observed sitting in her doorway without a right hand splint. Her right hand was resting in her lap with her fingers contracted over to her palm. In an observation on 1/18/17 at 9:30 AM, Resident #72 was sitting up in her recliner not wearing a right hand splint. Her right hand was resting in her lap with her fingers contracted over to her palm. Nursing assistant (NA) #1 was in the room. She stated she was not aware Resident #72 had a right hand splint but she was able to use her other hand to perform ROM to her right hand. In an interview on 1/18/17 at 12:20 PM, the Rehabilitation Director (RD) stated Resident #72 was turned over to restorative nursing for right hand splinting 10/13/15. He stated Resident #72 was assessed quarterly for worsening of her right hand contracture but she had not experienced any changes. He stated he was not aware that Resident #72 was refusing her right hand splint and it was not discontinued to his knowledge. The	F 318	of 10 reps to my right hand. It was also revised to include resident right hand splint is to be worn 2 hours daily. Check skin integrity daily before applying splint. Clean forearm and hand prior to application with soap and water. Passive ROM to be provided daily. 2 sets of 10 reps for 15 minutes. NA Splint. Care plan also has been revised to include I make my choice to refuse splint at times, and I may refuse to wear my splint at times and if I refuse, please notify my nurse. (Cross reference to F280). Resident Number # 83 On 1/18/2017, resident # 83 was ordered a splint. On 1/18/2017, the care plan for Resident # 83 was revised by the MDS Coordinator to include assistance with splint: before donning splint, clean and dry left upper extremity for good hygiene. Perform passive range of motion (ROM) exercises for left upper extremity all planes 2 sets of 10 once a day for 15 minutes. Left upper extremity apply and remove □ tolerate up to 2 hours: apply at 10 AM and remove at 12 PM. (Cross reference to F280) Identification of other residents who may be involved with this practice: All other current residents were assessed by the Rehabilitation Director and Director of Nursing on 1/23/17 for splinting. They found that there were no other residents in need of splinting/splinting devices as of 1/23/2017.	

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	345532	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 318	Continued From page 29 RD stated it should be applied as ordered. In an interview on 1/18/17 at 2:10 PM, the MDS nurse stated she reviewed the care plan with the last quarterly MDS assessment 12/19/16 and she did not care plan Resident #72 ' s refusal of her right hand splint because she was not aware she was not wearing the right hand splint as ordered. The MDS nurse stated the splint showed up on the Kardex for the Aides to document each morning when it was applied. The MDS nurse stated it was her understanding the Nurse #1 who was also the treatment nurse was responsible for splints since she did the skin assessment and would note or if any skin issues develop due to the splints. A review of Resident #72 ' s Kardex documentation report from 10/1/16 to present indicated staff were to initial off on day shift that the Resident #72 wore her right hand splint for 1-2 hours daily each morning after her morning medications and that Resident #72 could remove it independently. There was no observed initials where staff had attempted to apply the right hand splint or documented refusals. In an interview on 1/18/17 2:30 PM, Nurse #1 stated there was no one person responsible for restorative nursing and that the facility did not have a formal restorative program. She stated Resident #72 was known to refuse the right hand splint and the aide must have just stopped trying to apply the splint. In an observation on 1/19/17 8:00 AM, Resident #72 was eating breakfast and not wearing her right hand splint.	F 318	Systemic Changes: Facility Nursing Staff to include full time, part time and prn licensed and unlicensed staff (Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nursing Assistants (CNA)) were in-serviced 1/20/2017 through 2/10/2017 on application and refusal of splinting device(s) by the Director of Nursing (Registered Nurse). Nursing Staff listed above were educated to document refusals in the Point of Care (within Point Click Care), utilizing the Alert Tool, and notify the nurse if a resident has refused. The Minimum Data Set (MDS) Coordinator was educated by the Minimum Data Set (MDS) Corporate Registered Nurse (RN) consultant on the Resident Assessment Instrument (RAI) Process (care planning process) on 2/7/17. Nursing and Rehabilitation will re-evaluate and update for need, and changes in splinting needs, and d/c of splinting device(s) during quarterly review. Monitoring: To ensure compliance, Director of Nursing will monitor for decline for range of motion during weekly Quality of Life (QoL) utilizing Quality Assurance (QA) Tool for Splinting for the first four weeks and then monthly for three months. Splinting will be included on the care plan audit (cross	

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F 318	Continued From page 30 In another observation on 1/19/17 at 10:05 AM, Resident #72 was in her room sitting in her recliner wearing her right hand splint. Resident #72 stated she did not know why the staff started reapplying the right hand splint. In an interview on 1/19/17 at 11:40 AM, NA #2 stated she was not aware that Resident #72 was to have a right hand splint on each morning. She stated she had seen the splint mentioned on the Kardex but she had never seen a splint in Resident #72 ' s room. NA #2 stated she had worked at the facility around four or five months and had worked with Resident #72 on multiple occasions. In an interview on 1/20/17 at 9:00 AM, the DON stated it was her expectation that Resident #72 ' s splint be applied daily each morning as ordered and if she refused, it should be documented. 2. Resident #83 was originally admitted to the facility on 4/25/16 with multiple diagnoses including hypertension and cerebral infarction. The quarterly Minimum Data Set (MDS) assessment dated 11/1/16 indicated that Resident #83 had memory and decision making problems and had impairment in range of motion (ROM) on one side. The assessment also indicated that Resident #83 was not receiving restorative nursing program for range of motion or splint. Resident #83 was evaluated and treated by the Occupational Therapist (OT) for the left hand contracture from 7/19/16 through 8/4/16. The OT discharge instruction dated 8/17/16 was for	F 318	referenced to F280) and monitored that splints are applied as ordered and monitor refusals once weekly for four weeks and then monthly for three month or until resolved by Quality Assurance (QA) Committee. The weekly Quality of Life (QoL) Meeting is attended by the Director of Nursing (DON), Minimum Data Set (MDS) Coordinator, Support Nurse, Rehabilitation Director or Therapy designee, Health Information Manager (HIM), Certified Dietary Manager and the Nursing Home Administrator. Date of Compliance: 2/10/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	01/20/2017

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F 318	Continued From page 31	F 318		

nursing to continue with the splint schedule and ROM exercises. On 10/14/16, Resident #83 was again evaluated by the OT and OT had recommended to continue with restorative nursing program for splints and passive range of motion (PROM) exercises. The OT had rescreened the resident on 12/9/16 and 1/11/17 and indicated that " patient is at baseline and would not benefit from skilled OT at this time. "

Resident #83's care plan initiated on 8/4/16 and was last updated on 1/11/17 was reviewed. One of the care plan problems was " I am on restorative nursing for left upper extremity splinting/brace application. " The goal was " I will wear splint/brace to my left extremity for 2 hours per day in order to minimize risk for further decline in ROM to my left extremity x (times) 90 days. " The approaches included " assist me with application of brace according to schedule, observe my skin underneath splint/brace for redness, irritation, etc. (etcetera), and restorative nurse to review my progress periodically. "

On 1/18/17 at 11:10 AM and 3:45 PM and on 1/19/17 at 8:45 AM, Resident #83 was observed. His left hand was contracted and there was no splint or brace observed.
On 1/19/17 at 9:30 AM, NA (nursing assistant) #6 was interviewed. NA #6 stated that she was assigned to Resident #83. She stated that the splint for Resident #83 had been discontinued due to the sore on his wrist. She indicated that the nurses did not inform her to start applying the splint so she had not been applying it.
On 1/19/17 at 10:05 AM, the Director of Nursing (DON) was interviewed. The DON indicated that the facility had no restorative NAs or restorative nurse. The NAs working on the floor were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 318	Continued From page 32 responsible for applying the splints. She stated that splint application was documented on the activity of daily living (ADL) flow sheets. Resident #83's ADL flow sheets were reviewed. The September 2016 flow sheet indicated that the splint was not applied on 9/1, 9/2, 9/3, 9/4, 9/5, 9/6, 9/7, 9/9, 9/14 and 9/15/16. There was no flow sheet for October 2016 to indicate that the splint was applied. The November 2016 flow sheet indicated that the splint was not applied on 11/1, 11/2, 11/3, 11/4, 11/5, 11/6, 11/7, 11/8, 11/12, 11/25, 11/26 and 11/3016. The January 2017 flow sheet indicated that the splint was not applied on 1/4, 1/5, 1/6 and 1/17/17. On 1/19/17 at 2:35 PM, NA #3 was interviewed. She stated that she had been assigned to Resident #83. She stated that Resident #83 was not wearing his splints for a long time now. His splint was stopped due to the sore on his wrist and she was not informed by the nurses to resume applying the splint. 1/19/17 at 2:40 PM, interview with Nurse #3 was conducted. She stated that she was not aware that the splint was discontinued for Resident #83. She indicated that NAs were supposed to apply the splint every day. During a continued interview on 1/20/17 at 9:00 AM, the DON stated that she expected the splint to be applied consistently as care planned. She indicated that the facility had no restorative nurse who will monitor the splint application and who will evaluate the progress of the residents on splints.	F 318		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies	F 334		2/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 334	Continued From page 33 and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 334	Continued From page 34 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to administer a seasonal influenza vaccine and the recommended pneumonia vaccine for 2 of 5 residents (Resident # 26 and Resident #43. Findings included: A review of the facility policy entitled: " New and Annual Resident Vaccination " updated 9/2014 read the influenza vaccine would be offered annually unless declined or contraindicated. The pneumonia vaccine would be offered if greater than 5 years lapse since the vaccine was last given. 1. Resident #26 was admitted to the facility 1/16/16 with multiple diagnoses that included	F 334	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F334 SS=D 483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 334	Continued From page 35 history of falling, bradycardia, chronic kidney disease, hyperlipidemia and dementia without behavioral disturbance. The quarterly Minimum Data Set (MDS) dated 10/24/16 indicated Resident #26 had severe cognitive impairment and required extensive assistance with her most of her activities of daily living (ADLs). There was a signed consent for both the Influenza and pneumonia vaccine dated 9/30/16. Resident #26 received the Influenza vaccine on 10/7/16 but not the pneumonia vaccine. The electronic medical record indicated the pneumonia vaccine was administered 1/19/17. In an interview on 1/19/17 at 4:00 PM, Nurse #1 stated she administered the pneumonia vaccine today but was not able to offer an explanation as to why Resident #26 did not receive the pneumonia vaccine at the time consent was given. In an interview on 1/20/17 at 12:00 PM, the Director of Nursing (DON) stated she was the facility infection control nurse and it was her expectation that all ordered and consented vaccines be administered at the time of consent unless contraindicated. 2. Resident #43 was admitted 11/22/16 with multiple diagnoses of coronary artery disease, renal insufficiency and diabetes. The admission MDS dated 11/22/16 indicated Resident #43 had moderate cognitive impairment and required extensive assistance with most of his ADLs. There was a signed consent for both the influenza and the pneumonia vaccine dated 11/18/16. A review of the electronic medication	F 334	Corrective Action: On 9/30/16 consent was received for the Influenza and the Pneumococcal Vaccine for resident # 26. The resident received the Influenza Vaccine on 10/7/2016 administered by LPN Staff Nurse. Consent was confirmed again on 1/19/2017 for the Pneumonia Vaccine. Subsequently, the resident received the vaccine on 1/19/2017. On 11/18/2016, consent was received the Influenza Vaccine and the Pneumococcal Vaccine for Resident # 43. The resident received the Influenza Vaccine and the Pneumococcal Vaccine on 1/19/2017 administered by LPN staff nurse Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. The Health Information Manager Completed an Audit on 1/27/17 to ensure that consent or declination was received and those residents who consented received their immunizations. We found that there were 10 additional long term care residents who consented to receive the Pneumococcal vaccine and had not received the vaccine. We found that there were a total of 1 additional resident(s) who consented to receive the Influenza Vaccine that did not receive it. We had	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 334	Continued From page 36 record indicated both the influenza and the pneumonia vaccine were administered to Resident #43 on 1/19/17. In an interview on 1/19/17 at 4:00 PM, Nurse #1 stated she administered both the influenza and the pneumonia vaccine today but was not able to offer an explanation as to why Resident #43 did not receive the influenza and pneumonia vaccine at the time consent was given. In an interview on 1/20/17 at 12:00 PM, the Director of Nursing (DON) stated she was the facility infection control nurse and it was her expectation that all ordered and consented vaccines be administered at the time of consent unless contraindicated.	F 334	one new admission since who has consented to both the influenza and the pneumococcal vaccine and received it on 2/6/17. The support nurse has administered all immunizations 2/8/17 (for those consenting residents). Systemic Changes: Influenza and Pneumococcal Vaccines are addressed in the admissions process within the first 72 hours upon arrival. On 1/23/17 the Administrator in-serviced the new Admissions and Marketing Coordinator, Support Nurse and the Health Information Manager regarding the admissions process regarding vaccines. The admissions and marketing coordinator, upon endorsement by the resident, responsible party or the Power of Attorney will provide the consent or declination to the support nurse to obtain an order from the physician and administer the vaccines as appropriate. Monitoring: To ensure compliance, Health Information Manager (HIM) will monitor this issue weekly through an admission/resident audit. This will be monitored on a minimum of two admissions (if there are 0-1 admissions, then the Health Information Manager (HIM) will conduct an audit on a combination of new admissions and current residents) weekly for four weeks and then monthly for three	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 334	Continued From page 37	F 334	months for new admissions/current residents and reported in the weekly Quality of Life (QoL) meeting and the Quarterly Quality Assurance Meeting. The weekly Quality Assurance (QA) Meeting is attended by the Director of Nursing (DON), Minimum Data Set (MDS) Coordinator, Support Nurse, Rehabilitation Director (RD) or Therapy designee, Health Information Manager (HIM), Certified Dietary Manager and the Nursing Home Administrator. Date of Compliance: 2/10/16	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 371		2/9/17

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	345532	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 371	Continued From page 38 (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interviews the facility failed to seal, label and date food items in the nourishment room freezer of the refrigerator. The facility failed to dispose of expired food. The facility failed to thoroughly clean ten of nineteen knobs on appliances and two of two handles on the walk in cooler/freezer door handles. The facility failed to maintain food service equipment in a clean and unbroken manner. One of two walk in cooler/freezer door handles were broken and four of four wheels were in disrepair on the steamer. Twenty of twenty-eight wheels on food service equipment had buildup of grease, dirt, and debris. Findings Included: A. An observation was conducted of the kitchen 1/17/2017 at 10:26 AM and 1/19/2017 at 11:52 AM, 1/19/2017 at 11:52 AM, and on 1/20/2017 at 10:03 AM that revealed the following: a. The knobs on two of two of the flat top griddle and the oven and six of six knobs on the stove had a buildup of grease, dirt and debris. b. Four of four wheels on the steamer were broken and had buildup of grease, dirt and debris. c. Two of two knobs on the convection oven had buildup of grease, dirt, and debris. d. Four of four wheels on the drink cart had debris on them. e. The door handle on the walk in freezer was broken and the handle had a buildup of grease, dirt and debris. f. The base of the door to the walk in freezer	F 371	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F371 SS=E Corrective Action for Resident Affected: A. Dietary staff immediately cleaned the following during the dates of 1/17/17-1/20/17: - Knobs on two of the two flat top griddle(s) - Convection Oven cleaned immediately - All six stove knobs stove were cleaned of grease dirt, and debris - Four of the Four wheels on the steamer have been cleaned up of grease, dirt, and debris - The wheels on the steamer were repaired on 2/9/17. - Two of the two knobs on the convention oven had been cleaned immediately of	

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	345532	A. BUILDING _____ B. WING _____	01/20/2017

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LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 371	Continued From page 39 facing the kitchen had buildup of grease, dirt, and debris. g. The door handle on the walk in cooler had buildup of grease, dirt, and debris. h. The frame of the plate cover cart had grease and dirt on it. i. There was food and other debris on the floor behind the stove, steamer and convection oven. An interview that was conducted on 1/20/2017 at 10:13 AM with the Dietary Manager revealed the following: a. Her expectation was that appliance knobs and handles be clean and free from buildup of grease, dirt, and debris. b. The Dietary Manager was aware of the broken equipment and her expectation was that food service equipment that was broken needed to be repaired or replaced. c. Her expectation was that food service equipment needed to be kept clean during routine cleaning. B. An observation of the nourishment kitchen on 1/20/2017 at 10:52 AM revealed the following: a. There were 17 white foam cups with plastic covers on a red tray in the freezer of the refrigerator. There wasn ' t a label on the cup that indicated the contents within each cup. Also there wasn ' t a date or a time on the cups or the tray that the cups were on. b. There were three cartons of 2% milk in the freezer of the refrigerator. Two of the three were expired with an expiration date 1/19/2017. An interview with Dietary Manager on 1/20/2017 at 11:06 AM revealed that the frozen white foam cups contained nourishment shakes. The Dietary Manager further explained that her staff would	F 371	grease, dirt, and debris - Four of the Four wheels on the drink cart were immediately cleaned - Door handle on the walk in freezer which had build-up of grease, dirt, and debris was cleaned immediately - A new handle was ordered to replace the broken handle on the walk-in freezer on 1/20/17 - The base of the door to the walk-in freezer facing the kitchen that had grease, dirt, and debris was immediately cleaned - The door handle to the walk-in cooler that had grease, dirt, and debris was immediately cleaned - The Frame to the plate cover cart that had grease and dirt on it was immediately cleaned - The food and other debris, on the floor behind the stove, steamer, and convection oven were immediately cleaned - A deep cleaning of the entire kitchen was also conducted on 1/30/2017 by the Certified Dietary Manager and Cook. B. Food not properly stored, labeled, and dated appropriately to include supplements and milk were immediately disposed of on 1/20/17. Corrective Action for Resident Potentially Affected: A. All areas of the kitchen were assessed by the Certified Dietary Manager. The Certified Dietary Manager found the following Areas needed deep cleaning:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 371	Continued From page 40 have put the nourishment shakes into the refrigerator and not the freezer. She stated that she did not know who would have placed the nourishment shakes in the freezer. The Dietary Manager removed the frozen nourishment shakes and the expired milk and stated that she would dispose of them. The Dietary Manager stated that the dietary staff do not place any products in the freezer and would not have checked the freezer. The Dietary Manager clarified that it was not the dietary department ' s responsibility to check the freezer for expired product or product that was properly dated and labeled. The Dietary Manager stated that her expectation that food product must be dated and labeled and that exposed product must be disposed of. An interview with the Housekeeping Manager on 1/20/2017 at 11:16 AM revealed that the housekeeping department was responsible for checking the refrigerator in the nourishment room for the temperature, expired product, and products not being dated or labeled. The Housekeeping Manager provided further information that the housekeeping department was checking the refrigerator but was not checking the freezer portion of the refrigerator. The housekeeping manager stated that the housekeeping department would check the freezer from that point on. An interview conducted on 1/2/2017 at 10:29 AM with the Administrator revealed that her expectations were that all food should be dated and labeled, that knobs and handles in the kitchen be clean, food service equipment needed be clean, and if the equipment was broken it needed to be repaired or replaced and reported.	F 371	behind/around the Stove/Range/Oven, Fryer, and Steamer and were immediately cleaned by the Certified Dietary Manager, the Cook(s), and the Dietary Aide as of 1/20/2017. B. The kitchen and nourishment rooms were assessed on 1/20/17 by the Certified Dietary Manager and Cook and found to have no more expired and/or non-dated food. Systemic Changes: A. The Dietary Services Director instructed Dietary Staff to clean equipment and production areas identified during survey. Weekly cleaning schedules were modified to include cart wheels, equipment knobs and handles. Staff was in-serviced by the Certified Dietary Manager regarding changes to the Cleaning Schedule on 2/7/17. The Certified Dietary Manager conducted an in-service on Food Service Sanitation for all Dietary staff on 2/7/17. A Dietary QA Audit tool was put into place to monitor compliance with this policy 2/6/17. B. Dietary and Housekeeping staff were in-serviced on 2/7/17 by the Nursing Home Administrator regarding Food Storage Practices □ Nourishment Unit Kitchen. A QA tool for monitoring Food Storage Practices by Dietary and Housekeeping Staff has been implemented beginning 2/6/2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 371	Continued From page 41	F 371	Quality Assurance/Monitoring: A. The Dietary Services Director/Certified Dietary Manager will monitor this issue using the Dietary Quality Assurance (QA) Audit Tool. This will begin on 2/6/17 and be completed 5 days per week (at least one day must include a weekend) for two months and then weekly for one additional month or until resolved by Quality of Life (QOL)/Quality Assurance (QA) committee. Any concerns will be addressed immediately and reported to the Nursing Home Administrator (NHA) for follow up. Reports will be given to the weekly Quality of Life (QOL)/Quality Assurance (QA) committee and Corrective Action initiated as appropriate. The Quality of Life (QOL)/Quality Assurance (QA) committee is the main Quality Assurance Committee. This regularly scheduled weekly meeting is attended by The Nursing Home Administrator (NHA), Director of Nursing (DON), Dietary Services Director/Certified Dietary Manager, Minimum Data Set (MDS) Nurse, and Support Nurse. The Medical Director will review during the Quarterly Quality Assurance (QA) Meeting. B. A QA tool for monitoring Food Storage Practices by Dietary and Housekeeping Staff has been implemented beginning 2/6/2017. This will begin on 2/6/17 and be completed at a minimum of 5 days per week (at least one day must include a weekend) for two months and then weekly for one additional month or until resolved	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 371	Continued From page 42	F 371	by Quality of Life (QOL)/Quality Assurance (QA) committee. Any concerns will be addressed immediately and reported to the NHA for follow up. Reports will be given to the weekly Quality of Life (QOL)/Quality Assurance (QA) committee and Corrective Action initiated as appropriate. The Quality of Life (QOL)/Quality Assurance (QA) committee is the main Quality Assurance Committee. This regularly scheduled weekly meeting is attended by The Nursing Home Administrator (NHA), Director of Nursing (DON), Dietary Services Director, Minimum Data Set (MDS) Nurse, and Support Nurse. The Medical Director will review during the Quarterly QA Meeting. Date of Compliance: 2/9/17	
F 412 SS=D	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident-	F 412		2/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	01/20/2017

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LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 412	Continued From page 43 (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide routine dental services for one of thirty-five residents (Resident #38) reviewed for mouth care. Findings included: Resident #38 was admitted on 1/11/13 with multiple diagnoses that included: diabetes, bipolar disorder and depression. Resident #38 ' s last comprehensive assessment was an annual assessment that was completed with an Assessment Reference Date of 2/11/2016. The resident was coded as having no natural teeth or tooth fragment(s) (edentulous). Review of the resident's care area assessment for dental care was documented: Resident #38 had no natural teeth and did not wear dentures. Resident #38 reported no problems chewing or swallowing and was on a mechanically altered diet. Resident #38's most recent MDS assessment was a quarterly and the assessment date was 11/13/16. Resident #38 was coded as having no broken or loosely fitting full or partial dentures and was coded as having no mouth or facial pain, discomfort or difficulty with chewing. Resident #38 was cognitively intact. A review of Resident #38 ' s care plan that was	F 412	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 412 Routine/ Emergency Dental Services In NFS Corrective Action: On January 25, 2017, Resident #38 refused to see the dentist. Resident was offered again by the Facility Social Worker on 1/26/17 and 2/2/17 with much positive encouragement; and the resident continued to refuse see dentist on both occasions. Resident # 38 denies any dental pain, chewing problems and	

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F 412	Continued From page 44 most recently reviewed after the quarterly MDS assessment dated 11/13/2017 revealed that Resident # 38 had a focus area of: The resident had potential for oral health problems related to having no natural teeth and no dentures. The goal was listed as: The resident would be free of infection, pain or bleeding in the oral cavity by/through review date. The Interventions/Tasks listed were: Consult with dietitian and change if chewing/swallowing problems are noted. Coordinate arrangements for dental care, transportation as needed/as ordered. Monitor/document/report to the doctor as needed for signs and symptoms of oral/dental problems needing attention: Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed, Tongue (black, coated, inflamed, white, smooth), sores in mouth, Lesions. Provide mouth care as per activities of daily living (ADL ' s) personal hygiene. An interview that was conducted with resident #38 on 1/17/2017 at 2:34 PM revealed that the resident could not recall the last time she had seen the dentist since she was admitted to the nursing home in 2013. The resident indicated that she had her teeth pulled at one point and she was going to get dentures. The resident further clarified that she had gotten sick and never did receive dentures. An interview conducted with the facility social worker on 1/19/17 at 11:00 AM revealed that Resident #38 had not seen a dentist or received any dental services since 4/11/13. The social worker also stated that the facility's standard procedure was that residents were not seen routinely by the dentist unless there was an oral/dental issue. An interview conducted with the DON on 1/20/17	F 412	continues to not display any weight loss or concerns. Facility Social Worker will continue to offer dental services and provide upon resident□s request. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On January 23, 2017-Jan 27, 2017 all current residents were assessed and offered to see a dentist by the Facility Social Worker, Health Information Manager (HIM), Rehabilitation Director (RD), Certified Dietary Manager, Director of Nursing, Minimum Data Set (MDS) Nurse, and the Business Office Manager (BOM). Facility Social Worker made arrangements with Senior Dental Care for in-house services for residents. Senior Dental Care provided services to 13/60 residents on January 31, 2017 and plan to return on 6 February 2017. Arrangements have been scheduled for quarterly routine visits/exams, and dental hygiene every other month by Senior Dental Care for residents for dental services. New admissions will be assessed for any dental needs and will be placed for Senior Dental Care services for next scheduled visits, unless emergency dental arises. All emergency dental needs will be addressed immediately and residents will be sent to an outside dental provider on an individual basis.	

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F 412	Continued From page 45 at 9:00 AM revealed that her expectation was that all residents, including Resident #38, edentulous or with teeth, be provided routine dental services.	F 412	Systemic Changes: On Jan 23, 2017 the Administrator in serviced the Social Worker and Director of Nursing on the following: 1. Arranging dental services for identified residents that needed to see the dentist 2. Coordinating routine dental services for residents 3. Establishing dental services for new residents 4. Assisting with emergency dental services as needed 5. Educating nursing staff to communicate to lead nurse/DON/NHA/SW if resident is identified with any dental needs and/or voices dental needs 6. Establishing a process within facility with BSW of coordinating dental services for residents in facility 7. Importance of notifying Administration/Director of Nursing (DON) of any resident with dental needs/refusals The facility Nursing Home Administrator (NHA) and Social Worker has established routine services with Senior Dental Care for Quarterly dental services (exams) and dental hygiene every other month (cleanings) for residents. All emergency dental needs will be addressed immediately and residents will be sent to an outside dental provider on an individual basis. Monitoring:	

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F 412	Continued From page 46	F 412	To ensure compliance, Nursing Home Administrator (NHA) or Social Worker will monitor this issue using the Quality Assurance (QA) survey tool for Dental Services. Facility will monitor compliance of monitoring dental needs. This will be done on weekly basis for 4 weeks, then monthly for 3 months by the Social Worker. Reports will be presented to the weekly Quality Assurance (QA) Committee by the Nursing Home Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Nursing Home Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life (QoL) Meeting. Weekly Quality Assurance (QA) Committee meeting is attended by the Nursing Home Administrator (NHA), Director of Nursing (DON), Minimum Data Set (MDS) Coordinator, Support Nurse, Rehabilitation Director (RD), Health Information Manager (HIM), Certified Dietary Manager, and/or Activity Director. Date of Compliance: 2/10/17	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 431		2/10/17

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F 431	Continued From page 47 supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431		

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F 431	Continued From page 48 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to discard and replace an expired injectable glucagon (an injection used to treat severe low blood sugar). The facility also failed to date and refrigerate an open vial of injectable Lidocaine (numbing agent) for 2 of 3 medication carts observed for medication storage. Findings included: 1. In an observation of the 100 hall medication cart on 1/19/17 at 4:40 PM, revealed an injectable dose of glucagon 1 milligram (mg) with expiration of date November 2016. Nurse #1 stated the glucagon should have been removed and replaced. On 1/20/17 at 9:45 AM, the Director of Nursing (DON) stated the pharmacy reviewed the medication carts randomly and the night nurses were responsible to review the medication carts at least weekly. It was her expectation that the expired glucagon injection would have been replaced at the end of November 2016. 2. The facility's policy on medication storage (undated) was reviewed. The policy indicated that all injections must have a date opened sticker attached and the date must be written on the sticker. The policy also indicated that all injections were good for 30 days in refrigerator if it is a multi-dose vial.	F 431	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 431 Drug Records, Label/Store Drugs & Biologicals Corrective Action for Resident Affected: On 1/19/17 the expired glucagon on the 100 hall medication cart was removed from the medication cart and discarded. Also, on 1/19/17 the opened unlabeled vial of lidocaine on the 300 hall medication cart was removed from the medication cart and discarded immediately. Both nurses were provided just in time education on the facility policy of checking for expiration dates and on labeling vials when opened by the Registered Nurse	

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F 431	Continued From page 49 On 1/19/17 at 4:35 PM, the 300 hall medication cart was observed. There was an opened/used multiple dose vial of Lidocaine 1% (200 milligrams per 20 milliliter) vial with no date of opening. On 1/19/17 at 4:45 PM, Nurse #3 was interviewed. She stated that the Lidocaine vial should have been dated when opened and stored in the refrigerator. She added that the opened vial of Lidocaine was good for 30 days after opening. Nurse #1 was observed to discard the opened vial of Lidocaine. On 1/20/17 at 9:00 AM, the Director of Nursing (DON) was interviewed. The DON stated that the nurse who opened the Lidocaine vial should have dated it and stored it in the refrigerator after opening. She added that Lidocaine injections were good for 30 days after opening. She also indicated that she expected the nurses to follow the facility's policy on medication storage.	F 431	(RN) Director of Nursing (DoN). Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this practice. On 1/19/17 all medication carts, medications rooms and medication storage rooms were assessed for any further expired medications and opened vials that were not dated when they were opened. This audit was performed by the Registered Nurse (RN) Director of Nursing (DON) on 1/19/17, 1/27/17, and 2/3/147 and did not yield further expired medications and no areas of concerns were identified. Systemic Changes: On January 28, 2017 the Director of Nursing in serviced the full time, part time and prn Nursing staff (Licensed Practical Nurses (LPN) and Registered Nurses (RN) on the process of discarding expired medications and dating vials when they are opened. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance:	

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	345532	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 50	F 431	The Director of Nursing will monitor this issue using the Quality Assurance (QA) Survey Tool for monitoring Storage of Drugs & Biologicals observing for any expired medications and any opened vials that are not dated. Any issues will be reported to the Nursing Home Administrator (NHA). This will be done weekly for one month and then monthly for 3 months. Reports will be presented to the weekly Quality Assurance (QA)committee by the Nursing Home Administrator (NHA) or the Director of Nursing (DON) to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance (QA) Meeting. The weekly Quality Assurance (QA) Meeting is attended by the Director of Nursing (DON), Minimum Data Set (MDS) Coordinator, Support Nurse, Rehabilitation Director or Therapy Designee, Health Information Manager (HIM), Certified Dietary Manager and the Nursing Home Administrator (NHA). Compliance date: 2/10/17	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:	F 520		2/10/17

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	345532	A. BUILDING _____ B. WING _____	01/20/2017

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F 520	Continued From page 51 (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these	F 520	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in	

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	345532	A. BUILDING _____ B. WING _____	01/20/2017

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F 520	Continued From page 52 interventions that the committee put into place following the 1/29/2016 recertification survey. This was for two recited deficiencies in the areas of: Self-Determination-Right to Make Choices (F242) and Right to Participate Planning Care-Revise Care Plan (F280). These deficiencies were cited again on the current recertification survey of 1/20/2017. The continued failure of the facility during two federal surveys of record showed a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 1. F242 -Self- Determination-Right to make choices: Based on resident, family and staff interviews and record review, the facility failed to offer showers as scheduled for 2 of 3 (Resident #59 and Resident #26) reviewed for choices. During the recertification survey of 1/29/2016 the facility was cited F242 for failing to provide residents with showers/whirlpool baths. On the current recertification survey of 1/20/2017, the facility failed to offer showers as scheduled. 2. F280 - Right to Participate in Planning Care-Revise Care Plan: Based on observation, staff and resident interview and record review, the facility failed to revise a care plan for refusal of wearing a right hand splint (Resident #72) for 1 of 3 residents reviewed for range of motion (ROM). During the recertification survey of 1/29/2016 the facility was cited F280 for failing to update the care plan for pressure ulcers by failing to include the current interventions for a pressure ulcer. On the current recertification survey of 1/20/2017, the facility failed to revise a care plan to reflect the refusal of wearing a right hand splint. An interview was conducted with the Administrator on 1/20/2017 at 10:29 AM. The	F 520	compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F520 QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS Corrective Action: Resident # 59 was immediately offered a shower on 1/18/2017 by the Certified Nursing Assistant (C.N.A.) and refused. Resident was offered another shower by Certified Nursing Assistant (C.N.A.) on 1/21/2017 and accepted. On 1/27/17 resident #59 was interviewed by the Minimum Data Set (MDS) Nurse and she stated she preferred whirlpool baths on Wednesdays and Saturday mornings. Residents care plan and kardex was updated by the Minimum Data Set (MDS) Nurse on 2/3/17. Resident # 26 was immediately offered a shower by the Certified Nursing Assistant (C.N.A) on 1/20/2017 and accepted. Resident was interviewed by the Minimum Data Set (MDS) Nurse on 1/24/17 and stated that she prefers a whirlpool or shower on Tuesdays and Fridays between the times of 3 PM □to 11 PM. The care plan was revised by the Minimum Data	

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	345532	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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F 520	Continued From page 53 Administrator stated that the facility had Quality Assessment and Assurance (QAA) Review Committee. The QAA committee consisted of the Director of Nursing, a physician, at least 3 other members of the facility staff and the Administrator. The QAA committee met at least quarterly and that the QAA committee identified issues that required quality assessment and assurance activities. The Administrator stated that failing to provide showers/whirlpool baths and right to participate in planning care-revise care plan were repeat deficiencies from the previous recertification survey. She stated that the facility QAA committee had conducted resident reviews and showers had been part of the review. The Administrator further clarified that shower schedules and providing showers were not specifically discussed in the QAA committee. The administrator stated that care plan revisions were audited as part of a Minimum Data Set (MDS) audit that was still ongoing.	F 520	Set (MDS) Nurse on 2/6/2017 to indicate these preferences stated above. On 1/23/17, Resident # 72□s care plan was revised and updated to reflect the resident□s right to choices and refusal of splints. Resident□s care plan was updated by the MDS nurse. (Cross reference Tag F 242 and F 280) Identification of other residents who may be involved with this practice: All residents have the potential to be affected by this practice. All residents and/or responsible party were interviewed between 1/23/2017 through 1/27/2017 for bathing preferences (Whirlpool, Shower, or Bed Bath or bath of choice) and preferences relating to date and time by the . Interviews for bathing preferences were conducted by the administrative team to include the following: the Social Worker, the Medical Records or Health Information Manager (HIM), The Rehabilitation Director (RD), the Certified Dietary Manager, the Director of Nursing (DoN), the Minimum Data Set (MDS) Nurse, and the Business Office Manager (BOM) (assigned by room number) also known as the administrative staff. 64 updates were made to Care plans and Kardex-s to reflect changes in resident preferences conducted between 1/23/2017-1/27/2017 by the Minimum Data Set (MDS) Nurse and DON as of 2/9/2017.	

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	345532	A. BUILDING _____ B. WING _____	01/20/2017

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F 520	Continued From page 54	F 520	On 1/19/17 and 2/7/17, education was provided to the staff (Licensed and Unlicensed)by the DON on all shifts (Certified Nursing Assistants (CNA), Licensed Practical Nurses (LPN), and Registered Nurses (RN)including full time and part time and PRN to ensure that they communicate with the Minimum Data Set (MDS) Coordinator and facility Director of Nursing (DON) and other administrative staff about any residents on those who have portrayed any behaviors of refusals, resistance to care in-terms of Activities of Daily Living (ADL), refusal for care including showers or splints as identified. This education was provided by the Minimum Data Set (MDS) Corporate Registered Nurse (RN) Consultant. Twenty of the Sixty-one care plans and Karedex□s have been updated to reflect changes in resident preferences as of 2/9/2017. The care plans were updated by Minimum Data Set (MDS) nurse as of 2/9/2017. (Cross reference Tag F 242 and F 280) Systemic Changes: Nursing Staff (full time, part time and prn) both licensed and unlicensed (Certified Nursing Assistants (CNA), Licensed Practical Nurses (LPN), and Registered Nurses (RN)) were in-serviced 1/20/17	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 55	F 520	through 2/10/2017 by the DON regarding Activities of Daily Living (ADL) Care (Showers) giving showers according to the care plan, honoring choices/preferences, documenting refusal(s) of care and alerting the nurse of changes/refusals of care by the Registered Nurse (RN) Director of Nursing (DoN). This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance (QA) Process to verify that the change has been sustained. On 2/7/17, the Minimum Data Set (MDS) Coordinator and facility Director of Nursing (DON) were both provided with education that addressed appropriate care planning and updating of the care plan as appropriate to reflect the resident(s) current medical status. Education was provided by the Minimum Data Set (MDS) Corporate Registered Nurse (RN) Consultant. All full time, part time, and prn nursing to include both unlicensed and licensed staff (Certified Nursing Assistants (CNA), Licensed Practical Nurses (LPN), and Registered Nurses (RN) were in serviced to adequately communicate with the Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, the facility Director of Nursing (DON) and other administrative staff including the Nursing Home Administrator (NHA) on any current incidents such as falls, new pressure ulcers, refusal of wearing splints/Activities	

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F 520	Continued From page 56	F 520	of Daily Living (ADL) care and offering different approaches/redirecting residents. Minimum Data Set (MDS) Coordinator will ensure that Care Plans are appropriately updated with interventions on an as needed basis by the inter-disciplinary team (IDT). This information has been integrated into the routine in service(s) for Registered Nurse (RN) Minimum Data Set (MDS) Coordinator / Minimum Data Set (MDS) support nurse and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance (QA) Process to verify that the change is maintained. A facility must maintain a quality assessment and assurance committee consisting of the director of nursing (DON) services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	

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F 520	Continued From page 57	F 520	(Cross reference Tag F 242 and F 280) Monitoring: To ensure compliance, The NHA will monitor this issue using the Quality Assurance (QA) Compliance survey tool. Nursing Home Administrator will monitor compliance of monitoring the completion of 100 percent audits performed, a minimum of two resident satisfactions surveys and a minimum of two sampled number of care plans. This will be done weekly x 4 weeks. Then this will be done on a monthly basis for 3 months by the Nursing Home Administrator. Reports will be presented to the Quality Assurance (QA) Committee by the Nursing Home Administrator or Director of Nursing (DoN) to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Quarterly Quality of Life (QoL) Meeting. Quality Assurance (QA) Committee meeting is attended by Nursing Home Administrator (NHA), Director of Nursing (DoN), Minimum Data Set (MDS) Coordinator, Support Nurse, Rehabilitation Director or Therapy Designee, Health Information Manager (HIM), Certified Dietary Manager, and the Nursing Home Administrator (NHA). (Cross reference Tag F 242 and F 280)	

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F 520	Continued From page 58	F 520	Date of Compliance: 2/10/17	