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 _____	C 07/06/2023

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 27332

(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 000	INITIAL COMMENTS A complaint investigation was completed on 7/5/23 through 7/6/23. Three of the eleven allegations resulted in a deficiency. See # QHY011. The following intakes were investigated: NC00201349, NC00201763, NC00203218, NC00203890, NC00204354 and NC00204407.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, and record review, the facility failed to transfer a resident with a mechanical lift according to the care planned intervention for Resident #2. This deficient practice was for 1 (Resident #2) of 3 residents reviewed for supervision to prevent accidents. The findings included: Resident #2 was admitted to the facility on 04/23/21 with diagnosis that included limited movement of Bilateral Lower Extremities (BLE) due to severe osteoarthritis of bilateral knees. Resident #2's care plan last revised 02/02/23 indicated the problem area of activities of daily living (ADL) self-care performance deficit related	F 689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F689 The facility failed to transfer a resident following the designated transfer status on the care plan. 1. Corrective action for resident(s)	8/15/23

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

Electronically Signed | 08/04/2023

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F 689	Continued From page 1 to activity Intolerance and debility. Interventions included resident to be transferred via mechanical lift with 2 staff member assistance. The significant change in status Minimum Date Set (MDS) assessment dated 04/28/23 indicated Resident #2's cognition was moderately impaired. Resident #2 was also coded as requiring extensive assistance with 2 people with bed mobility, total assistance with 2 people for transfers, and range of motion (ROM) impairment to both sides of lower extremities. Review of nursing note in the medical record dated 04/20/23 revealed Resident #2 reported to Nurse #2 that she had pain to her right hand that started after getting out of bed this afternoon. Nurse #2 documented her assessment of Resident #2 ' s right hand, at her knuckle at third digit was starting to bruise, appeared swollen, and resident reported increased pain with use. Resident #2 ' s Kardex (a guide for resident care needs used by Nursing Assistant (NA) was observed on the NAs electronic documentation system. The Kardex revealed Resident #2 was to be transferred by 2 staff members via a mechanical lift. An interview with the Rehab Director was conducted on 07/05/23 at 10:04 AM. He indicated he was familiar with mechanical lifts. He also indicated nurses, or the Director of Nursing (DON) would reach out to the therapy department if they have concerns regarding a resident needing a mechanical lift. He indicated a therapist would evaluate for the need of a mechanical lift and the evaluation and determination were based on the safety of staff and residents during a	F 689	affected by the alleged deficient practice: On 7/28/2023 resident #2 was assessed for any signs/symptoms of potential injury by the assigned nurse and resident designated method of transfer by assigned staff was observed by the Director of Nurses with no identified concerns. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 7/31/2023 the Director of Nurses and Assistant Director of Nurses identified residents that were potentially impacted by this practice by observing all Certified Nursing Assistants and Nurses, to include agency, ability to access and utilize the kardex prior to initiation of care. The results included: All Certified Nursing Assistants were able to demonstrate the ability to access the Kardex and transfer status. This was completed as of 8/5/2023. On 8/01/2023 the Director of Nurses and Assistant Director of Nurses began auditing of all resident care plans/kardex for the accuracy of the resident□s transfer status on the care plan/Kardex and for refusal to follow the designated transfer status. The results included: No concerns identified. This was completed as of 8/05/2023. On 7/31/2023 the unit manager and assigned nurses completed head to toe assessments on all non-alert residents for any signs or symptoms of injuries. The results included: No concerns were identified. On 8/03/2023 the Social Worker	

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F 689	Continued From page 2 transfer. Interview with Resident #2 was conducted on 07/05/23 at 1:23 PM. She stated she does not remember what happened to her hand at the end of April. She indicated staff used to just slide her over from the bed to the chair and not use any mechanical machine. She also stated she does not like for staff to use the mechanical lift, but now she knows they must use it for safety reasons. Observation of Resident #2 ' s right hand revealed no bruising or swelling. A phone interview was conducted with Nurse #2 on 07/05/23 at 2:25 PM. She stated when she went in on 04/20/23 to give Resident #2 her medications she complained of pain to her right hand. She also stated she administered her a pain pill and assessed her hand for injuries. Her skin at the knuckle and third digit was purplish in color and appeared swollen, and Resident #2 reported increased pain with use of her hand. She indicated when she asked the resident what had happened the resident reported she was transferred from her bed to her to her recliner earlier today by the Nursing Assistant (NA) and felt pain immediately after the transfer. She further stated she had not reported that she had pain after the transfer. A phone interview was conducted with NA #1 on 07/05/23 at 2:33 PM. She indicated that when she transferred Resident #2 from the bed to the recliner that the resident requested that she not use the mechanical lift on 04/20/23. She stated she slid the chair over to the bed, adjusted the bed so it was leveled with the chair and Resident #2 then pushed herself from the bed into the chair. She further stated Resident #2 had not	F 689	interviewed all alert and oriented residents for any concerns related to transfers. The results included: No concerns identified. On 07/31/2023 the Director of Nurses audited incident reports for the last 30 days for any similar incidents. The results included: no similar findings found 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 07/28/2023 the Director of Nurses and Assistant Director of Nurses began education of all nurses and certified nursing assistants full time, part time, as needed and agency on implementation of transfer safety interventions to include accessing the resident kardex/care plan prior to initiating a transfer, following the designated transfer status, notifying the nurse of resident refusal to follow the designated transfer status prior to transferring a resident or of any complaints of pain or potential injuries that occur during a transfer. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency, Nurses and Certified Nursing Assistants who provide residents care in the facility. As of 8/14/2023 any nursing staff who does not receive scheduled in-service training will not be allowed to work until	

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F 689	Continued From page 3 complained of pain to her right hand until the time of the transfer and she did not observe any discoloration to her right hand. An interview with the Director of Nursing (DON) was conducted on 07/06/23 at 3:33 PM. She indicated the nursing staff were to access the Kardex (a guide for resident care needs used by Nursing Assistants) to obtain information prior to providing care. She further indicated that Nursing Assistant #1 should have used a mechanical lift with 2 people to assist with the transfer of Resident #2 to ensure safety.	F 689	training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F689 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Director of Nursing will monitor to ensure that the transfer status of residents is implemented following the care plan interventions and that resident refusals are reported to the nurse. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 08/15/2023	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including	F 867		8/15/23

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F 867	Continued From page 4	F 867		

adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after

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implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects

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F 867	Continued From page 6 conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented effective procedures and monitor the interventions that the committee put into place following recertification surveys dated 2/17/22 and 2/9/23 for one deficiency in the area of supervision to prevent accidents (F689). The continued failure of the facility during three federal surveys of record showed a pattern of the	F 867	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	

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F 867	Continued From page 7 facility's inability to sustain an effective QAPI program. Findings included. This tag is cross referenced to: F689 Based on staff and resident interviews, and record review, the facility failed to transfer a resident with a mechanical lift according to the care planned intervention for Resident #2. This deficient practice was for 1 (Resident #2) of 3 residents reviewed for supervision to prevent accidents. During the recertification survey dated 2/17/22 the facility failed to prevent repeated falls by not providing effective interventions for each fall for 1 of 4 residents reviewed for accidents. The resident sustained fracture of the fingers on 9/10/21 and left and right hip fractures on 9/24/21 after the fall. During the recertification survey dated 2/9/23 the facility failed to prevent a fall for a resident with cognitive impairment and poor decision-making skills who required extensive staff assistance with bed mobility and positioning for 1 of 8 residents reviewed for accidents. The resident rolled for her side onto the floor resulting in a left femur fracture. The bed was in the high position while the Nursing Assistant left the room to throw dirty linens in the laundry bin outside the resident's room. An interview was completed on 7/6/23 at 1:00 PM with the Interim Administrator. He stated his first day was 7/3/23 and felt the repeat citation for supervision to prevent accidents was due to staff	F 867	corrected by the dated indicated. 1. Corrective action for resident (s) affected by the alleged deficient practice. Based on observations, record review, and resident and staff interviews, the facility□s Quality Assurance and Performance Improvement (QAPI) Committee failed to maintain effective procedures and monitor the interventions that the committee put into place following the recertification surveys dated 2/17/22 and 2/9/23 for one deficiency in the area of supervision to prevent accidents (F689). The continued failure of the facility during three federal surveys of record showed a pattern of the facility□s inability to sustain an effective QAPI program. 2. Corrective action for residents with the potential to be affected by the deficient practice: " Corrective action has been taken for the identified concerns in the area of supervision to prevent accidents (F689). The Quality Assurance Performance Improvement (QAPI) Committee held a meeting on 7/13/2023 to review the deficiencies from the July 5-6 complaint survey. On 7/11/2023 the Regional Clinical Consultant in-serviced the facility administrator and Quality Assurance Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. 3. Measures/Systemic changes to	

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F 867	Continued From page 8 and management turnover since the pandemic.	F 867	prevent recurrence of alleged deficient practice: On 7/13/23 the Administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nursing, Rehab Director, Activities Director, Housekeeping Manager, and Dietary Manager on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. This in-service was incorporated in the new employee facility orientation for the QAPI Committee members identified above. This will be reviewed by the Quality Assurance process to verify that change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 5 weeks then monthly x 3 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing to ensure corrective action has initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Committee meeting indefinitely or until no longer deemed necessary. The weekly Quality	

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F 867	Continued From page 9	F 867	Assurance Committee is attended by the Administrator ,Director of Nursing, Rehab Director, Activities Director, Housekeeping Manager, and Dietary Manager.	