STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	09/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTYWOOD NURSING CENTER	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record review the facility failed to prevent the occurrence of a pressure ulcer for one of one resident with hand splints. Resident #75. The findings were: Resident #75 was admitted to the facility on 8/31/2010 with diagnoses including Sepsis, Anoxic Brain Injury, Acute Respiratory Failure, and Sinus Tachycardia. Review of the Minimum Data Set (MDS) dated 6/21/12, a Quarterly, assessed the resident as having impairment with range of motion, on both sides of the upper and lower extremities. Resident #75 was totally dependent on staff for all of her activities of daily living. Based on this MDS, Resident #75 was assessed as being in a persistent vegetative state. Review of the monthly orders for August and	F 314	**F 314** **A** The Director of Nursing (DON) and Physical Therapist initiated a sweep of the building for people who are at risk for skin breakdown related to splinting. All residents with a diagnosis for an unavoidable risk were assessed . A list of residents was then developed by the DON and reviewed with treatment nurse for evaluation of assessment for possible skin breakdown related to splinting. This will be monitored by the DON x3 months. Alleged Date of compliance 10.10.12 **B** All new admissions as well as residents with a diagnosis for unavoidable risk of open area related to splinting will be discharged from splinting and immediately referred to the treatment nurse for wound care treatment. Any resident found to have skin breakdown related to splinting will be added to weekly Plan of Care meeting held by the DON, unit coordinators, and dietary and monitored weekly x4	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 10/1/12

Any deficiency statement ending 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	09/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTYWOOD NURSING CENTER	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 314	Continued From page 1 September 2012 revealed Resident #75 was to wear a right and left palm protectors for 24 hours. The palm protectors could be removed for range of motion (ROM) needs and hygiene. Review of the "Accident/Incident" report dated 9/5/12, revealed the open area on the hand was found during hand hygiene. The wound measured approximately 1 inch, and was described as a laceration to right hand. The interventions included providing treatment to the wound and the splint was discontinued until the wound healed. Review of the wound assessment completed by the treatment nurse was dated 9/5/12. Review of the documentation revealed she had been advised by 11-7 shift that Resident #75 had an open area between the right thumb and right index finger. Resident #75 had a severe contracture of this hand. The wound measured 2.8 centimeters (cm) in length, 1.3 cm in width and .2 cm in depth. The wound was a Stage II (two), located directly in the web of the hand. The wound "appeared fresh with 100% granulation tissue present." Care Plan review revealed a problem of a wound on the right hand with a review date of 9/7/12. Review of the care plan for this resident revealed no instructions for applying the hand splints or checking the skin under the splints. Observations were made on 9/12/12 at 10:18 AM, of wound care treatment to the right hand. An open area was observed between the thumb and forefinger. The wound had a red center with scar tissue surrounding. The wound was healing and	F 314	weeks, or until area is healed. Treatment nurse to assess and monitor until such time the resident is no longer deemed at risk for skin breakdown as a result of splinting. This will be monitored by the DON using the 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 for evaluation of assessment for possible for skin breakdown related to splinting. All new admissions as well as residents with a diagnosis for unavoidable risk of open area related to splinting will be discharged from splinting and immediately referred to the treatment nurse for wound care treatment. Any resident found to have skin breakdown related to splinting will be added to weekly plan of care meeting held by the DON, unit coordinators, and dietary. Treatment nurse to assess and monitored until such time the resident is longer deemed at risk for skin breakdown as a result of	

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	345520	A. BUILDING _____ B. WING _____	09/13/2012

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F 314	Continued From page 2 90% closed at the time of the observation. The length of the fingernails were at the top of fingertips Interview on 9/12/12 at 10:26 AM with the treatment nurse revealed the wound was a Stage 2, (the top layers of the skin were gone). She further explained the wound was healing, and there was no odor to the wound. Continued interview revealed the splint could have caused the wound if it was applied too tight on the hand. Interview with nurse #1 on 9/12/12 at 10:36 AM revealed she would check the skin under the splints of residents when she worked. Nurse #1 worked on the day shift Monday through Friday. Further interview revealed she was not working when the wound was first discovered. It was explained Resident #75 had fragile skin, and she wore a splint on the right hand. The right hand splint was discontinued until the wound had healed. Interview with nurse aide #1 on 9/12/12 at 12:00 PM revealed she had worked with Resident #75 on day shift the first week of September. Interview revealed she would refer to the Kardex for information about her residents, the care that was required and ask the nurses. Nurse aide #1 explained Resident # 75 was totally dependent on staff for care. She provided this resident a bath, oral care and put on her clothes. Nurse aide #1 did not provide any restorative care for the contracted hands. During this interview, nurse aide #1 explained a "cloth" was now kept in the resident's right hand, which had not been there before. Nurse aide #1 had washed the resident's hands every day the first week of September, and	F 314	splinting. This will be monitored by the DON x3 months. Alleged Date of compliance 10.10.12 D A list of residents was then developed by the DON and reviewed with treatment nurse for evaluation of assessment for possible for skin breakdown related to splinting. All new admissions as well as residents with a diagnosis for unavoidable risk of open area related to splinting will be discharged from splinting and immediately referred to the treatment nurse for wound care treatment. Any resident found to have skin breakdown related to splinting will be added to weekly Plan of Care meeting held by the DON, unit coordinators, dietary and treatment nurse to be assessed and monitored until such time the resident is no longer deemed at risk for skin breakdown as a result of splinting. Alleged Date of compliance 10.10.12	

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F 314	Continued From page 3 did not remember any skin problems. Interview with nurse aide #2 on 9/12/12 at 4:30 PM revealed she knew what to do to provide care by the book that has the care plans. If she didn't know, she would ask the nurse. Nurse aide #2 explained she cleaned the inside of Resident #75's hands during her shift. She had to work to open up her fingers to clean the palm. She then placed a washcloth inside the palm to help with "buildup from moisture. " She stated her nails were not long, but came to end of fingertips. Interview with nurse aide #3 on 9/13/12 at 9:05 AM revealed Resident #75 had a splint on the right hand. She had smelled an odor of the right hand, at end of July or the first of August 2012. Nurse aide #3 had reported the odor to the charge nurse. Continued interview revealed she did not know care was to be provided by the aides to the hands, remove the splints and/or wash the hands on her shift. During the interview, nurse aide #3 explained the nurse would check the splints and take care of any problems that were observed. Nurse aide #3 explained she had smelled an odor to the right hand the first week of September and had informed the charge nurse. The charge nurse looked at the hand. Interview with the Director of Nursing on 9/13/12 at 9:38 AM revealed the floor nurses were to inspect the skin under the splints if it is written on the Medication Administration Record. The aides should wash the splinted limb and report any problems to the nurse.	F 314	**Assessment results will be reviewed in QA x3 months. Date of alleged compliance 10.10.12**	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		

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	345520	A. BUILDING _____ B. WING _____	09/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 318	Continued From page 4 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility failed to apply a palm protector to the left hand of Resident #75 to manage a contracture for one of one resident with hand splints. Resident #75 The findings were: Resident #75 was admitted to the facility on 8/31/2010 with diagnoses including Sepsis, Anoxic Brain Injury, Acute Respiratory Failure, and Sinus Tachycardia. Review of the care plan with original date of 4/18/12 revealed a problem for range of motion (ROM) contractures/limitation of movement of bilateral upper and lower extremities. The stated goal was maintaining present ROM for the next 90 days. Approaches for this goal included staff were to assist with turning and repositioning every 2 hours and as needed (PRN), assist with activities of daily living (ADLs) as needed, Occupational Therapy and Physical Therapy to screen quarterly for possible intervention. The approaches did not include the use of palm	F 318	**F 318** **A** The Director of Nursing (DON) and Physical /Occupational Therapist initiated a sweep of the building for people who are at risk for contractures. All residents with a diagnosis for an unavoidable risk were assessed. A list of residents was then developed by the DON and reviewed with therapy department for physical/occupational therapy evaluation of assessment for possible splinting and Range of Motion. Alleged Date of compliance 10.10.12 **B** All new admissions as well as residents with a diagnosis for unavoidable risk for a contracture will be referred to physical/occupational therapy for splinting and range of motion. If a resident is deemed appropriate for splinting, they will be put on Physical/ Occupational Therapy case load until such time it is deemed appropriate to discharge to restorative nursing for splinting and range of motion exercises. All other	

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F 318	Continued From page 5 protectors. Review of the Minimum Data Set (MDS) dated 6/21/12, a Quarterly, assessed the resident as having impairment with range of motion, on both sides of the upper and lower extremities. Resident #75 was totally dependent on staff for all of her activities of daily living. Based on this MDS, Resident #75 was assessed as being in a persistent vegetative state. Review of the monthly orders for August and September 2012 revealed Resident #75 was to wear a right and left palm protectors for 24 hours. The palm protectors could be removed for ROM needs and hygiene. Medical record review revealed the Treatment Administration Record (TAR) for August 2012 revealed Resident #75 had instructions to wear right and left palm protectors 24hrs (continuously). The palm protectors could be removed for range of motion (ROM) needs and hygiene. Licensed nurse initials were present on each shift during the month of August 2012 on the TAR. Review of the most recent order dated 9/5/12, to "DC (discontinue) 24 hour hand splint to R (right) hand secondary R hand wound. " Review of the TAR for September 2012 revealed both palm protectors had been discontinued on 9/5/12. The order was not rewritten to continue application of the left palm protector. Interview on 9/1012 at 11:58 AM with nurse # 4 revealed Resident #75 had contractures of both	F 318	residents will be assessed and monitored by the licensed nursing staff quarterly and as needed. Alleged date of compliance: 10.10.12 C A list of residents was then developed by the DON and reviewed with therapy dept. for physical/occupational therapy evaluation of assessment of possible splinting and range of motion for risk of contracture. All new admissions as well as residents with a diagnosis for unavoidable risk for a contracture will be referred to physical/occupational therapy for splinting and range of motion. If a resident is deemed appropriate for splinting, they will be put in physical/occupational therapy case load until such time it is deemed appropriate to discharge to restorative nursing for splinting and range of motion exercises. All other residents will be assessed and monitored by the licensed nursing staff quarterly and as needed. Alleged Date of compliance 10.10.12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	09/13/2012

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F 318	Continued From page 6 hands and wore palm guards on both hands. Observations on 9/1012 at 12:14 PM revealed Resident #75 did not have a palm protector on the left hand. Observations on 9/12/12 at 10:38 AM revealed Resident #75 did not have a palm protector on the left hand. Interview with restorative nurse supervisor on 9/12/12 at 11:00 AM revealed the palm guards (palm protectors) were applied by the nurse's aides who worked on the floor. Resident #75 was not on restorative caseload. During this interview, this nurse did not know when restorative aides stopped applying the palm protectors and the floor aides began. Interview with nurse aide #1 on 9/12/12 at 12:00 PM revealed she worked on the 7-3 shift. Interview revealed nurse aide #1 had worked with Resident #75 and was familiar with the care that was required. She knew what to do for Resident #75 by the kardex and asked the nurses. The resident was total care, and provided a bath, oral care and put clothes on the resident. Continued interview revealed she did not do any restorative care and did not remember Resident #75 having a splint or palm guard on either hand. It was further stated " Now there is a cloth" placed in her right hand. An interview was conducted with the physical therapist on 9/12/12 at 2:18 PM. During this interview it was revealed Resident #75 had been discontinued from therapy and restorative was to provide range of motion and splint application to	F 318	**D** The DON and Physical Therapist initiated a sweep of the building for people who are at risk for contractures. All residents with a diagnosis for an unavoidable risk were assessed . All new admissions as well as residents with a diagnosis for unavoidable risk for a contracture will be referred to physical/occupational therapy for splinting and range of motion. If a resident is deemed appropriate for splinting, they will be put in physical/occupational therapy case load until such time it is deemed appropriate to discharge to restorative nursing for splinting and range of motion exercises. All other residents will be assessed and monitored by the licensed nursing staff quarterly and as needed. **Assessment results will be reviewed in QA x3 months. Date of alleged compliance 10.10.12**	

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F 318	Continued From page 7	F 318		

both hands. The transfer to restorative services occurred about a year ago. No specific date of the transfer could be provided. Continued interview revealed Resident #75 was transferred from restorative to nursing (aides on the floor). Therapy had not had any referrals this month for OT to evaluate or screen the resident for services.

Interview with nurse aide #3 on 9/13/12 at 9:05 AM revealed Resident #75 had a splint on the right hand. She had smelled an odor of the right hand, at end of July or the first of August 2012. Nurse aide #3 had reported the odor to the charge nurse. Continued interview revealed she did not know care was to be provided by the aides to the hands, remove the splints and/or wash the hands on her shift.

Interview with nurse #3 on 9/12/12 at 3:25 PM revealed the nurse's initials on the TAR meant the hand was checked, splints were in place and the skin had been inspected. Resident #75 had a washcloth in the right hand. During this interview, nurse #3 clarified the order for the left hand splint had not been discontinued, but the right hand splint was discontinued due to the wound. Continued interview with nurse #3 revealed she had checked Resident #75 today and the left hand splint was not applied yesterday. The explanation provided revealed the treatment nurse had requested the left hand splint on 9/12/12 when noticing it was not in use during the treatment to the right hand. Resident #75 had been provided two right hand splints, instead of a right and left. This staff member could not provide an explanation for not having the left

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	345520	A. BUILDING _____ B. WING _____	09/13/2012

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F 318	Continued From page 8 hand splint. Interview on 9/12/12 at 3:29 PM with the Assistant Director of Nursing revealed the aides have a kardex with instructions for providing care to the residents. The kardexes are revised by her when changes occur. Review of the kardex for Resident #75 revealed instructions to apply a right and left palm protector for 24 hours.	F 318		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING 01 - BUILDING 01 B. WING	10/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTYWOOD NURSING CENTER	1028 BLAIR STREET THOMASVILLE, NC 27360

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the 2000 LSC and its referenced publications. This building is Type II(222) construction, one story, with out a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	K – 012 A. Upon learning that a ceiling tile had a hole, a new ceiling tile was installed to replace the one that had the hole. 10/15/2012 B. An audit of the entire building was conducted by the Maintenance Director, and any and all ceiling tiles that were identified for any defect have been replaced. 10/15/2012 C. A ceiling tile audit tool has been developed to ensure all ceiling tiles are not compromised and 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. 10/15/2012 D. The ceiling tile 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. 10/15/2012	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation, on October 2, 2012 at approximately 9:00am onward, there are unsealed holes in the rated roof/ceiling assembly of the following area: 1. administration corridor area facing wing #1 nurse's station. 42 CFR 483.70(a)	K 012		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by:	K 046		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 10/11/12

Any deficiency statement ending 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.

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345520	A. BUILDING 01 - BUILDING 01 B. WING _____	10/02/2012

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K 046	Continued From page 1 Based on observation, on October 2, 2012 at approximately 9:00am onward, there is no emergency light in the combination dining and recreation space - located beside kitchen. 42 CFR 483.70(a)	K 046	K - 046 A. Upon learning that there was not a light on the back up generator in the dining/recreation area, an emergency light with back up battery power has been installed. 10/15/2012 B. An audit of the entire building was conducted by the Maintenance Director, and any dining/recreation room that did not have a light on the emergency generator had one installed . 10/15/2012 C. An emergency back up light audit tool has been developed to ensure all dining/recreation areas 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. 10/15/2012	
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, on October 2, 2012 at approximately 9:00am onward, door to the kitchen would not self close to form a smoke-tight seal. Adjacent dining room is being used as an exhaust air plenum for fresh air supply.	K 067		
	42 CFR 483.70(a)			
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation, on October 2, 2012 at approximately 9:00am onward, there is no baffle between the deep fryer and kitchen range.	K 069		
	42 CFR 483.70(a)			
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING ' 01 - BUILDING 01 B. WING _____	10/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTYWOOD NURSING CENTER	1028 BLAIR STREET THOMASVILLE, NC 27360

(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
K 147 SS=D	Continued From page 2 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, on October 2, 2012 at approximately 9:00am onward, the armor cable metal jacket is detached from the electrical junction box fitting - circuit serves the electric deep fryer under kitchen range hood. The armor cable is missing required bushing between metal jacket and electrical conductors. 42 CFR 483.70(a)	K 147	D.The emergency back up light 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. 10/15/2012	

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. 10/25/2012

D) 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, MDS Nurse, Wound Care Nurse, Dietary Manager, Housekeeping 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 Baffle 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 LibertyWood 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.