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PRINTED: 09/28/2012 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OCT 0 3 2017 OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A, BUILDING B. WING V WALL 345520 09/13/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET LIBERTYWOOD NURSING CENTER THOMASVILLE, NC 27360 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 314 483.25(c) TREATMENT/SVCS TO F 314 F 314 PREVENT/HEAL PRESSURE SORES SS=D A Based on the comprehensive assessment of a resident, the facility must ensure that a resident The Director of Nursing (DON) who enters the facility without pressure sores and Physical Therapist initiated a does not develop pressure sores unless the sweep of the building for people individual's clinical condition demonstrates that who are at risk for skin breakdown they were unavoidable; and a resident having related to splinting. All residents pressure sores receives necessary treatment and with a diagnosis for an services to promote healing, prevent infection and unavoidable risk were assessed. prevent new sores from developing. A list of residents was then developed by the DON and reviewed with treatment nurse for This REQUIREMENT is not met as evidenced evaluation of assessment for possible skin breakdown related to Based on observations, staff interviews and medical record review the facility failed to prevent splinting. This will be monitored the occurrence of a pressure ulcer for one of one by the DON x3 months. resident with hand splints. Resident #75. Alleged Date of compliance 10.10.12 The findings were: В Resident #75 was admitted to the facility on All new admissions as well as 8/31/2010 with diagnoses including Sepsis, residents with a diagnosis for Anoxic Brain Injury, Acute Respiratory Failure, unavoidable risk of open area and Sinus Tachycardia. related to splinting will be discharged from splinting and Review of the Minimum Data Set (MDS) dated 6/21/12, a Quarterly, assessed the resident as immediately referred to the having impairment with range of motion, on both treatment nurse for wound care sides of the upper and lower extremities. treatment. Any resident found to Resident #75 was totally dependent on staff for all have skin breakdown related to of her activities of daily living. Based on this MDS, splinting will be added to weekly

LABORATORY DIRECTOR'S OR PROVIDERSUPPLIER REPRESENTATIVE'S SIGNATURE

Review of the monthly orders for August and

Resident #75 was assessed as being in a

persistent vegetative state.

Plan of Care meeting held by the

DON, unit coordinators, and dietary and monitored weekly x4

Any deficiency statement enting with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		NSTRUCTION	(X3) DATE SUF COMPLETE	
		345520	B. WING	i		09/1:	3/2012
		ER TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL	ID PREFIX	1028 BI	DDRESS, CITY, STATE, ZIP CODE  LAIR STREET  ASVILLE, NC 27360  PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE	DATE
F 314	September 2012 rev wear a right and left The palm protectors of motion (ROM) ner Review of the "Acci 9/5/12, revealed the found during hand h measured approxim described as a lacer interventions include wound and the splin wound healed.  Review of the wound the treatment nurse the documentation r advised by 11-7 shift open area between index finger. Reside contracture of this h 2.8 centimeters (cm and .2 cm in depth. (two), located direct wound "appeared fi tissue present."  Care Plan review re on the right hand wi Review of the care p no instructions for a checking the skin ur  Observations were re of wound care treatir open area was obse forefinger. The wound	realed Resident #75 was to palm protectors for 24 hours. could be removed for range eds and hygiene.  dent/Incident" report dated open area on the hand was ygiene. The wound ately 1 inch, and was ation to right hand. The ed providing treatment to the t was discontinued until the discontinued until	F3	114	weeks, or until area is healed. Treatment nurse to assess a monitor until such time the resident is no longer deemerisk for skin breakdown as a of splinting. This will be monitored by the DON using monitoring tool x3 months. Alleged Date of compliance 10.10.12  C  A list of residents was then developed by the DON and reviewed with treatment nurse valuation of assessment for possible for skin breakdown related to splinting. All new admissions as well residents with a diagnosis for unavoidable risk of open arrelated to splinting will be discharged from splinting an immediately referred to the treatment nurse for wound of treatment. Any resident four have skin breakdown related splinting will be added to we plan of care meeting held by DON, unit coordinators, and dietary. Treatment nurse to a and monitored until such time resident is longer deemed at for skin breakdown as a result.	nd d at a result ag the es rse for r as or ea and are ea to to to eekly the essess ae the risk	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER  LIBERTYWOOD NURSING CENTER	343320	s	STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360	09/13/2012
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
length of the fingernalls fingertips  Interview on 9/12/12 at treatment nurse revealed 2, (the top layers of the further explained the wo there was no odor to the interview revealed the set the wound if it was appl.  Interview with nurse #1 revealed she would che splints of residents whee worked on the day shift. Further interview revealed when the wound was fire explained Resident #75 wore a splint on the right splint was discontinued healed.  Interview with nurse aid PM revealed she had we on day shift the first weel Interview revealed she for information about he was required and ask explained Resident #75 staff for care. She prove oral care and put on he did not provide any rest contracted hands. During aide #1 explained a "close resident's right hand, where the proverse is the first weel and the provide and the pr	of the observation. The were at the top of  10:26 AM with the ed the wound was a Stage skin were gone). She bound was healing, and e wound. Continued splint could have caused ied too tight on the hand.  on 9/12/12 at 10:36 AM eck the skin under the en she worked. Nurse #1 Monday through Friday. Hed she was not working est discovered. It was is had fragile skin, and she ent hand. The right hand until the wound had  the #1 on 9/12/12 at 12:00 worked with Resident #75 ek of September. would refer to the Kardex er residents, the care that the nurses. Nurse aide #1 5 was totally dependent on yided this resident a bath, it clothes. Nurse aide #1 to retive care for the	F 31	splinting. This will be monit by the DON x3 months. Alleged Date of compliance 10.10.12  A list of residents was then developed by the DON and reviewed with treatment nur evaluation of assessment for possible for skin breakdown related to splinting. All new admissions as well residents with a diagnosis for unavoidable risk of open are related to splinting will be discharged from splinting ar immediately referred to the treatment nurse for wound contract treatment. Any resident four have skin breakdown related splinting will be added to well and treatment nurse to be as and monitored until such timesident is no longer deemer risk for skin breakdown as a of splinting.  Alleged Date of compliance 10.10.12	se for  as or ea  ad defined to deto deto deto eekly by the etary esessed me the dat a result

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u>
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345520	B. WIN			09/13	3/2012
	OVIDER OR SUPPLIER		<u> </u>	10	EET ADDRESS, CITY, STATE, ZIP CODE 128 BLAIR STREET HOMASVILLE, NC 27360		
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F 314	Interview with nurse a PM revealed she kne by the book that has know, she would ask explained she cleane #75's hands during he open up her fingers to placed a washcloth in "buildup from moistur were not long, but can Interview with nurse a AM revealed Resider right hand. She had hand, at end of July on Nurse aide #3 had re charge nurse. Continuid did not know care was aides to the hands, rewash the hands on hinterview, nurse aide would check the splir problems that were on explained she had so hand the first week on informed the charge tooked at the hand.  Interview with the Dir at 9:38 AM revealed inspect the skin under the charge of the skin under the skin	y skin problems.  If she didn't the care plans. If she didn't the nurse. Nurse aide #2 did the inside of Resident er shift. She had to work to be clean the palm. She then uside the palm to help with e. " She stated her nails me to end of fingertips.  y skin problems.  If she didn't she with the plant to help with end of the palm to help with e. " She stated her nails me to end of fingertips.  y saide #3 on 9/13/12 at 9:05 at #75 had a splint on the right or the first of August 2012.  ported the odor of the right of the provided by the emove the splints and/or er shift. During the #3 explained the nurse with and take care of any beserved. Nurse aide #3 and take care of any beserved.	L.	314	Assessment results will be reviewed in QA x3 months. of alleged compliance 10.10		
	should wash the splir problems to the nurse	SE/PREVENT DECREASE	E-	318			:

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SU COMPLE	
AND PLAN OF	CORRECTION	i DERINIOANOR NOMBER	A. BUILDING			
		345520	B. WNG		09/1	3/2012
	OVIDER OR SUPPLIER VOOD NURSING CENTE	R	11	EET ADDRESS, CITY, STATE, ZIP CODE 028 BLAIR STREET HOMASVILLE, NC 27360		
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F 318	Based on the compre resident, the facility resident, the facility resident, the facility resident, the facility resident, and resident facilities and staff interviews to palm protector to the	ehensive assessment of a nust ensure that a resident of motion receives t and services to increase or to prevent further motion.  T is not met as evidenced ons, medical record review he facility failed to apply a left hand of Resident #75 to re for one of one resident	F 318	F 318  A  The Director of Nursing (Physical /Occupational Thinitiated a sweep of the bupeople who are at risk for contractures. All residents diagnosis for an unavoidal were assessed.  A list of residents was the developed by the DON an reviewed with therapy department for physical/occupational ther evaluation of assessment f possible splinting and Ran Motion.	nerapist  ilding for  with a  ble risk  d  apy	
	8/31/2010 with diagr Anoxic Brain Injury, and Sinus Tachycard Review of the care p 4/18/12 revealed a p (ROM) contractures/ bilateral upper and le goal was maintaining 90 days. Approache were to assist with the every 2 hours and a activities of daily living Occupational Theral screen quarterly for	dmitted to the facility on closes including Sepsis, Acute Respiratory Failure, dia.  Idan with original date of composition of movement of composition of movement of composition of the next personal repositioning and repositioning is needed (PRN), assist withing (ADLs) as needed, compossible intervention. The include the use of palm		All new admissions as wel residents with a diagnosis unavoidable risk for a contwill be referred to physical/occupational ther splinting and range of mot resident is deemed appropriately Occupational The load until such time it is deappropriate to discharge to restorative nursing for splirange of motion exercises.	Il as for tracture apy for ion. If a riate for on erapy case eemed inting and	

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NAME OF PROVIDER OR SUPPLIER  LIBERTYWOOD NURSING CENTER	₹		102	ET ADDRESS, CITY, STATE, ZIP CODE 28 BLAIR STREET OMÁSVILLE, NC 27360		
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6/21/12, a Quarterly, a having impairment wit sides of the upper and Resident #75 was tota of her activities of daily Resident #75 was ass persistent vegetative so Review of the monthly September 2012 revewers a right and left palm protectors on needs and hygiene.  Medical record review Administration Record revealed Resident #75 right and left palm protectors of the most represent the TAR.  Review of the most represent the TAR.  Review of the most represent the TAR.  Review of the TAR for both palm protectors in 9/5/12. The order was application of the left palm protectors in 19/5/12. The order was application of the left palm in the test in the	m Data Set (MDS) dated assessed the resident as h range of motion, on both d lower extremities. ally dependent on staff for all y living. Based on this MDS, assed as being in a state.  I orders for August and aled Resident #75 was to alm protectors for 24 hours. could be removed for ROM  I revealed the Treatment of (TAR) for August 2012 in the ctors 24hrs alm protectors could be motion (ROM) needs and arse initials were present on month of August 2012 on the cent order dated 9/5/12, to hour hand splint to R (right) and wound. "  I September 2012 revealed had been discontinued on s not rewritten to continue	F	318	residents will be assessed a monitored by the licensed staff quarterly and as need.  Alleged date of compliance.  C  A list of residents was there developed by the DON and with therapy dept. for physical/occupational there evaluation of assessment of splinting and range of mot of contracture.  All new admissions as well residents with a diagnosis unavoidable risk for a comwill be referred to physical/occupational the splinting and range of more resident is deemed appropriate to discharge to restorative nursing for splinting of motion exercises residents will be assessed monitored by the licensed staff quarterly and as need.  Alleged Date of compliance.	nursing ed. e: 10.10.12 el reviewed apy f possible ion for risk  l as for tracture rapy for tion. If a riate for in tapy case eemed of inting and All other and nursing ed.	

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F 318	hands and wore palm Observations on 9/10 Resident #75 did not the left hand. Observations on 9/12 Resident #75 did not the left hand. Interview with restora 9/12/12 at 11:00 AM (palm protectors) we aides who worked or not on restorative ca- this nurse did not kno stopped applying the floor aides began. Interview with nurse PM revealed she wo Interview revealed no Resident #75 and wa was required. She k #75 by the kardex ar resident was total ca care and put clothes interview revealed sh care and did not rem a splint or palm guar further stated "Now her right hand.  An interview was con therapist on 9/12/12 interview it was reve discontinued from th	an guards on both hands.  2/12 at 12:14 PM revealed have a palm protector on 2/12 at 10:38 AM revealed have a palm protector on ative nurse supervisor on revealed the palm guards re applied by the nurse's at the floor. Resident #75 was seload. During this interview, ow when restorative aides a palm protectors and the aide #1 on 9/12/12 at 12:00 rived on the 7-3 shift. The palm protectors are that new what to do for Resident and asked the nurses. The re, and provided a bath, oral on the resident. Continued the did not do any restorative tember Resident #75 having don either hand. It was a there is a cloth" placed in at 2:18 PM. During this aled Resident #75 had been erapy and restorative was to tion and splint application to	F	318	The DON and Physical Ther initiated a sweep of the build people who are at risk for contractures. All residents widiagnosis for an unavoidable were assessed. All new admas well as residents with a differ unavoidable risk for a conwill be referred to physical/occupational therap splinting and range of motion resident is deemed appropriate splinting, they will be put in physical/occupational therap load until such time it is deem appropriate to discharge to restorative nursing for splint range of motion exercises. A residents will be assessed an monitored by the licensed mestaff quarterly and as needed.  Assessment results will be reviewed in QA x3 months alleged compliance 10.10.1	th a risk issions agnosis atracture  y for If a te for  y case med  ing and Ill other d ursing i.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		345520	B. WIN	G		09/	13/2012
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F 318	both hands. The tran occurred about a yea the transfer could be interview revealed Refrom restorative to nu Therapy had not had OT to evaluate or services.  Interview with nurse and revealed Residen right hand. She had shand, at end of July of Nurse aide #3 had recharge nurse. Continued in not know care was	sfer to restorative services r ago. No specific date of provided. Continued esident #75 was transferred raing (aides on the floor), any referrals this month for each the resident for aide #3 on 9/13/12 at 9:05 at #75 had a splint on the smelled an odor of the right or the first of August 2012, ported the odor to the used interview revealed she is to be provided by the emove the splints and/or	II.	318			
	revealed the nurse's in the hand was checked the skin had been instrused washcloth in the right nurse #3 clarified the had not been discontinued Continued interview what checked Residen hand splint was not appeared to the right of the provided the requested to 1/12/12 when noticing treatment to the right been provided two right and left. This states	vith nurse #3 revealed she t #75 today and the left oplied yesterday. The revealed the treatment the left hand splint on j it was not in use during the hand. Resident #75 had ht hand splints, instead of a		THE PROPERTY OF SECURITY AND ASSESSMENT AND ASSESSMENT			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
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	OVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP C 1028 BLAIR STREET THOMASVILLE, NC 27360		
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F 318	hand splint.  Interview on 9/12/12 Assistant Director of have a kardex with it to the residents. The when changes occur Resident #75 reveal	ge 8  It at 3:29 PM with the If Nursing revealed the aides Instructions for providing care It ekardexes are revised by her It. Review of the kardex for It ed instructions to apply a It rotector for 24 hours.	F3	118		

PRINTED: 10/11/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OCT 11 7017 OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (XI) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER; COMPLETED A BUILDING D1 - BUILDING OF B. WING 345520 10/02/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET LIBERTYWOOD NURSING CENTER THOMASVILLE, NC 27360 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XE) JD PREFIX (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG DEFICIENCY) K-012 K 000 **INITIAL COMMENTS** K 000 Upon learning that a celling tile had This Life Safety Code(LSC) survey was a hole, a new ceiling tile was conducted as per The Code of Federal Register installed to replace the one that at 42CFR 483.70(a); using the Existing Health had the hole, 10/15/2012 Care section of the 2000 LSC and its referenced An audit of the entire building was publications. This building is Type II(222) conducted by the Maintenance construction, one story, with out a complete automatic sprinkler system. Director, and any and all ceiling tiles that were identified for any The deficiencies determined during the survey defect have been replaced. are as follows: 10/15/2012 K 012 NFPA 101 LIFE SAFETY CODE STANDARD K 012 c. A ceiling tile audit tool has been SS=D developed to ensure all ceiling tiles Building construction type and height meets one of the following. 19.1.6,2, 19.1.8,3, 19.1.6,4, are not compromised and will be 19.3.5.1 monitored weekly times 4 weeks, then monthly times 3 months, it will be reviewed weekly by the Administrator at the daily morning Interdisciplinary team meeting x3 This STANDARD is not met as evidenced by: months, then quarterly to ensure Based on observation, on October 2, 2012 at approximately 9:00am onward, there are compliance. 10/15/2012 unsealed holes in the rated roof/ceiling assembly D. The celling tile audit log will be of the following area: monitored by the Quality Assurance Committee x3 months. 1. administration comidor area facing wing #1 The QA committee consists on the nurse's station. Director of Nursing, Unit Managers, 42 CFR 483.70(a) Activities Director, Business Office K 048 NFPA 101 LIFE SAFETY CODE STANDARD K 048 Manager, Social Worker, SS=D Administrator, Staff Development Emergency lighting of at least 11/4 hour duration is Coordinator, Admissions provided in accordance with 7.9. 19.2.9.1. Coordinator, MDS Nurse, Wound Care Nurse, Dietary Manager, Housekeeping Supervisor, Medical This STANDARD is not met as evidenced by:

Any deficiency streement ending with an expense (") denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclossible 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclossible 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation,

LABORATORY PIRECTOR'S OF

PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE

Records, 10/15/2012

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TITLE

(XII) DIVITE

PRINTED: 10/11/2012 FORM APPROVED OMB NO, 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	1	AULTIF ALDING	PLE CONSTRUCTION 01 - BUILDING 01	(X3) DATE S GOMPLI	ETED
		345520	B, Wi	NG		10/0	2/2012
	ROVIDER OR SUPPLIER WOOD NURSING CE	NTER		10	EET ADDRESS, CITY, STATE, ZIP CODE 128 BLAIR STREET HOMASVILLE, NC 27380		
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K 046 K 067 SS=D	approximately 9:00 emergency light in recreation space - 42 CFR 483.70(a) NFPA 101 LIFE SA Heating, ventilating with the provisions in accordance with	age 1 tion, on October 2, 2012 at learn onward, there is no the combination dining and located beside kitchen.  AFETY CODE STANDARD of section 9.2 and are installed the manufacturer's 9,5.2.1, 9.2, NFPA 90A,		046	K - 046  A. Upon learning that ther not a light on the back u generator in the dining/recreation area, a emergency light with battery power has been installed. 10/15/2012  B. An audit of the entire bu was conducted by the Maintenance Director, a dining/recreation room to not have a light on the	p ck up ilding nd any	
K 069 SS=D	Based on observa approximately 9:00 kitchen would not see al. Adjacent dining exhaust air plenum 42 CFR 483,70(a) NFPA 101 LIFE SA Cooking facilities a with 9.2.3. 19.3.2 This STANDARD Based on observa approximately 9:00	is not met as evidenced by: tion, on October 2, 2012 at learn onward, door to the self close to form a smoke-tight ing room is being used as an if for fresh alr supply.  AFETY CODE STANDARD ITS protected in accordance 2.6, NFPA 96  Is not met as evidenced by: tion, on October 2, 2012 at learn onward, there is no baffle fryer and kitchen range.	ĸ	069	emergency generator hat installed 10/15/2012  C. An emergency back up lit audit tool has been deverto ensure all dining/recreareas will be monitored times 4 weeks, then mon times 3 months. It will be reviewed weekly by the Administrator at the daily morning interdisciplinary meeting x3 months, then quarterly to ensure comp 10/15/2012	ght doped dation weekly thly team	
K 147	42 CFR 483.70(a) NFPA 101 LIFE SA	AFETY CODE STANDARD	К	147			

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				<del></del>	0930-0031
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	ROVIDER OR SUPPLIER	ismero		11	EET ADDRESS, CITY, STATE ZIP CODE 028 BLAIR STREET		
LIBERTY	WOOD NURSING CE	:NIEK		T	HOMASVILLE, NC 27360	2011	(20)
(X4) ID PREFIX TAG	/ピタクリ ひここけいけいひ	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ΊX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	3UL& B€.	COMPLETION
	Continued From particular Continued From Continued F	age 2 Id equipment is in accordance tional Electrical Code. 9.1.2 Is not met as evidenced by: Ition, on October 2, 2012 at Dam onward, the armor cable ached from the electrical – circuit serves the electric itchen range hood. The armor equired bushing between metal al conductors.		147	D.The emergency back up light audit log will be monitored the Quality Assurance Committee x3 months. The committee consists on the Director of Nursing, Unit Managers, Activities Director Business Office Manager, Schworker, Administrator, Staff Development Coordinator, Admissions Coordinator, Mill Nurse, Wound Care Nurse, Dietary Manager, Housekee Supervisor, Medical Records 10/15/2012	t d by QA r, cial f	
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K - 067

- A) Upon learning that the kitchen door was not closing completely, a new closure was installed to correct this deficiency.
   10/25/2012
- B) An audit of the entire building was conducted by the Maintenance Director, and any door that did not close properly has been repaired. 10/25/2012
- C) A door closure audit tool has been developed to ensure all doors will be monitored weekly times 4 weeks, then monthly times 3 months. It will be reviewed weekly by the Administrator at the daily morning interdisciplinary team meeting x3 months, then quarterly to ensure compliance.
- O) The door closure audit log will be monitored by the Quality Assurance Committee x3 months. The QA committee consists on the Director of Nursing, Unit Managers, Activities Director, Business Office Manager, Social Worker, Administrator, Staff Development Coordinator, Admissions Coordinator, MOS Nurse, Wound Care Nurse, Dietary Manager, Hausekeeping Supervisor, Medical Records. 10/25/2012

K - 069

- A) Upon learning that the fryer and stove were not separated by a Baffle, a new Baffle was installed to correct this deficiency. 10/10/2012
- B) An audit of the kitchen was conducted by the Maintenance Director, and any other area that needed a Baffle had one installed, 10/10/2012
- C) A Baffle audit tool has been developed to ensure all Baffle's were installed will be monitored weekly times 4 weeks, then monthly times 3 months. It will be reviewed weekly by the Administrator at the daily morning interdisciplinary team meeting x3 months, then quarterly to ensure compliance. 10/10/2012
- D) The Baffie audit log will be monitored by the Quality Assurance Committee x3 months. The QA committee consists on the Director of Nursing, Unit Managers, Activities Director, Business Office Manager, Social Worker, Administrator, Staff Development Coordinator, Admissions Coordinator, MDS Nurse, Wound Care Nurse, Dietary Manager, Housekeeping Supervisor, Medical Records. 10/10/2012

K - 147

- A) Upon learning that the Bushing at the end of the electrical cord in the kitchen was missing, a new Bushing was installed to correct this deficiency. 10/10/2012
- B) An audit of the kitchen was conducted by the Maintenance Director, and any other cord that needed a Bushing had one Installed. 10/10/2012
- C) A Bushing audit tool has been developed to ensure all Bushing's were installed will be monitored weekly times 4 weeks, then monthly times 3 months. It will be reviewed weekly by the Administrator at the daily morning interdisciplinary team meeting x3 months, then quarterly to ensure compliance. 10/10/2012
- D) The Bushing audit log will be monitored by the Quality Assurance Committee x3 months. The QA committee consists on the Director of Nursing, Unit Managers, Activities Director, Business Office Manager, Social Worker, Administrator, Staff Development Coordinator, Admissions Coordinator, MDS Nurse, Wound Care Nurse, Dietary Manager, Housekeeping Supervisor, Medical Records, 10/10/2012

Preparation and submission of this plan of corrections is in response to the 2567 from the survey of ilbertyWood Nursing Center. It does not constitute an agreement of admission by LibertyWood Nursing Center of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiencies, the finding, conclusions, and the actions of the Agency. This plan of correction (and any attached documents) is prepared and submitted solely because of state and federal regulations and also functions as the facility's credible allegations of compliance.