STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

(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 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the	F 159		4/6/16

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

Electronically Signed | 04/24/2016

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
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F 159	Continued From page 1 SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on financial record review and staff interview, the facility failed to notify 1 of 31 sampled residents and/or their responsible person of resident ' s funds reaching $200.00 within the SSI(social security income) resource limits(Resident #50). The findings included: Resident #50 was admitted to the facility on 9/25/14 and discharged to another facility on 12/4/15. The resident monthly social security deposits were in the amount of $1,589.00. Review of the facility managed trust fund account on 3/31/16, revealed Resident #50 had an account balance of $2,534.04 as of 3/31/16. Further review of the account revealed after patient liability and miscellaneous deductions were made Resident #50 " s account balances from 8/3/15 were $2,410.08, 9/3/15 $2470.09, 10/2/15 $2,080.74 and 11/3/15 $2,534.04. During an interview on 3/31/16 at 11:48AM, the Business of Manager (BOM) indicated the resident and/or representative should have been sent a letter to notify them of the spend down process of any monies approaching the $2,000.00 limit for Medicaid residents. In addition, when a resident was transferred to another facility the money should have been forwarded to the new facility within 30 days of discharge. The BOM confirmed the money had	F 159	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 the 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. Corrective Action for Resident Affected Resident #50 refund was processed and mailed to him on 4/5/16. Corrective Action for Residents Potentially Affected All residents have the potential to be affected by this alleged practice. On 4/5/16 the Business Office Manager reviewed all resident personal funds to ensure no other resident was reaching the $200 threshold of the social security resource limit. No other residents were found to be affected by this practice. Systemic Changes	

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F 159	Continued From page 2 not been forwarded to the resident at the new facility as of 3/31/16. During an interview on 3/31/16 at 1:24PM, the Administrator indicated the expectation was for the BOM to forward monies in accordance to policy within 30 days to the new facility. The BOM should have communicated with resident/family about the Medicaid limits and the spend process for Medicaid residents with funds over $2,000.00.	F 159	On 4/5/16 the Administrator inserviced the Business Office Manager regarding processing refunds for any resident with personal funds reaching the $200 threshold of the social security resource limit. This information has been integrated into the standard orientation training for any Business Office Manager during orientation and a required refresher course for the Business Office Manager and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Administrator will monitor this issue using the Quality Assurance Survey Tool, reviewing the resident personal accounts. This will be done weekly for one month or until resolved by the Quality Assurance Committee. Reports will be presented to the weekly Quality Assurance Committee by the Administrator to ensure corrective action initiated is appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Rehabilitation Director, Dietary Manager and the Administrator.	
F 160 SS=C	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final	F 160		4/5/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 160	Continued From page 3 accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on financial record review and staff interviews, the facility failed to forward the balance of expired resident ' s personal funds to the clerk of court for 2 of 3 residents reviewed with a personal funds account (Resident #I14 and #86). The findings included: Resident #14 was admitted to the facility on 1/18/12 and expired on 11/23/15. Resident #14 account balance of $452.19 in the personal funds account in the facility. The balance of the funds had not been forwarded to the clerk of court as of 3/31/16. During an interview on 3/31/16 at 11:48AM, the Business of Manager (BOM) indicated the expectation was when a resident expired or transfers to another facility the remaining money should be either sent to the resident estate and/or the clerk of court. The BOM confirmed the remaining balance had not been sent to the clerk of court as of 3/31/16. During an interview on 3/31/16 at 1:24PM, the Administrator indicated the expectation was the BOM to forward all remaining monies to clerk of court within 30 days of the resident ' s expiration.	F 160	Corrective Action for Resident Affected Resident #14 and #86 funds were processed and mailed to the Clerk of Court on 4/5/16. Corrective Action for Residents Potentially Affected Residents who have expired have the potential to be affected by this alleged practice. On 4/5/16 the Business Office Manager and Administrator reviewed the resident financial records of all residents to determine if any other expired residents had funds in a personal account that were not refunded. No other residents were identified as affected by this practice. Systemic Changes On 4/5/16 the Administrator inserviced the Business Office Manager regarding refunding the personal funds of an expired resident within 30 days of death. This information has been integrated into the standard orientation training and in the required inservice refresher course for any Business Office Manager and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Administrator will monitor this issue	

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F 160	Continued From page 4	F 160	using the Quality Assurance Survey Tool. Reviewing all resident personal fund accounts weekly for one month or until resolved by the Quality Assurance Committee. Reports will be presented to the weekly Quality Assurance Committee by the Administrator to ensure corrective action initiated is appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Rehabilitation Director, HIM, Dietary Manager and the Administrator.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and record reviews, the facility failed to provide a medical justification for the use of a waist restraint for 1 of 1 sampled residents reviewed for physical restraints (Resident #49). The findings included: Resident #49 admitted to the facility on 3/20/13. The diagnoses included dementia, congestive heart failure and history of falls. The quarterly Minimum Data Set (MDS) dated 12/6/15,	F 221	Corrective Action for Resident Affected Resident #49 completed restraint reduction program and restraint was discontinued on 4/8/16. Corrective Action for Residents Potentially Affected All residents have the potential to be affected by this alleged practice. From 4/20 to 4/25/16 User Defined Assessments - Device and Bedrail	4/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	03/31/2016

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LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 221	Continued From page 5 indicated that Resident #49 had severe memory and decision making problems. She required assistance with all activities of daily living. Reviewed a handwritten note dated 10/22/14 from the family giving the facility authorization for the use of a waist restraint for only 30 days. Review of the physician order dated 12/29/14, revealed the use of a posey belt in wheelchair related to multiple falls with facial injuries, related to dementia. May release at meals and when family visiting, then re-apply. Review of the revised care plan dated 8/25/15, identified the problem as: resident was at risk for falls. The goal included resident would not have any serious injuries related to falls. The approaches included a trunk restraint to wheelchair with staff monitoring and release, referral to rehabilitation therapy, provision of bed/chair alarm and ensure proper foot wear in place. During an observation on 3/28/16 9:28AM, Resident #49 was placed in a soft blue waist restraint by the nursing assistant. Resident# 49 was able to sit independently and reposition self without any difficult. She did not demonstrate any behaviors/aggression, she was cooperative due to confusion and sat calmly as staff applied restraint around waist and back of chair. The resident was unable to remove the resident. NA#12 indicated the resident wore the restraint all day to prevent falls and family requested. During an observation on 3/28/16 at 4:00PM, Resident #49 was sitting in room with waist restraint tied around the waist and to the back of the wheelchair. The resident did not demonstrate any repetitive movements or attempts to stand. Resident #49 was very calm and quiet with personal items in hand.	F 221	Review was completed on all residents. The User Defined Assessment assesses a residents utilization of a device and then if a device is identified, the assessment is utilized to determine if the device is a restraint. No other residents were found to be affected by this practice. Systemic Changes On 4/20, 4/22, 4/23 the Administrator inserviced the full time, part time and PRN staff from all departments regarding definitions of restraints and limits to use of, potential dangers in use of restraints. This information has been integrated into the standard orientation training and in the required inservice refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Administrator will monitor this issue using the Quality Assurance Survey Tool, observing 10 residents a week. This will be done for one month or until resolved by the Quality Assurance Committee. Reports will be presented to the weekly Quality Assurance Committee by the Administrator to ensure corrective action initiated is appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Rehabilitation Director, HIM, Dietary Manager and the Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 221	Continued From page 6	F 221		

During an observation on 3/29/16 at 8:40AM to 9:30AM, staff delivered the breakfast tray to Resident #49 who was seated in her wheelchair without the restraint in place. The blue waist restraint was lying in a regular chair behind the resident. Resident#49 was seated in the wheelchair with meal in front of her eating and repositioning self without any problems. There was no staff assistance or supervision. She did not have any repetitive movements in any directions. Resident#49 dropped her stuffed bunny at her feet. She did not lean forward in an excessive manner she picked up bunny and reposition herself back in chair and resumed eating. The NA #13 that delivered the meal did not apply the restraint which remained in the chair behind the resident. The nursing assistant just entered the room and picked up the tray.

During an interview on 3/29/16 at 9:30AM, NA#13 indicated that Resident#49 required verbal cues for meal consumption and stated Resident #49 had not made any attempts to stand or get out of the chair unassisted due to the restraint being in place per family request.

During an observation on 3/29/16 at 10:38AM, NA #13 applied the restraint to Resident #49. Resident#49 was seated quietly and comfortable in the chair with roommate. There were no attempts to lean in any direction, stand or walk.

During an observation on 3/29/16 at 12:45PM, Resident #49 was being escorted to the dining area by family member. The restraint was not in place. Resident#49 sat quietly and comfortably in the wheelchair with no repetitive movements or attempts to exit the chair. The resident had no

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LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 221	Continued From page 7 difficulty repositioning self in wheelchair. During an interview/observation at 3/29/16 at 12:45PM, the family member stated that he requested that his mother have the restraint on to prevent her from falling and injuring herself. He further stated that resident had two previous falls some time ago. The family member added the facility had explained all the risk factors and he did not care what the facility or the doctor had to say about the restraint he did not want it off. The family member added the expectation was for the restraint to be on at all times unless he or another family member were visiting, then it could be removed. In addition, he stated Resident #49 didn't have to have a medical reason for the use of the restraint as long as she was protected from falls. During an interview on 3/29/16 at 2:15PM, the Administrator indicated that several conversations had been held with the family member regarding the use and continuation of the restraint. He had been informed of the risk factors and concerns with injuries. The family member was very adamant that he did not want the restraint removed. She further discussed that restraint reduction had been discussed with the family member, therapy department and director of nursing in an attempt to remove the restraint. The reduction discussion began a few weeks ago with the agreement from therapy to use the cushion for positioning purpose and removal the restraint. The administrator confirmed and acknowledged there had not been a medical justification for the use and continuation of the restraint. During an interview on 3/29/16 at 2:56PM, the Occupational therapist (OT) indicated Resident	F 221		

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	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 221	Continued From page 8	F 221		

#49 had been evaluated for seating and positioning and a pommel cushion was provided on 3/29/16. The OT staff attempted to remove the restraint and the family member became upset and would not allow the removal of the restraint, so the restraint remained in place in addition to the cushion. The OT indicated being unaware of any major concerns with Resident #49 ' s general positioning in the wheelchair. The cushion was put into place a measure to keep the hips positioned in the chair.

Review of the OT plan of care dated 3/15/16, revealed the reason for referral for therapy evaluation was for an appropriate wheelchair cushion to eliminate need for restraint.

During an observation on 3/29/16 at 3:00PM, Resident#49 was seated in wheelchair in the room with another family friend with the restraint in place and a soft get cushion. Resident#49 sat quietly and comfortable. The family friend indicated that resident didn ' t move she just sat in chair and rambled around in the area around to what could be reached.

During an interview on 3/29/16 at 3:40PM, Nurse #2 indicated that expected removal of the restraint was only when son visits. She further stated family gets very upset when Resident #49 was not in the restraint and felt if it was removed Resident #49 would fall. Resident#49 generally sat in chair without any problems when the restraint is not in place,

During an observation on 3/30/16 8:30AM to 10:00AM, Resident#49 completed breakfast in the room without staff assistance or supervision and the blue restraint was located in a chair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 221	Continued From page 9	F 221		

behind the resident. Resident#49 was seated quietly with roommate watching television and there were no movements in any direction. She was able to reposition self in wheelchair independently with no excessive leaning in any direction.

During an interview on 3/30/16 at 10:02AM, NA#14 indicated Resident#49 was required to wear the restraint every day and removed every 2 hours and meals per family request and her risk for falls.

During an observation on 3/30/16 at 10:02AM, NA#14 entered Resident#49 ' s room and confirmed that the restraint was located in the chair behind the resident. The NA stated, Resident#49 was should to have the restraint on at all times. She stated resident did not move much and confirmed the resident sat quietly with arms folded and no behaviors exhibited. She indicated that resident fed herself only needed set up assistance. When asked who monitors the resident when she was in the room without restraint, there was no response.

During a follow-up observation on 3/30/16 at 10:05AM, NA#13, indicated that her family wanted the restraint on all the time. She further stated that the resident just sat in the spot you place her in. She confirmed she had set the resident up for breakfast for the past two days and the restraint was not in place at the time of the meal. She confirmed that the blue restraint was located in the chair behind the resident. She attempted to put the restraint on the resident and the resident continued to push the restraint and staff hand in her attempt to apply. The NA went to get Nurse#2 for assistance because the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 221	Continued From page 10 would not allow the staff to put on the restraint. Nurse#2 indicated that the restraint should be on all day due to family request and removed when he visits. She confirmed the resident was sitting in chair without any behaviors or problems. During an interview on 3/30/16 at 11:17AM, the Nurse Consultant indicated that it was not the expectation of the facility to restrain individuals based on family request. She further stated that restraints should be reviewed and assessed in accordance to policy. During a telephone interview on 3/30/16 at 1:21PM, the Director of Nursing (DON) indicated that she had inherited the restraint situation on 12/25/15. She indicated that they had just started speaking with the family about the restraint to educate him on the regulation and the medical perspective of why the restraint was not medically necessary for the resident. The DON confirmed there was no medical reason for use of the restraint.	F 221		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by:	F 273		4/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 273	Continued From page 11 Based on medical record review and staff interview, the facility failed to conduct a comprehensive admission assessment within 14 days of a resident's admission for 1 of 21 residents reviewed for complete and accurate assessment information (Resident #210). Findings included: Resident #210 was admitted to the facility on 3/7/16. Upon review on 3/29/16, only the entry Minimum Data Set (MDS, the assessment that drives the care for residents) dated 3/7/16 could be found. The admission MDS dated 3/14/16 was not completed and stated "In Progress" as its status. The Interim Director of Nursing (DON) was interviewed on 3/29/16 at 2:33 PM. She indicated that the MDS nurse and the back up to the MDS nurse have had to take extended leave from their positions. The facility has brought in an MDS nurse from another facility and a corporate nurse consultant to fill in, but have not been able to keep up with the MDS demands. She also indicated that she just recently became the Interim DON and had not been monitoring the completion of the MDS assessments for the residents. The nurse consultant was interviewed on 3/30/16 at 2:50 PM. She stated "I admit we are late with the MDS assessments."	F 273	Corrective Action Resident #210: Comprehensive Assessment: Assessment Reference Date 3/14/16 Mary Maas, State RAI Coordinator for North Carolina was contacted. Recommended to complete and submit assessment. Comprehensive Assessment with Assessment Reference Date of 3/14/16 was completed and submitted to QIES database. The assessment was accepted as indicated on the validation report. Corrective Action for Residents Potentially Affected All residents who are determined to have a Comprehensive Assessment due 14 days after admit have the potential to be affected by the alleged practice. All Comprehensive Assessments for all current residents due 14 days after admit were reviewed. 6 residents were determined to have comprehensive assessments due 14 days after admit as "in progress". Mary Maas, State RAI Coordinator for North Carolina was contacted. Recommended to complete and submit assessments. All Comprehensive Assessments due 14 days after admit, for the 6 residents were completed and submitted to QIES database. The assessments were accepted as indicated on the validation report. Systemic Changes On 4/21/16 the RN MDS Coordinator, Director of Nursing, Social Worker,	

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	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 273	Continued From page 12	F 273	Dietary Manager, Therapy Manager, HIM and any other interdisciplinary team member who participates in completing an MDS Assessment were inserviced on conducting a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the residents physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave). The Director of Nursing, or MDS Coordinator/RN Designee will review new admissions excluding readmissions in which there is no significant change in the residents physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization for therapeutic leave). The Director of Nursing or MDS Coordinator/RN Designee will ensure that each resident who has a Comprehensive Assessment due 14 days after admit, must have the assessment conducted and completed within the 14th calendar day and submitted to the QIES database. Any issues will be reported to the Director of Nursing or Administrator for appropriate action. During the daily Clinical Meeting (Monday through Friday), the RN MDS Coordinator or Designee will review assessment reference dates for all comprehensive assessments due 14 days	

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	345496	A. BUILDING _____ B. WING _____	03/31/2016

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F 273	Continued From page 13	F 273	after admit for each day. The RN MDS Coordinator will discuss the due date of each Comprehensive Assessment 14 days after admit. The daily clinical meeting is attended by the Director of Nursing, Unit Managers, MDS Coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Social Worker, Administrator and others as needed. Quality Assurance To ensure compliance, the Director of Nursing will conduct a review using the Quality Assurance MDS Assessment Tool. 5 residents with Comprehensive Assessments 14 days after admit will be reviewed weekly for 4 weeks and then monthly for 3 months. The items reviewed on the Quality Assurance MDS Assessment Tool will include: Date of Admission, assessment reference date of comprehensive assessment 14 days after admit, and date of completion section Z0500A. Identified issues will be reported immediately to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Rehabilitation Director, HIM, Dietary Manager and the Administrator.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive	F 274		4/21/16

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	345496	A. BUILDING _____ B. WING _____	03/31/2016

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LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 274	Continued From page 14 assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to conduct a timely comprehensive significant change assessment for 1 of 21 residents reviewed for complete and accurate assessment information (Resident #106). Findings included: Resident #106 was admitted to the facility on 8/21/14 and significantly declined resulting in hospice enrollment on 3/4/16. Upon review of the medical record on 3/29/16, the significant change Minimum Data Set (MDS, the assessment that drives the care for residents) dated 3/11/16 was not complete. It stated "In Progress" as its status. The Interim Director of Nursing was interviewed on 3/29/16 at 2:33 PM. She indicated that the MDS nurse and the back up to the MDS nurse have had to take extended leave from their positions. The facility has brought in an MDS nurse from another facility and a corporate nurse consultant to fill in, but have not been able to keep up with the MDS demands. She also	F 274	Correction Action for the Resident Affected Resident #106: Comprehensive Assessment: Assessment Reference Date 3/11/16. Mary Maas, State RAI Coordinator for North Carolina was contacted. Recommended to complete and submit assessment. Comprehensive assessment with assessment reference date of 3/11/16 was completed and submitted to QIES database. The assessment was accepted as indicated on the validation report. Corrective Action for Residents Potentially Affected All residents who are determined to have significant change comprehensive assessment due have the potential to be affected by the alleged practice. All significant change assessment	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 274	Continued From page 15 indicated that she just recently became the Interim DON and had not been monitoring the completion of the MDS assessments for the residents. The nurse consultant was interviewed on 3/30/16 at 2:50 PM. She stated "I admit we are late with the MDS assessments."	F 274	comprehensive assessments for all current resident due were reviewed. No residents were determined to have significant change comprehensive assessments due. Mary Maas, State RAI Coordinator for North Carolina was contacted. No recommendation was given. Systemic Changes On 4/21/16 the RN MDS Coordinator, Director of Nursing, Social Worker, Dietary Manager, Rehabilitation Director, HIM and/or any other interdisciplinary team member who participates in completing and MDS assessment were inserviced on conducting a significant change in status comprehensive assessment of a resident with 14 days after the facility determines that there has been a significant change in the residents physical or mental condition. (For purposes of this section, a significant change means a major decline or improvement in the residents status that will not normally resolve itself without further intervention by staff or by implementing standard disease related clinical interventions that has an impact on more than one area of the residents health status and requires interdisciplinary review or revision of the care plan or both). The Director of Nursing or MDS Coordinator or RN Designee will ensure that each resident who has a significant change in status comprehensive	

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F 274	Continued From page 16	F 274	assessment due must have the assessment conducted and completed with 14 days after the facility determines that there has been a significant change and submitted to the QIES database. Any issues will be reported to the Director of Nursing or Administrator for appropriate action. During the daily Clinical Meeting (Monday through Friday) the RN MDS Coordinator or Designee will review assessment reference dates for all significant change in status comprehensive assessments due for each day. The RN MDS Coordinator will discuss the due date of each significant change in status comprehensive assessment. The daily Clinical Meeting is attended by the Director of Nursing, Unit Managers, MDS Coordinators, Support Nurse, Rehabilitation Director, HIM, Dietary Manager, Social Worker, Administrator and others as needed. Quality Assurance To ensure compliance, the Director of Nursing will conduct a review using the Quality Assurance MDS Assessment Tool. 5 residents with comprehensive assessments (admission assessment, significant change in status assessment, significant correction to prior comprehensive assessment) will be reviewed weekly for 4 weeks and then monthly for 3 months. The items reviewed on the Quality Assurance MDS Assessment Tool will include: date of admission, assessment reference date of significant change in status	

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F 274	Continued From page 17	F 274	comprehensive assessment and date of completion Section Z0500A. Identified issues will be reported immediately to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Rehabilitation Director, HIM, Dietary Manager and Administrator.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to conduct a comprehensive quarterly assessment for 1 of 21 residents reviewed for complete and accurate assessment information (Resident #74). Findings included: Resident #74 was admitted to the facility on 12/12/14. Upon review on 3/29/16, the most updated comprehensive Minimum Data Set (MDS, the assessment that drives the care for residents) was dated 12/17/15. The quarterly comprehensive MDS was due on 3/16/16 but stated "In Progress" as its status. The Interim Director of Nursing (DON) was interviewed on 3/29/16 at 2:33 PM. She indicated	F 276	Correction Action for Resident Affected Resident #74: Quarterly Assessment: Assessment Reference Date 3/16/16. Mary Maas, State RAI Coordinator for North Carolina was contacted. Recommended to complete and submit assessment. Quarterly Assessment with assessment reference date of 3/16/16 was completed and submitted to QIES database. The assessment was accepted as indicated on the validation report. Corrective Action for other Residents Potentially Affected	4/21/16

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	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 276	Continued From page 18 that the MDS nurse and the back up to the MDS nurse have had to take extended leave from their positions. The facility has brought in an MDS nurse from another facility and a corporate nurse consultant to fill in, but have not been able to keep up with the MDS demands. She also indicated that she just recently became the Interim DON and had not been monitoring the completion of the MDS assessments for the residents. The nurse consultant was interviewed on 3/30/16 at 2:50 PM. She stated "I admit we are late with the MDS assessments."	F 276	All residents who are determined to have Quarterly Assessments due have the potential to be affected by the alleged practice. All quarterly assessments for all current resident due were reviewed. 11 residents were determined to have Quarterly Assessments due. Mary Maas, State RAI Coordinator for North Carolina was contacted. Recommended to complete and submit assessments. All quarterly assessments due for the 11 residents were completed and submitted to QIES database. The assessments were accepted as indicated on the validation report. Systemic Changes On 4/21/16 the RN MDS Coordinator, Director of Nursing, Social Worker, Dietary Manager, Rehabilitation Director, HIM and/or any other interdisciplinary team member who participates in completing as MDS assessment were inserviced on the fact that a facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. The Director of Nursing or MDS Coordinator or RN Designee will ensure that each resident who has a quarterly assessment due, must have the assessment conducted and completed within 14 days after the assessment reference date and submitted to the QIES database. Any issues will be reported to the Director of Nursing or Administrator for appropriate	

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	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 276	Continued From page 19	F 276	action. During the daily Clinical Meeting (Monday through Friday) the RN MDS Coordinator or Designee will review assessment reference dates for all quarterly assessments due for each day. The RN MDS Coordinator will discuss the due date of each quarterly assessment. The daily Clinical Meeting is attended by the Director of Nursing, Unit Managers, MDS Coordinators, Support Nurse, Rehabilitation Director, HIM, Dietary Manager, Social Worker, Administrator and others as needed. Quality Assurance To ensure compliance, the Director of Nursing will conduct a review using the Quality Assurance MDS Assessment Tool. 5 residents with quarterly assessments will be reviewed weekly for 4 weeks and then monthly for 3 months. The items reviewed on the Quality Assurance MDS Assessment Tool will include: date of admission, assessment reference date of quarterly assessment and date of completion Section Z0500A. Identified issues will be reported immediately to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality Assurance Meeting. The weekly Quality Assurance meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Rehabilitation Director, HIM, Dietary Manager and Administrator	
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		4/25/16

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	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 312 SS=D	Continued From page 20 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interview, and medical record review, the facility failed to provide activities of daily living care as it relates to personal hygiene of maintaining clean, trimmed fingernails, maintaining clean ears, and maintaining facial hair for 3 of 4 residents reviewed for Activities of Daily Living (ADLs) (Resident #7, #178, and #67). Findings included: Resident #7 was admitted to the facility on 11/19/2014 with cerebral palsy with bilateral hands bent towards the inner forearms. Upon observation on 3/29/2016 at 2:26 PM, the resident demonstrated limited range of motion at the wrists. The Minimum Data Set dated 2/2/16 indicated that the resident was cognitively intact and was determined to be totally dependent on one person assistance for personal hygiene. Resident #7 was care planned on 3/29/16 for deficits in ADL care. The care plan instructed staff to check nail length and trim and clean an necessary, among other things. On 03/29/2016 at 2:26 PM, Resident #7 was observed in her room. She was observed to have long, jagged nails with dirt and grime built up under the nails. She was also noted to have 2 clumps of chin hairs, and brown ear wax built up in her left ear. Resident #7 stated " Staff is	F 312	Corrective Action for Resident Affected Resident #7 nails were trimmed and cleaned, ear wax was removed and facial hair removed on 3/31/16. Resident #178 nails were trimmed and has had palm guard put in place on 3/31/16. Resident #67 hands were cleaned and nails were trimmed on 3/31/16. Corrective Action for Residents Potentially Affected All residents have the potential to be affected by this alleged practice. On 4/3/16 Certified Nursing Assistants checked all residents, trimmed and cleaned nails, check for visible ear wax building up and removed any facial hair. Systemic Changes On 4/21, 4/22 and 4/23/16 the Director of Nursing and/or Administrator inserviced the full time, part time and PRN Nursing Staff. Topics included: proper nail care, cleaning and trimming nails, cleaning and checking ears for visible ear wax, removal of facial hair. These expectations have been integrated into the standard orientation training and in the required	

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	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 312	Continued From page 21 doing the best they can. They trim nails and chin hairs when I ask. " She did not address the ear wax build up at this time. On second observation on 03/30/2016 at 3:15 PM, the resident was noted to be eating cake, cupcake, and cheese puffs for a birthday celebration. Resident #7 ' s nails were still jagged, dirty, and long. She stated " No one offered to help me wash my hands today. They sometimes give me a wet wipe for me to clean my hands but no one offered it today. " Four members of nursing aide staff were interviewed on 3/30/2016 at 3:30 PM during shift change. None were able to confirm that ADL care regarding nail care, facial hair care, and ear care was provided to Resident #7 that day. They indicated that the care for Resident #7 is supposed to be provided during second shift during Resident #7 ' s shower days, which are Wednesday and Saturdays. They also indicated that nursing aides rotate through the building and that none of the four had been assigned to Resident #7 during her shower days during the past few weeks. On third observation, on 03/30/2016 at 4:00 PM, Resident #7 was observed with a wet wipe in hand. She stated " I am trying to clean myself as best as I can. I don't like it when I have long dirty nails; I like my nails short. I don ' t like chin hairs either. I know that they are trying their best but I need help. I cannot do it by myself. I need their help. " The Interim Director of Nursing was present during the interview with the resident on 03/30/2016 at 4:00 PM. She acknowledged that	F 312	inservice refresher courses for all Nursing Staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the Quality Assurance Survey Tool, observing 10 residents per week for 4 weeks. Any issues will be reported to the Administrator. This will be completed weekly for one month or until resolved by the Quality Assurance Committee. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing to ensure corrective action initiated is appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Rehabilitation Director, HIM, Dietary Manager and the Administrator.	

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F 312	Continued From page 22	F 312		

Resident #7 had long, jagged, unclean finger nails, chin hairs, and a noticeable build-up of ear wax. She stated "ADL care is not being done. I can see that this is an area for which I will have to re-educate the staff immediately. "

2) Resident #178 was admitted to the facility on 1/5/16. Diagnoses included stroke, high blood pressure, seizures, and depression.

The Minimum Data Set (MDS) initial assessment dated 1/12/16 revealed the resident was cognitively intact. The resident required an extensive assistance from two assistants with bed mobility and transfers and an extensive assist with one assist with all other activities of daily living (ADLs). The resident had impairment to one side on the lower and upper extremity and used a wheelchair.

A review of the care plan updated on 1/5/16 revealed a plan of care for a stroke (hemiparesis) affecting left non dominant side. The interventions were to apply a left palm guard in left hand daily as tolerated and remove during bath times and remove if resident requests.

A review of a physician ' s order written on 3/21/16 revealed an order for left hand to be inspected daily for breakdown related to contracture.

An interview was conducted with the Occupational Therapist (OT) on 3/31/16 at 9:54 am. The OT reported the resident was seen on 2/29/16. On 2/29/16, a procedure called diathermy was performed to aid in passive range of motion (PROM). PROM and hand hygiene

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	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 312	Continued From page 23	F 312		

was done. The OT also started the use of the palm guard for the left hand. The OT reported she notified the second shift nurse (no name provided) the resident ' s fingernails needed to be cut so that the palm guard could be applied and tolerated. The OT did not know if the resident ' s nails were ever cut. The OT did not have to provide education to apply the palm guard. She reported the NAs knew how to apply it. The resident was to wear the palm guard to prevent from skin breakdown for more than three hours in order to reduce further progression or development of contractures showing no insult to skin integrity. The OT reported that once they initiated the palm guard it was up to nursing to ensure it was being applied as recommended. The resident was no longer on therapy caseload after this was initiated.

An observation was conducted with Nurse #1 on 3/31/16 at 11:08 am. Resident #178 was noted to be in the bed lying down. The resident was wearing bed clothes. The nurse removed the palm guard from the resident ' s hand. All four fingers were folding inward toward the palm. The nurse slowly extended the fingers. The fingernails were noted to be approximately ¼ - ½ long and jagged. There were two small puncture marks noted on the palm in the areas where the pinky fingernail was lying and where the middle fingernail would rest.

During an interview with the resident on 3/31/16 at 11:00 am, she revealed she did not know the last time the NAs cut her nails. The resident also reported she had pain in her hand.

During an interview with the nurse on 3/31/16 at 11:10 am she revealed she did not know when the nails were cut. The nurse reported the NAs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

(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 312	Continued From page 24	F 312		

usually do this when the residents get a shower or during care.

A review of the ADL record revealed the resident had a shower on 3/30/16. The NA (NA #1) that performed this shower was unable to be reached.

During an interview with NA #4 on 3/31/16 at 11:17 am, the NA reported no morning care had been done on Resident #178 as of this time. NA #4 added she was the only one on the unit and it was taking her a long time to get everyone up. The NA reported the aides are responsible for trimming and cleaning the resident ' s nails as well as bathing them completely.

3) Resident # 67 was admitted to the facility on 6/6/12. Diagnoses included stroke, high blood pressure, high cholesterol, dementia, hernia, anemia, depression, peripheral vascular disease, encephalopathy, pain, neuropathy, bowel obstruction, osteoarthritis, and gastro reflux disorder.
The Minimum Data Set (MDS) quarterly assessment dated 1/10/16 revealed the resident was cognitively impaired. She required extensive assistance from one assistant with all activities of daily living (ADLs). The resident had impairment to one side to the upper and lower extremities and used a wheelchair.

A review of the updated care plans revealed a plan of care dated 3/9/16 for ADL self-care performance deficit related to a diagnosis of hemiplegia (stroke). Interventions included to check nail length and trim and clean as necessary.

An observation of Resident #67 was conducted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

(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 312	Continued From page 25 on 3/31/16 at 2:15 pm with NA #4. The resident was fully dressed, well groomed and sitting upright in her wheelchair in the hallway. NA #4 approached Resident #67 and assisted the resident to open her contracted left hand. Upon opening the hand it was noted the fingernails on the index finger and the middle finger were approximately 1/2 inch long and were jagged. There were no open wounds on the hand, however the hand was noted to be dirty and odorous. An interview was conducted with NA #4. The NA reported that she felt like it was not possible to complete all the tasks assigned during the shift if the NA was the only one on the unit. The NA was the only NA on the unit until noon due to a staff member calling out. The NA reported she was not able to get to other tasks including trimming nails, showers, and applying splints. The NA performed morning care on Resident #67 but she reported she did not open her hand and clean it. She only cleaned the outer part of her hand. The NA reported she was rushing to do care since she was the only one on the unit. The NA confirmed the resident ' s hand was dirty, odorous and the fingernails were long and jagged. A record review of the ADL sheet revealed no nail care was done 3/30/16 or 3/31/16. During an interview with the Administrator on 3/31/16 at 1:30 pm she revealed her expectation was that staff complete nail care as needed as part of the ADLs that are to be done for each resident to maintain skin integrity and prevent infections.	F 312		
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		4/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 318 SS=D	Continued From page 26 IN RANGE OF MOTION 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, record review, staff and resident interviews, the facility failed to use prescribed hand splints to promote comfort and to prevent further contracture on 2 of 2 residents. (Residents #26 and #178) 1) Resident #178 was admitted to the facility on 1/5/16. Diagnoses included stroke with left sided weakness, high blood pressure, seizures, and depression. The Minimum Data Set (MDS) initial assessment dated 1/12/16 revealed the resident was cognitively intact. The resident required an extensive assist with two assist with bed mobility and transfers and an extensive assist with one assist with all other activities of daily living (ADL's). The resident had impairment to one side on lower and upper extremity and used a wheelchair. The resident was always incontinent of bowel and bladder. A record review of the care plan dated 1/5/16 revealed a plan of care for a stroke (hemiparesis) affecting left non dominant side. The updated	F 318	Corrective Action for Resident Affected Resident #26 and #178 have appropriate hand splint and palm guard in place. Instruction was given to Nursing Staff by Occupational Therapist for placement of splint/palm guard, including cleaning of hand, range of motion exercises appropriate for each resident prior to placement. Corrective Action for Residents Potentially Affected All residents with contractures have the potential to be affected by the alleged practice. Between 4/13 and 4/19/16 the Occupational Therapist assessed all residents for contractures and the need for range of motion exercises, splints or palm guards. Assessments have been documented on the Occupational Therapy Screen Tool for each resident. Systemic Changes On 4/7, 4/8 and 4/25/16 the Rehabilitation Director inserviced all full time, part time and PRN Nursing Assistants. Topics	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	03/31/2016

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LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 318	Continued From page 27 interventions were to apply a left palm guard in left hand daily as tolerated. Remove palm guard during bath times and remove if resident requests, therapy to evaluate and treat as ordered and range of motion active or passive with morning and evening care daily. A record review of a physician ' s order written on 3/21/16 revealed an order for left hand to be inspected daily for breakdown related to contracture. During an interview with the resident on 3/28/16 at 9:00 am the resident revealed she had not had her palm guard on her hand for a " good bit now. " The resident could not remember the last time the facility put the palm guard on her left hand. The resident ' s left hand was noted to have all four fingers and the thumb folded into her palm. The resident reported that therapy suggested she wear it all times as long as she could tolerate it. The palm guard was noted to be sitting on the resident ' s nightstand on the left side of her bed. Observations on 3/28/16 at 10:00 am, 11:00 am, 12:00 pm, 1:00 pm and 2:00 pm revealed each time the resident was not wearing the palm guard. The palm guard was noted each time to be on the nightstand in the same position. During an interview with Resident #178 on 3/28/16 at 2:00 pm, the resident revealed no one applied her palm guard today. The resident was asked if she ever refused her palm guard when they asked her to put it on and she replied " no. " Observations on 3/29/16 at 9:00 am, 10:00 am, 11:00, 12:00, 1:30pm and 2:00pm revealed the palm guard was not on the residents hand each	F 318	included: demonstrations on active and passive range of motion with all joints, importance of applying splints and palm guards per the Therapists recommendation and training. This information has been integrated into the standard orientation training and in the required inservice refresher courses for all Nursing Assistants and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the Quality Assurance Survey Tool, observing 5 residents per week for 4 weeks. Any issues will be reported to the Administrator. This will be completed weekly for one month or until resolved by the Quality Assurance Committee. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing to ensure corrective action initiated is appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Rehabilitation Director, HIM, Dietary Manager and the Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 318	Continued From page 28	F 318		

time. The palm guard remained in the same position on the night stand.

During an interview with Resident #178 on 3/29/16 at 3:05 pm, the resident reported that no staff member applied her palm guard to her left hand today.

Observations on 3/30/16 at 5:15 am, 6:00 am, 6:30 am, 7:30 am, 9:00 am, 10:00 am, and 11:45 am revealed there was no palm guard on the resident ' s left hand. The palm guard remained in the same position on the nightstand.

During an interview with Resident #178 on 3/30/16 at 11:45 am she revealed that she would not refuse to wear the splint but the staff did not ask to put it on her.

An interview with Nursing Assistant #1 (NA) at 11:51 am on 3/30/16 revealed that she was not sure if resident wore a palm guard.

An interview with Nurse #1 on 3/30/16 at 12:43 pm revealed the resident wears her palm guard every day. There is no set time that it goes on or comes off, it depends on what the resident wants. The nurse reported the palm guard was supposed to be on her as long as she could tolerate it each day. The nurse was unaware the resident was not wearing the splint while being observed on 3/28/16 thru 3/30/16.

An interview was conducted with the Occupational Therapist (OT) on 3/31/16 at 9:54 am. The OT reported the resident was seen on 2/29/16. The OT started the use of the palm guard for the left hand. The OT did not have to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

(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 318	Continued From page 29	F 318		

provide education to apply the palm guard. She reported the NA ' s knew how to apply it. The resident was to wear the palm guard to prevent from skin breakdown for more than three hours in order to reduce further progressing or development of contractures showing no insult to skin integrity. The OT reported that once they initiated the palm guard it was up to nursing to ensure it was being applied as recommended. The resident was no longer on therapy caseload after this was initiated.

During an interview with the Administrator on 3/31/16 at 1:30 pm she revealed her expectation was that anyone that was expected to wear a splint or a devise to promote skin integrity should have them on as ordered. Additionally, she added the nursing staff should be aware of any and all residents requiring such devices.

2)
Resident #26 was admitted to the facility on 12/11/12. Diagnoses included a stroke with left sided weakness and contracture of left hand.

A record review of the Minimum Data Set (MDS) quarterly assessment dated 2/5/16 revealed the resident was mildly cognitively impaired. The resident required an extensive assist with two assist with bed mobility and transfers. He was independent with locomotion on and off the unit and supervision with set up only for meals. He was limited assist with one assist with dressing and hygiene and extensive assist with one assist with toileting. The resident was always incontinent of urine and frequently incontinent of bowel. The resident had impairment on one side to upper and lower extremity and used a wheelchair. He was not steady but able to stabilize with staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

(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 318	Continued From page 30	F 318		

assistance. There was no indication for a splint on the MDS.

A record review of the care plans updated on 3/9/16 revealed a plan of care for alteration in muscle skeletal status related to a contracture to left hand. The intervention was to encourage and assist with use of splint.

Multiple observations were made from 3/28/16 to 3/31/16 from the hours of 5:00 am thru 5:00 pm revealing the resident had no splint on his left hand.

An interview was conducted with the resident on 3/28/16 at 9:20 am. The resident revealed he was
suppose to wear a splint and has not had one in a long time. The resident reported "I want to wear one."

An interview with Nursing Assistant (NA) #1 on 3/30/16 at 12:00 pm revealed she did not know if the resident was supposed to wear a splint. The NA spoke with nurse at this time and she reported "at one time he did, but he does not have it anymore. "

An interview with Nurse #1 on 3/30/16 at 12:30 pm, revealed the resident had an order to wear one to apply in the morning and remove at bedtime. The nurse further added that when the facility switched over to computers over a year ago, we lost a lot of stuff and this order may not have been transcribed over. The nurse reported that it was up to the nursing staff to make sure it is put on, but she was not sure how long the resident had not been wearing it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 318	Continued From page 31	F 318		

An interview with NA #5 on 3/30/16 at 1:30 pm revealed the resident was supposed to have a splint, but it had not been seen on the resident for a very long time. The NA reported the resident does not have one in his room anymore.

An interview with OT #1 on 3/31/2016 at 10:13 am revealed the resident was evaluated to wear a left wrist hand splint on 9/9/16 per the nurse ' s recommendation due to worsening contracture and loss of left hand splint. The OT reported that the recommendations were for the resident to wear the splint on an eight hour schedule. The resident was fitted for a resting hand splint to accommodate range of motion limitations and was educated on the importance of the hand splint. The resident was followed by OT from 9/9/15 to 10/6/15. Post occupational therapy discharge recommendations was for caregivers to follow through including continuing to assist resident in caring for the splint, wearing splint for an eight hour schedule and providing passive and active range of motion.

During an interview with Nurse #1 on 3/31/16 at 12:35 pm she reported she knew it had not been on Resident #26 for a long time. The nurse reported there used to be list of who wore splints hanging on the door by the nurse ' s station, but that was long gone. The nurse was asked how the staff keep track of who wears a splint. The nurse stated she just remembered by "mental note" who was supposed to wear a splint on the assigned unit. The nurse stated " there used to be a book that NA's signed off when the splint was applied and removed. " The nurse does know where that went. The nurse confirmed there was no system in place at this time to track who was wearing a splint and who was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 318	Continued From page 32 During an interview with the Administrator on 3/31/16 at 1:30 pm she revealed her expectation was that anyone that was expected to wear a splint or a devise to promote skin integrity should have them on as ordered. Additionally, she added the nursing staff should be aware of any and all residents requiring such devices.	F 318		