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 _____	C 10/28/2016

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 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, the facility failed to deliver mail to residents of the facility on Saturday. (Resident # 42). Findings included: Resident # 42 was originally admitted to the facility on 04/11/16. According to the most recent Minimum Data Set (MDS) dated 09/11/16, Resident # 42 cognition was intact. During an interview on 10/26/16 at 8:40 AM, Resident # 42 revealed the facility did not deliver mail on Saturday it was put on the activity director ' s desk. She stated they (residents) received mail on Monday. During an interview on10/28/16 at 1:11PM, the Activity Director stated the manager on duty was to deliver the mail on Saturday. She revealed she delivered mail Monday thru Friday. During an interview on 10/28/16 at 11:14 AM, Nurse #1 indicated she had not observed mail delivery on Saturday. During an interview on 10/28/16 at 11:15 AM, Nurse # 2 indicated he had not observed mail delivery on Saturday.	F 170	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 170 A corrective action for Affected Resident has been accomplished by: On 11/21/16, the Activity Director discussed the new procedure for the weekend manager on duty delivering mail to residents on the weekends with resident #42 and #107. Effective 11/25/16, the new procedure for delivering mail to residents on Saturday is that the weekend manager on duty will retrieve all mail from the mailbox, sort, and deliver it as part of their duties on Weekends.	11/25/16

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

Electronically Signed | 11/23/2016

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F 170	Continued From page 1 During an interview on 10/28/16 at 11:17 AM the Dietary Manager indicated when she was the manager on duty she put the mail on the activity directors desk. During an interview on 10/28/16 at 11:49 AM, Resident #107 who cognitively intact, indicted mail was not delivered on Saturday. During an interview on 10/28/16 at 1:44 PM, the Administrator stated starting Saturday, 10/1/16 a manager was responsible for ensuring mail delivery.	F 170	A corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On 11/21/16, the Activity Director held a resident council meeting. All resident's present received information on the new procedure for delivering mail to residents on Saturdays. Systemic changes made were: By 11/25/16, the following procedure was put in place for mail to be delivered to residents on the weekends. The weekend manager on duty will be responsible for retrieving the mail from the mail box, sorting the mail, and distributing that mail to the residents. On 11/23/16, the management team members with weekend manager duties were in-serviced by the Administrator on the new procedure for delivering mail to residents over the weekend. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: The Administrator will monitor this issue using the Mail Delivery Quality Assurance Tool for ensuring mail is delivered to residents according to the new procedure on the weekends. This will be completed weekly for 4 weeks then monthly times 2	

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F 170	Continued From page 2	F 170	months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Dietary Manager and the Administrator.	
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews the facility failed to: 1) honor resident choices for frequency of showers and/or choice of tub bath, (resident #107), and 2) failed to honor resident choices for activities on 3 of 5 residents reviewed for choices (Resident #6, #56). Findings Included: 1) Resident #6 was admitted on 11/19/14. Diagnoses included in part cerebral palsy, contractures, and Bell's palsy. The Minimum	F 242	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	11/25/16

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F 242	Continued From page 3 Data Set (MDS) quarterly assessment dated 8/4/16 revealed the resident was cognitively intact. The resident was dependent with assistance of one staff member with all activities of daily living (ADLs), she had an impairment to one side of her upper extremity and both lower extremities and used a wheelchair. The MDS indicated it was very important to be involved in groups of people, to do favorite activities, go outside, and participate in religious services. A review of the updated care plan on 10/10/16 revealed a plan of care for activities. The resident enjoyed activities such as music, animals, food related, large and small groups, and religious activities. The interventions included the resident would actively participate in different activities daily, provide assistance to attend activities as needed, ensure the resident was up and ready to attend each activity. An interview with Resident #6 on 10/23/16 at 10:08 am revealed for the last week the resident was told by staff that "we can't get you up today, there was not enough staff." The resident stated she really enjoyed going to activities and she was sad that she was unable to go. She watched TV in her room, but she would have preferred to have gone to activities. She enjoyed going to church and participating in activities including bingo, group socials and going outside. She reported these were very important to her and she looked forward to it. Resident #6 reported she watched a lot of TV during this time and would have preferred to have been out of her room. An observation of Resident #6 on 10/23/16 at 10:08 am revealed the resident was lying down in	F 242	F 242 A corrective action for Affected Resident has been accomplished by: All residents were interviewed by the Nurse Management Team for their preferences regarding showers/bed baths/tub baths, attending activities, and frequency for getting out of bed. This was completed by 11/25/16. Each resident's preferences were then care planned or added to task as indicated by the MDS Coordinator. This process was completed by 11/25/2016. A corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: All cognitively intact residents with preferences not currently being met for showers, getting out of bed and attending activities have the potential to be affected by the alleged deficient practice. On 11/17/16, the Nurse Management Team began interviewing all cognitively intact residents for their preferences regarding showers, getting out of bed, and attending activities. This was completed by 11/25/16. Once preferences were determined, the Nurse Management Team updated each residents care plan and or task as indicated with their preference. This was completed by 11/25/2016. Newly admitted residents will be interviewed by the Activities Director regarding their shower/bathing and activities preferences within 14 day of	

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F 242	Continued From page 4 bed with her pajamas on. The resident was watching TV at that time. An interview with NA #4 on 10/23/16 at 10:45 am revealed that residents stayed in bed because they didn't have the staff to get them up. NA #4 reported the aids tried to get the residents up but some days they just couldn't. An interview with Nurse #5 on 10/24/16 at 9:45 am revealed that the residents have not gotten out of bed on the 200 hall to go to activities because there hasn't been enough staff. Nurse #5 explained that most of the residents on this hall required the assistance of two staff members because they required a mechanical lift and you needed two people to do this task safely. An interview with the resident ' s family member (FM) on 10/25/16 at 1:10 pm revealed that she was left in bed for a week. The FM came in every day to visit and the resident reported to the FM that there was not enough staff to get her up so she had to stay in bed. An interview with the Activity Director (AD) on 10/26/16 at 12:00 pm revealed Resident #6 enjoyed going to many activities. The AD reported when the residents do not come to activities, she would try and touch base or check in with the resident. The AD reported she was allowed to get the residents out of bed, but she could ensure they had an activity they enjoyed. The AD confirmed that the resident enjoyed activities and with her age/condition she should be encouraged to go to the activities of her interest. 2. Resident #56 was admitted on 1/8/16. Diagnoses included in part quadriplegia,	F 242	admission. The resident's preferences will be documented and updated in care plan and or task as indicated with their preference by the MDS Coordinator. Systemic changes made were: On 11/17/16 an in-service was conducted by the Staff Development Coordinator for all Full-time and Part-time, PRN, and agency RN's, LPN's, Med Aide's, and CNA's. The topics included: • honoring resident preferences and request • offering residents to get OOB daily and offering to assist resident's to activities as desired • providing timely assistance to residents for request • honoring preference for showers • how to access the kardex for resident preferences • how to document resident refusal This education was provided by an Education Training Packet on honoring resident preferences. Any staff member who did not receive in-service training by 11/25/2016 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nurses (DON) will monitor	

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F 242	Continued From page 5 dysfunction of bladder, chronic pain, and dependent on oxygen. The MDS dated 10/10/16 quarterly assessment revealed the resident was cognitively aware. The resident required an assist with two staff members with bed mobility and transfers. The resident required total dependence with an assist of one staff member for all ADLs and had an impairment to both sides to upper and lower extremities and used a wheelchair. The MDS indicated it was very important for the resident to choose his clothes, get tub/shower/bath, have music, do favorite activities and go outside. A review of the care plan updated on 10/4/16 revealed a plan of care for ADLs for quadriplegia to include assistance with all ADLs and an activities care plan which included to make own leisure decisions and activity involvement but may need some assistant related to quadriplegia. The interventions were to assist the resident to attend activities, ensure the resident was up and ready to attend each activity, encourage resident to attend activities and going outside. An interview with Resident #56 on 10/23/16 at 1:15 pm revealed that the resident had been in bed for the last 5 days. He reported he did not know what was going on with the staff, but he had not been able to get up for 5 days. The resident reported he liked to get up before 10:00 am because he enjoyed going to activities. He had not been to activities for a number of days. Nor has he been out of bed. When he asked staff if he could get up, the staff replied, "we don't have enough help today, you'll have to stay in bed. " The resident stayed in bed and watched TV. The resident reported he did not file a grievance	F 242	this issue using the Preferences Met QA Tool for monitoring resident's preferences for showers, getting out of bed, and attending activities. This will be completed weekly x 4weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Dietary Manager and the Administrator.	

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F 242	Continued From page 6	F 242		

report but he did tell the Administrator and the Director of Nursing (DON).

An interview with NA #4 on 10/23/16 at 1:45 pm reported that the staff haven't been able to get residents out of bed because they did not have the help.

An interview with Nurse #5 on 10/24/16 at 9:45 am revealed that the residents have not gotten out of bed on the 200 hall to go to activities because there hadn ' t been enough staff. Nurse #5 explained that most of the residents on this hall required the assistance of two staff members because they required a mechanical lift and you needed two people to do this task. Nurse #5 added that there was one nurse and one aid on the hall most of the time and it was difficult for the nurse to be pulled away to do ADL care with the Aid.

An interview with the Activity Director (AD) on 10/26/16 at 12:00 pm revealed Resident #56 enjoyed going to activities, especially the morning ones. The AD reported Resident #56 shared a concern a couple of months ago to the AD that he was not getting to participate in activities. The AD reported she asked the resident if there was anything she could bring for him. The AD confirmed that the resident enjoyed activities and with his age/condition he should be encouraged to go to the activities of his interest.

An interview with the Administrator on 10/28/16 at 5:00 pm revealed that her expectation was that the choice to participate in activities would be honored for the residents.

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F 242	Continued From page 7	F 242		

(3) Resident # 107 was admitted to the facility with diagnoses which included hemiplegia, dysarthria following cerebral infarctions. Resident #107 most recent quarterly Minimum Data Set (MDS) dated 09/06/2016 revealed the resident was cognitively intact. A functional assessment revealed Resident #107 needed limited assistance with transfers, bed mobility, walk in room and corridor, dressing, showers and personal hygiene. Supervision was required with eating. Extensive assistance was needed with toilet use. The assessment revealed Resident #107 was not steady in seated to standing, walking, turning in the opposite direction and moving on and off the toilet.

A grievance form dated 10/08/2016 revealed Resident #107 had to wait for over an hour for assistance to go to go to the bathroom to get washed for the day. The facility stated they were working on nurse staffing, and staff from a sister facility Springwood were helping to cover the staffing issues as well.

A review of the nurse ' s notes in Resident#107 ' s medical record revealed no indication of the resident refusing showers. Further review of Resident #107 ' s bath record revealed the last shower was 08/29/2016. The daily bed baths had been documented.

An interview was conducted with Resident #107 on 10/23/2016 at 10:03 AM. The resident stated her last shower was perhaps two weeks ago, but it may have been before then. Resident #107 stated she scheduled to get showers Monday and Thursday. The resident stated in between shower

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F 242	Continued From page 8 she was washed in the bathroom. A follow-up interview was conducted on 10/25/2016 at 3:30 PM. Resident #107 stated the lack of staffing and lack of assistance had not gotten better. An interview was conducted with Nursing Assistant (NA) #19 on 10/23/2016 at 8:10 AM. The NA stated most residents were to be showered based on individual preferences but usually it was twice a week. The NA was unsure when Resident #107 ' s last shower was. An interview was conducted with Nurse #5 on 10/25/216 at 9:54 AM. The nurse stated residents were to get showers twice a week or more frequently if the resident requested. The nurse stated she was uncertain when the last shower was for Resident #107. An interview was conducted with the Director of Nursing (DON) on 10/27/2016 at 2:00 PM. The DON stated residents should be showered at least twice a week per the residents ' preferences The DON stated the expectation would be for the nurses to make sure the showers were being provided to the residents. An interview was conducted with the administrator on 10/28/2106 at 3:00 PM. The administrator stated the expectation was that the choices of each resident should be honored in regard to bathing or showering.	F 242		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility	F 244		11/25/16

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F 244	Continued From page 9 must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to respond to Resident Council grievances of shortage of staff. The findings include: During the interview on 10/26/2016 at 8:48 AM, with the Resident Council representative who indicated the activity director forwarded the concerns to the department that the concern applied. The staffing had been a problem for the last few months. The response we got was the Administrator, or the Director of Nursing were working on it and were aware of it. There were no results. Nothing was ever resolved. Review of the resident council minutes dated 6/29/16, revealed in part, " staff working short. " Response from administration dated 7/1/16 was, " multiple C.N.A openings, NHA (administrator), DON (Director of Nursing) and HR (Human Resources) recruiting and hiring as quickly as possible. " Review of the resident council minutes dated 7/27/16, revealed in part, " short staffing continues to be an issue. " There was no response to the councils concern. Review of the resident council minutes dated 8/31/16, revealed in part, " Residents voiced concerns with staffing. " Response to the councils concern dated 9/29/16 was " Admin	F 244	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F244 A corrective action for Affected Resident has been accomplished by: On 11/21/16, the Administrator met with Resident #42 the previous Resident Council representative. During this meeting, the Administrator explained to the resident the new procedure for handling resident council concerns. The new procedure is, effective 11/25/16, within 3 days of receiving the resident council concerns, the Administrator or Director of Nursing will meet with the resident council representative regarding the general concerns received and will	

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F 244	Continued From page 10 (administration) is continuing to work on hiring staff. " Review of the resident council minutes dated 09/29/16, revealed " Most residents continue to voice concern over the staffing and lack of help when they need it. It was explained that administration is continually attempting to hire new employees. " On 10/28/2016 at 1:11 PM, the Administrator indicated when she arrived in July she addressed the July resident council regarding the lack of staff in the facility. She had met with the concerned residents and families privately. She indicated staffing had been a problem before she had come to the facility and was an ongoing issue. She indicated they had unsuccessful job fairs, sent out emails to nurses and aides in the community and borrowed staff from another facility in the area. She indicated she knew staffing was a continued problem and had proposed to corporate an increased wage. There had been challenges to fill the positions. On 10/26/2016 at 1:44 PM the Activity Director, indicated the grievances were forwarded to the department head, they respond and she read the response at the next meeting. The ongoing grievance was staffing for several months, and that care was not being done.	F 244	meet with the individual resident regarding their individual concerns. Within 7 days of receiving the concerns, the Administrator or Director of Nursing will provide a written response back to the resident council representative regarding the general concerns received and to the individual resident regarding their individual concerns. A corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On 11/21/16, a resident council meeting was held. All residents who attended received information from the Administrator on the new procedure for addressing resident council concerns. The new procedure is, effective 11/25/16, within 3 days of receiving the resident council concerns, the Administrator or Director of Nursing will meet with the resident council representative regarding the general concerns received and will meet with the individual resident regarding their individual concerns. Within 7 days of receiving the concerns, the Administrator or Director of Nursing will provide a written response back to the resident council representative regarding the general concerns received and to the individual resident regarding their individual concerns. Systemic changes made were: On 11/21/16 an in-service was conducted by the Clinical Nurse Consultant to the Administrator and Director of Nursing.	

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F 244	Continued From page 11	F 244	The topics included: the new procedure for responding to resident council grievances. The new procedure is, effective 11/25/16, within 3 days of receiving the resident council concerns, the Administrator or Director of Nursing will meet with the resident council representative regarding the general concerns received and will meet with the individual resident regarding their individual concerns. Within 7 days of receiving the concerns, the Administrator or Director of Nursing will provide a written response back to the resident council representative regarding the general concerns received and to the individual resident regarding their individual concerns. This information has been integrated into the standard orientation training for Administrators and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: The Administrator will monitor this issue using the Resident Council QA Tool for monitoring timely response and resolution to resident council concerns. This will be completed monthly x 3 months or until resolved by QOL/QA committee. Reports will be presented to the monthly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA	

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F 244	Continued From page 12	F 244	Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Dietary Manager and the Administrator.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to provide a maintained, safe, and comfortable interior on 3 of 5 resident halls (100 hall, 200 Hall, and 300 Hall) as evidenced by peeling wallpaper, scrapped wooden doors, scuffed paint on resident room doors, dents in the drywall and cove molding in disrepair. The findings included: 1a. Observations on 10/23/2016 at 12:30 PM on the 100 hallway revealed the nourishment room wooden door chipped and scraped wood. Also there were depression and dings observed on the walls outside of room #107. b. Observations on 10/23/2016 at 12:35 PM in room #102 revealed a wooden bathroom door chipped and scraped, drywall depression and dings at the entry door, drywall depression and dings under the grab bar in the bathroom, a rust colored stained streaks in the toilet and a sagging mattress with a deep depression. c. Observations on 10/23/2016 at 12:35 PM of room #103 revealed a wooden bathroom door	F 253	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 253 A corrective action for Affected Resident has been accomplished by: No residents appear to be affected. 1a. The 100 hallway nourishment room wooden door was puddied and restained on 11/18/16. Due to the depth of the chips	11/25/16

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F 253	Continued From page 13 was chipped and scraped. d. Observations on 10/23/2016 at 12:40 PM on the 200 hallway revealed the drywall was cracked and missing near the janitor ' s closet door, the wooden janitor ' s closet door and a supply closet door was chipped and scraped, the wooden shower room door was chipped and scrapped and a handrail with chipped wood outside of room #204. e. Observation on 10/23/2016 at 12:40 PM of room #209 revealed a sagging mattress with a deep depression. f. Observation on 10/23/2016 at 12:45 PM of room #313-A revealed missing paint on the wall behind the head of the bed on the right side. g. Observation on 10/23/2016 at 12:45 PM of room #314 revealed rust colored stained streaks in the toilet, a wooden entry door chipped and scraped and a sagging mattress with a deep depression. h. Observation on 10/24/2016 at 5:35 AM of room #312 revealed scrapped paint behind the head of the bed, rust colored stained streaks in toilet and a sagging mattress with a deep depression. i. Observation on 10/24/2016 at 5:35 AM on the 300 hallway revealed 28 loose seems of wallpaper, 17 door frames had missing paint from the floor to approximately 12 inches off the floor, cove molding dented with a black substance on the surface, a hole in the wallboard on the corner near room #308. j. Observation on 10/24/2016 at 8:00 AM of room #308 revealed a mattress with a deep depression and smelled of urine. k. Observation on 10/24/2016 at 9:30 AM of room #205-B revealed a wet puddle of urine under the bed, a dried ring of urine under the bed and dried urine on the bed frame. l. Observation on 10/25/2016 at 4:00 PM of the	F 253	in the door a professional contractor was hired to repair the door. He is scheduled to start repairs on 11/28/16. The dings and depressions on the wall outside of room #107 were repaired on 11/18/16. b. Room 102 bathroom door, entry door dings and depressions was puddied and restained on 11/17/16. Due to the depth of the chips in the door a professional contractor was hired to repair the door. He is scheduled to start repairs on 11/28/16. Bathroom dings under the grab bar and rust color stains in the toilet were all repaired by 11/22/16. The sagging mattress was replaced on 11/18/16. c. Room 103 bathroom door was puddied and restained on 11/18/16. Due to the depth of the chips in the door a professional contractor was hired to repair the door. He is scheduled to start repairs on 11/28/16. d. The cracked/missing drywall on the 200 hallway was repaired on 11/18/16. The janitor's closet door and supply closet door was puddied and restained on 11/18/16. Due to the depth of the chips in the door a professional contractor was hired to repair the door. He is scheduled to start repairs on 11/28/16. The shower room door was was puddied and restained on 11/18/16. Due to the depth of the chips in the door a professional contractor was hired to repair the door. He is scheduled to start repairs on 11/28/16. Handrail beside room 204 was repaired by 11/18/16.	

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F 253	Continued From page 14 300 hallway shower revealed a dark substance on the grout lines of the two lowest rows of tile in the left corner of the adjoining front side walls approximately 12 inches from the floor. An interview was conducted on 10/25/2016 at 4:00 PM with the housekeeper. The housekeeper stated the dividing wall and shower head on the 300 hallway were cleaned and disinfected daily. The housekeeper stated the tub, sinks and toilet on the left side of the shower room were disinfected daily. The housekeeper stated the current routine was used to clean the shower room but was not aware of a deep cleaning schedule. The housekeeper stated once daily the resident rooms were cleaned and mopped. The housekeeper stated if urine was noted on a bed frame or under the bed it would be cleaned and disinfected. An interview was conducted with the maintenance director on 10/27/2016 at 3:00 PM. The maintenance director stated we have work order requisition slips that were placed in a hanging folder near the janitor closet pocket across from the nurses ' station on the 100 through 300 hallways. The maintenance director stated a twice daily walk through of the facility was accomplished to pick up work order requests; and if there were immediate problem areas the work would begin. The maintenance director stated when a mattress was reported to be flat or sagging the mattress would be replaced. The maintenance director stated we have recently been given permission to start updating the 100, 200, and 300 hallways. The maintenance director stated it would include getting rid of the wallpaper and painting to make the facility brighter and more up to date with brighter colors.	F 253	e. Room 209 sagging mattress was replaced on 11/18/16 f. Room #313A wall was repaired on 11/22/16. g. Room #314 rust stained toilet repaired by 11/17/16. The entry door was puddied and restained on 11/17/16. Due to the depth of the chips in the door a professional contractor was hired to repair the door. He is scheduled to start repairs on 11/28/16. The sagging mattress in room 314 was replaced on 11/22/16. h. Room 312 wall was repaired and rust stained toilet was repaired by 11/22/16. The sagging mattress in room was replaced on 11/22/16. i. Three Paint Contractors were contacted on 11/17/16 to request quotes to remove the wallpaper and paint the 300 hall. A quote and scheduled date for contractors to remove the wallpaper on the 300 hall was scheduled on 11/23/16. They are scheduled to remove the wallpaper and paint on the 300 hall starting 11/28/16. The 17 doorframes were repainted by 11/25/16. The cove molding on the doorframes was cleaned by 11/25/16. The hole in the wallboard near room 308 was repaired by 10/26/16. j. The mattress in room 308 was replaced on 10/26/16.	

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F 253	Continued From page 15 An interview was conducted with the administrator on 10/28/2016 at 1:55 PM. The administrator stated the expectation would be for the facility to be maintained, clean and comfortable for the residents.	F 253	k. The floor and bed frame in room 205 was cleaned by 11/25/16 l. The 300 hall shower room grout lines were cleaned by 11/25/16. A contractor was hired on 11/23/16 to sand and restain the identified doors with dings and depressions. He is scheduled to start on 11/28/16. A corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: All Residents on the 100, 200 and 300 hall have the potential to be affected by the alleged deficient practice. All resident rooms on the 100, 200, and 300 halls were assessed by the Administrator and Maintenance Director for cleanliness and repairs on 11/22/16. The Administrator and Maintenance/HK Director will create work orders and schedules for necessary repairs to be completed. Systemic changes made were: On 11/22/16 an in-service was conducted by the Staff Development Coordinator for all Full-time and Part-time and PRN Nurses, Med Aides, and Nursing Assistants. The topics included: how to place work orders for equipment repairs. Any in-house staff member who did not receive in-service training by 11/25/16 will not be allowed to work until training has	

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F 253	Continued From page 16	F 253	been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. An in-service was conducted by the Housekeeping Manager for all Full-time and Part-time and PRN Housekeepers by 11/25/16. The topics included: routine and deep cleaning procedures. Any in-house staff member who did not receive in-service training by 11/25/16 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all housekeeping employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: The Administrator will monitor this issue using the Facility Observations QA Tool for monitoring cleanliness and repairs throughout the facility. This will be completed weekly x 4weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the	

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F 253	Continued From page 17	F 253	weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Dietary Manager and the Administrator	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow orders to obtain weights for 3 of 11 residents reviewed (Resident #42, Resident #99, and Resident #105). Findings included: 1. Resident #42 was admitted to the facility on 05/05/15 with diagnoses that included congestive heart failure, history of myocardial infarction, chronic obstructive pulmonary disease with acute exacerbation, and morbid obesity. The care plan dated 09/07/16 had three interventions related to weight: weigh as ordered, review the weights, and report significant weight changes to the physician. On 09/09/16 the physician ordered Lasix 40 mg by mouth every Monday through Saturday and daily weights. The quarterly Minimum Data Set (MDS) dated 09/13/16 revealed the resident was cognitively intact. A review of the medical record revealed that no weights were recorded for Resident #42 for 26 of	F 281	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 281 A corrective action for the Affected Resident/s has been accomplished by: Resident #42's weight was collected on 11/17/16 by Nurse. Resident #99, was weighed on 11/6/16 by Nurse. Resident #105, was weighed on 11/6/16 by Nurse. A corrective action has been accomplished on all residents with the	11/25/16

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F 281	Continued From page 18 the 49 days between 09/10/16 and 10/28/16. Weights on the following days were missing: 09/10, 09/11, 09/12, 09/17, 09/18, 09/22, 09/25, 09/26, 10/02, 10/03, 10/04, 10/05, 10/08, 10/09, 10/10, 10/12, 10/13, 10/15, 10/19, 10/21, 10/22, 10/23, 10/24, 10/25, 10/27, and 10/28. A review of the electronic Certified Nursing Assistant (CNA) Task List for Resident #1 showed three different entries related to weight: "daily weights," "weights x1 week," and "weigh on Monday." A monthly note by Nurse Practitioner #1 dated 10/10/16 (one month after the order was written for daily weights) referred to an "8 lb. gain" in weight for Resident #42. The medical record documented that the resident weighed 252.8 lbs. on 09/09/16 and 261.8 lbs. on 10/07/16. An interview was conducted with Nurse #9 on 10/26/16 at 10:53 a.m. She stated that physician orders for weights were entered into the CNA Task List by the nurse. If an order was changed, the previous order should have been deleted if it was inconsistent with the new order. CNAs reviewed the Task List for each resident daily for instructions on when to weigh residents. Nurses monitored the Task Lists to see that weights have been obtained as ordered. Nurse #9 said the discrepancy between the entries for both daily and weekly weights for Resident #42 should have been identified and corrected by the nurse. In an interview with the Dietician on 10/27/16 at 2:40 p.m., she indicated that the Dietary Manager was responsible for tracking daily weights. Clinical personnel should be including weights in their 24-hour report for those residents with daily weights ordered. 2. Resident #99 was admitted to the facility on 01/13/14 with diagnoses that included unspecified dementia and diabetes mellitus type 2.	F 281	potential to be affected by the alleged deficient practice by: All current residents with weights not obtained according to current MD orders have the potential to be affected by the alleged deficient practice. On 11/18/16, all current resident's orders were reviewed for weight frequency orders. This was completed by running an order listing report for current weight orders. Once this report was reviewed, a weight report was generated from Point Click Care to identify if weights were obtained according to the ordered frequency. Resident's that were noted without weights obtained as ordered, were immediately weighed and their weights were entered into Point Click Care. This process was completed by the Nurse Management Team. This was completed by 11/25/16. Systemic changes made were: On 11/18/16, a weight review meeting was held by the Nurse Management Team and Clinical Nurse Consultant to determine the procedure for obtaining weights per MD order. New procedure: A master list was created for residents requiring weights more frequently than monthly. Daily Monday through Friday, the Director of Nursing will monitor the completion of the weights according to the master list. The master list will be updated as needed according to new MD orders for weights received. By the 14th day of the month, a monthly weight report will be printed from Point Click Care by the Director of Nursing to ensure all monthly weights have been obtained.	

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F 281	Continued From page 19 Monthly weights were ordered on 08/04/16. The care plan dated 10/01/16 stated that the resident had a history of weight loss with an oral intake of less than 75% at times. The plan had three interventions related to weight: weigh as ordered, review the weights, and report significant weight changes to the physician. The quarterly MDS dated 10/07/16 revealed that the resident was severely cognitively impaired. A review of the medical record revealed that Resident #99's weight was missing for the month of September. She weighed 131.2 lbs. on 08/03/16 and 133.2 lbs. on 10/07/16. Approximately 3 weeks later on 10/26/16, a weight of 120.8 lbs. was recorded, a loss of 12.4 lbs. A progress note dated 10/26/16 by the Dietician indicated "significant weight loss, variable intake, recommend No-salt-added Fortified Shake twice a day for additional protein." 3. Resident #105 was admitted to the facility on 05/20/14 with diagnoses that include hemiplegia and hemiparesis following an unspecified cerebrovascular accident and aphasia. Monthly weights were ordered 08/03/16. The care plan dated 10/01/16 identified the resident as a "very picky eater ...a history of weight loss. " Care plan interventions dated 10/01/16 were to review weights and report to the physician any signs of significant weight change. The quarterly MDS dated 10/07/16 revealed the resident was moderately cognitively impaired. The CNA Task List for Resident #105 had an entry for "monthly weights on the 3rd." A review of the medical record revealed that Resident #105 weighed 102 lbs. on 07/13/16. Weights were missing for the months of August and September. The resident weighed 96 lbs. on 10/07/16, a weight loss of 6 lbs. This was the first	F 281	On 11/18/16 an in-service was conducted by the Clinical Nurse Consultant the Nurse Management Team. The topics included: the new procedure for ensuring all weights are obtained per MD order. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Nurse Management employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: The Administrator will monitor this issue using the Monitoring Weights QA Tool for monitoring weights being obtained according to MD order. This will be completed weekly x 4weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Dietary Manager and the Administrator.	

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F 281	Continued From page 20 recorded weight after the order for monthly weights was placed 08/03/16. In an interview with the DON on 10/28/16 at 2:45 p.m. she stated her expectation was that CNAs obtain resident weights as ordered by the medical provider and that nurses monitored the process.	F 281		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation record review and staff and resident interviews the facility failed to provide sufficient staff to provide showers for 1 of 5 residents (Resident #107) and to assist 2 of 5	F 353	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	11/25/16

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F 353	Continued From page 21 residents (Resident #6 and Resident #56) to the activities of their choice. Findings included: This tag was cross referred to: F242 Based on observation, record review and resident and staff interviews the facility failed to: 1) honor resident choices for frequency of showers and/or choice of tub bath, (resident #107), and 2) failed to honor resident choices for activities on 3 of 5 residents reviewed for choices (Resident #6, #56). 1) Resident #6 was admitted on 11/19/14. Diagnoses included in part cerebral palsy, contractures, and Bell's palsy. The Minimum Data Set (MDS) quarterly assessment dated 8/4/16 revealed the resident was cognitively intact. The resident was dependent with assistance of one staff member with all activities of daily living (ADLs), she had an impairment to one side of her upper extremity and both lower extremities and used a wheelchair. The MDS indicated it was very important to be involved in groups of people, to do favorite activities, go outside, and participate in religious services. A review of the updated care plan on 10/10/16 revealed a plan of care for activities. The resident enjoyed activities such as music, animals, food related, large and small groups, and religious activities. The interventions included the resident would actively participate in different activities daily, provide assistance to attend activities as needed, ensure the resident	F 353	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 353 A corrective action for Affected Resident has been accomplished by: All residents were interviewed by the Nurse Management Team for their preferences regarding showers/bed baths/tub baths, attending activities, and frequency for getting out of bed. This was completed by 11/25/16. Each resident's preferences were then care planned or added to task as indicated by the MDS Coordinator. This process was completed by 11/25/2016. The staff schedule was reviewed by the Director of Nursing and the Administrator on 11/17/16 to ensure adequate staff to meet patient needs. A corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: All cognitively intact residents with preferences not currently being met for showers, getting out of bed and attending activities have the potential to be affected by the alleged deficient practice. On	

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

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F 353	Continued From page 22 was up and ready to attend each activity. An interview with Resident #6 on 10/23/16 at 10:08 am revealed for the last week the resident was told by staff that "we can't get you up today, there was not enough staff." The resident really enjoyed going to activities and she was sad that she was unable to go. She watched TV in her room, but she would have preferred to have gone to activities. She enjoyed going to church and participating in activities including bingo, group socials and going outside. She reported these were very important to her and she looked forward to it. Resident #6 reported she watched a lot of TV during this time and would have preferred to have been out of her room. An observation of Resident #6 on 10/23/16 at 10:08 am revealed the resident was lying down in bed with her pajamas on. The resident was watching TV at this time. An interview with NA #4 on 10/23/16 at 10:45 am revealed that residents stayed in bed because they didn't have the staff to get them up. NA #4 reported the aids try to get the residents up but some days they just couldn't. An interview with Nurse #5 on 10/24/16 at 9:45 am revealed that the residents have not gotten out of bed on the 200 hall to go to activities because there hasn't been enough staff. Nurse #5 explained that most of the residents on this hall required the assistance of two staff members because they required a mechanical lift and you needed two people to do this task safely. An interview with the resident ' s family member (FM) on 10/25/16 at 1:10 pm revealed that she	F 353	11/17/16, the Nurse Management Team began interviewing all cognitively intact residents for their preferences regarding showers, getting out of bed, and attending activities. This was completed by 11/25/16. Once preferences were determined, the Nurse Management Team updated each residents care plan and or task as indicated with their preference. This was completed by 11/25/2016. Newly admitted residents will be interviewed by the Activities Director regarding their shower/bathing and activities preferences within 14 day of admission. The resident's preferences will be documented and updated in care plan and or task as indicated with their preference by the MDS Coordinator. Systemic changes made were: On 11/17/16 an in-service was conducted by the Staff Development Coordinator for all Full-time and Part-time, PRN, and agency RN's, LPN's, Med Aide's, and CNA's. The topics included: • honoring resident preferences and request • offering residents to get OOB daily and offering to assist resident's to activities as desired • providing timely assistance to residents for request • honoring preference for showers • how to access the kardex for resident preferences • how to document resident refusal This education was provided by an Education Training Packet on honoring	

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F 353	Continued From page 23 was left in bed for a week. The FM came in every day to visit and the resident reported to the FM that there was not enough staff to get her up so she had to stay in bed. An interview with the Activity Director (AD) on 10/26/16 at 12:00 pm revealed Resident #6 enjoyed going to many activities. The AD reported Resident #6 when the residents do not come to activities, she would try and touch base or check in with the resident. The AD reported she was allowed to get the resident out of bed, but she could ensure they had an activity they enjoyed. The AD confirmed that the resident enjoyed activities and with her age/condition she should be encouraged to go to the activities of her interest. 2) Resident #56 was admitted on 1/8/16. Diagnoses included in part quadriplegia, dysfunction of bladder, chronic pain, and dependent on oxygen. The MDS dated 10/10/16 quarterly assessment revealed the resident was cognitively aware. The resident required an assist with two staff members with bed mobility and transfers. The resident required total dependence with an assist of one staff member for all ADLs and had an impairment to both sides to upper and lower extremities and used a wheelchair. The MDS indicated it was very important for the resident to choose his clothes, get tub/shower/bath, have music, do favorite activities and go outside. A record review of the care plan updated on 10/4/16 revealed a plan of care for ADLs for quadriplegia to include assistance with all ADLs and an activities care plan which included to	F 353	resident preferences. Any staff member who did not receive in-service training by 11/25/2016 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: Effective 11/25/16, rounds are conducted by the Administrator or Director of Nursing to ensure staffing is adequate to meet resident needs according to preferences. Rounds will occurs 5 times a week across various shifts weekly x 4weeks then monthly x 2 months or until resolved by QOL/QA committee. This is measured by interviewing 5 residents 5 times a week to ensure needs/preferences are being met. The Director of Nurses (DON) will monitor this issue using the Preferences Met QA Tool for monitoring resident's preferences for showers, getting out of bed, and attending activities. This will be completed weekly x 4weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM,	

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make own leisure decisions and activity involvement but may need some assistant related to quadriplegia. The interventions were to assist the resident to attend activities, ensure the resident was up and ready to attend each activity, encourage resident to attend activities and going outside.

An interview with Resident #56 on 10/23/16 at 1:15 pm revealed that the resident had been in bed for the last 5 days. He reported he did not know what was going on with the staff, but he had not been able to get up for 5 days. The resident reported he liked to get up before 10:00 am because he enjoyed going to activities. He has not been to activities for a number of days. Nor has he been out of bed. When he asked staff if he could get up, the staff replied, "we don't have enough help today, you'll have to stay in bed. " The resident stayed in bed and watched TV. The resident reported he did not file a grievance report but he did tell the Administrator and the Director of Nursing (DON).

An interview with NA #4 on 10/23/16 at 1:45 pm reported that the staff haven't been able to get residents out of bed because they do not have the help.

An interview with Nurse #5 on 10/24/16 at 9:45 am revealed that the residents have not gotten out of bed on the 200 hall to go to activities because there hasn't been enough staff. Nurse #5 explained that most of the residents on this hall required the assistance of two staff members because they required a mechanical lift and you needed two people to do this task. Nurse #5 added that there was one nurse and one aid on the hall most of the time and it was difficult for the

Dietary Manager and the Administrator.

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nurse to be pulled away to do ADL care with the Aid.

An interview with the Activity Director (AD) on 10/26/16 at 12:00 pm revealed Resident #56 enjoyed going to activities, especially the morning ones. The AD reported Resident #56 shared a concern a couple of months ago to the AD that he was not getting to participate in activities. The AD reported she asked the resident if there was anything she could bring for him. The AD confirmed that the resident enjoys activities and with his age/condition he should be encouraged to go to the activities of his interest.

An interview with the Administrator on 10/28/16 at 5:00 pm revealed that her expectation was that the choice to participate in activities would be honored for the residents.

3) Resident # 107 was admitted to the facility with diagnosis which included hemiplegia, dysarthria following cerebral infarctions. Resident #107 most recent Minimum Data Set (MDS) dated 09/06/2016 revealed the resident was cognitively intact. A functional assessment revealed Resident #107 needed limited assistance with transfers, bed mobility, walk in n room and corridor, dressing, showers and personal hygiene. Supervision was required with eating. Extensive assistance was needed with toilet use. The assessment revealed Resident #107 was not steady in seated to standing, walking, turning in the opposite direction and moving on and off the toilet.

A grievance form dated 10/08/2016 revealed Resident #107 had to wait for over an hour for assistance to go to go to the bathroom to get

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washed for the day. The facility stated they were working on nurse staffing, and staff from a sister facility Springwood were helping to cover the staffing issues as well.

A review of the nurse ' s notes in Resident#107 medical record revealed no indication of the resident refusing showers. Further review of Resident #107 bath record revealed the last shower was 08/29/2016. The daily bed baths had been documented.

An interview was conducted with Nursing Assistant (NA) #19 on 10/23/2016 at 8:10 AM. The NA stated most residents were to be showered based on individual preferences but usually it was twice a week. The NA was unsure when Resident #107 last shower was.

An interview was conducted with Nurse #5 on 10/25/216 at 9:54 AM. The nurse stated resident were to get showers twice a week or more frequently if the resident requested. The nurse stated she was uncertain when the last shower was for Resident #107.

An interview was conducted with Resident #107 on 10/23/2016 at 10:03 AM. The resident stated my last shower was perhaps two weeks ago, but it may have been before then. Resident #107 stated I am scheduled to get showers Monday and Thursday. The resident stated in between showers I wash in the bathroom.

A follow-up interview was conducted on 10/25/2016 at 3:30 PM. Resident #107 stated the lack of staffing and lack of assistance had not gotten better.

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F 353	Continued From page 27 An interview was conducted with the Director of Nursing (DON) on 10/27/2016 at 2:00 PM. The DON stated residents should be showered at least twice a week per the residents ' preference. The DON stated the expectation would be for the nurses to make sure the showers were being provided to the residents. An interview was conducted with the administrator on 10/28/2106 at 3:00 PM. The administrator stated the expectation was that the choices of each resident should be honored in regard to bathing or showering. On 10/28/2016 at 1:11 PM, the Administrator indicated when she arrived in July she addressed the July resident council regarding the lack of staff in the facility. She had met with the concerned residents and families privately. She indicated staffing had been a problem before she had come to the facility and was an ongoing issue. She indicated they had unsuccessful job fairs, sent out emails to nurses and aides in the community and borrowed staff from another facility in the area. She indicated she knew staffing was a continued problem and had proposed to corporate an increased wage. There had been challenges to fill the positions.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and	F 356		11/25/16

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F 356	Continued From page 28 unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to post the daily staffing and census accurately. Findings included: An observation on 10/23/16 at 9:30 am was conducted. The facility daily staffing was noted to be posted on a bulletin board in the hallway with the most current staff posted dated 10/23/16. The census number was not posted on the daily staffing. The daily staffing for the 7am - 3pm shift	F 356	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be	

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F 356	Continued From page 29 indicated there was one Registered Nurse (RN), three Licensed Practical Nurses (LPNs) and five unlicensed nursing staff. A tour of the facility was conducted at this time and there was noted to be no RN in the building, one LPN, one Medication Aid and four unlicensed nursing staff. An interview with Nurse #1 on 10/23/16 at 9:30 am revealed there was no RN in the building at this time. She reported the Director of Nursing (DON) came in early this morning, posted the census and left the building. An interview with the Medication Aid #1 on 10/23/16 at 9:30 am reported she was not a LPN she was a Medication Aid. An interview was conducted on 10/23/16 with the DON upon arrival to the facility at 10:45 am. The DON reported she was the RN for the building for this day. The DON reported she came in this morning at about 7:00 am and then left to get breakfast. The DON reported one of the LPNs and 1 of the unlicensed nursing staff were included in the staff posting, but they were staff for the facility ' s assisted living unit. An interview with the Administrator on 10/ 28/16 at 5:00 pm reported her expectations were that the correct daily census and staffing should be posted every day. She further added her expectation was for a RN to be in the building every day 7 days a week for 8 consecutive hours.	F 356	corrected by the dates indicated. F 356 A corrective action for Affected Resident has been accomplished by: No actual residents were identified as affected. A corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: All current residents have the potential to be affected by the alleged deficient practice. On 11/17/16, the Director of Nursing posted the correct number of RN's, LPN's, CNA's and current resident census. This was confirmed by the Administrator on 11/17/16. Systemic changes made were: On 11/21/16 an in-service was conducted by the Clinical Nurse Consultant for the Administrator and Director of Nursing on the procedure for ensuring the correct staffing numbers are posted at the beginning of each shift. By 11/25/16, the Staff Development Coordinator in-serviced all Full-time, Part-time and PRN Nurses the topics included: the requirements and procedure for nursing staff posting daily and at the beginning of each shift. This education was provided by an Education Training Packet on required posting. This information has been integrated into the standard orientation training for Administrator, Nurse Management staff, and all nurses	

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F 356	Continued From page 30	F 356	and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: The Administrator will monitor this issue using the Daily Nursing Staff Posting QA Tool for monitoring accurate posting of nursing staff. This will be completed weekly x 4weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Dietary Manager and the Administrator.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		11/25/16

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F 431	Continued From page 31 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, the facility failed to: 1) dispose of single use bottles of acetic acid solution for one of one resident, resident #56, 2) secure one of six medication carts (#300 right), 3) dispose of an expired insulin pen for one of one resident, and 4) maintain clean medication carts on four of six carts. Findings included: 1) Resident #56 was admitted on 1/8/16. Diagnoses included in part quadriplegia, dysfunction of bladder, chronic pain, and dependent on oxygen.	F 431	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 431	

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F 431	Continued From page 32 The MDS dated 10/10/16 quarterly assessment revealed the resident was cognitively aware. The resident had a suprapubic catheter and was incontinent of bowel. A review of the care plan updated on 10/4/16 revealed a plan of care for suprapubic catheter care which included flushing the catheter daily. All the interventions and goals were appropriate and measurable. An observation on 10/24/16 at 9:09 am revealed an opened bottle of 0.25% acetic acid solution was in the window of Resident # 56 ' s room. The expiration date was 1/15/18. A label on the bottle read " single use only " and " discard unused product. " Multiple observations between 10/25/16 through 10/28/16 between the hours of 8:00 am and 10:30 am revealed an opened bottle of 0.25% acetic acid solution with an expiration of 7/15/18 was found in Resident #56 ' s window sill. A review of Resident #56 ' s October electronic Medication Administration Record (eMAR) revealed the order was to flush the suprapubic catheter daily with 0.25% acetic acid. An interview with Resident #56 revealed the nurse flushed the catheter with the 0.25% acetic acid every day and they always left the rest of the bottle in the window. An interview with Nurse #5 on 10/27/16 at 8:10 am revealed the product should not have been left in the resident ' s room. The nurse reported the unused solution should be discarded after every use. She further reported it was a one-time use solution.	F 431	A corrective action for Affected Resident has been accomplished by: Resident #56, the single use bottle of acetic acid was discarded on 10/28/16 by the nurse. The nurse for #300 hall cart was in-serviced by 11/25/16 on procedures for securing the medication cart when unattended. The identified expired insulin pen was discarded on 10/27/16 by the nurse. The four affected medication carts were cleaned on 11/18/16 by Nurse Management Team. A corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: All residents have the potential to be affected by the alleged deficient practice. All medication carts were audited for opened unlabeled or expired medications and single use bottles for need of discarding. This was completed on 11/17/16 by the cart nurses and Nurse Management Team. On11/18/16, all six medication carts were cleaned by the Nurse Management Team. On 11/18/16, all six medication carts were observed to be locked when not in sight. Systemic changes made were: All Nurses, RNs, LPNs, and Med Aides (full, part time, agency, and PRN) were in-serviced on the following: • Need to date and label all open multi-use medications and to discard when expired, to discard single use bottles when opened and after one use and proper storage	

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F 431	Continued From page 33 An interview with the Director of Nursing (DON) on 10/28/16 at 4:30 pm revealed her expectation was that the nurses follow the instructions on the bottle and discard any unused solution. 2) An observation of the 300 right hall medication cart on 10/27/16 at 8:10 am revealed the cart was unlocked and unsupervised. An interview with Nurse #5 on 10/27/16 at 8:10 am revealed she got busy and forgot to lock it. Continued observations at this time on the 300 right hall cart revealed the second draw had multiple loose pills at the bottom of the draw and the third draw was sticky to touch with a significant amount of brown liquid substance spilled out. 3) An observation of the 200 hall medication cart on 10/27/16 at 8:20 am revealed an insulin pen opened on 9/28/16. The pen was labeled with a sticker to discard 28 days from the opened date (10/25/16). Additionally, there were multiple loose pills found on the bottom of the second draw. An interview with Nurse #5 on 10/27/16 at 8:30 am confirmed the insulin pen should have been removed from the cart on October 25th. Nurse #5 also reported the night shift nurses were assigned to clean out the medication carts and remove any expired medications but it was the responsibility of all the nurses as well. 4) An observation of the 100 hall medication cart on 10/27/16 at 9:20 am revealed multiple loose pills were found on the bottom of the second draw.	F 431	• to secure medication carts when unattended, and to ensure medication carts are kept clean by immediately wiping up spills and removing loose pills or trash as accumulated • adhering to the weekly cart cleaning and inspection for expired medication schedule as designated at each nurses station (11-7 nurse responsibility) This education was provided by an Education Training Packet on Medication Storage. Any in-house staff member who did not receive in-service training by 11/25/2016 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing or Staff Development Coordinator will check medication carts for cleanliness and expired medications also to ensure open medications are dated, labeled and stored correctly. This will be completed weekly x 4 weeks then monthly for 2 months or until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be	

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	345496	A. BUILDING _____ B. WING _____	C 10/28/2016

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F 431	Continued From page 34 An observation of 300 left hall medication cart on 10/27/16 at 9:30 am revealed multiple loose pills were found on the bottom of the second draw. An Interview with Nurse #2 on 10/27/16 at 9:30 am revealed the night shift nurses were supposed to check the medication carts each night to be sure they were clean and all expired medications were removed. Nurse #2 reported that it was the responsibility of all the nurses to check their medication carts. An interview with the DON revealed her expectations was that all the nurses kept their medication carts clean and orderly and disposed of any expired medications. She further added her expectation of the nurses was to make sure their carts were locked at all times when they were not being used.	F 431	monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Dietary Manager and the Administrator.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		11/25/16

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F 441	Continued From page 35 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to dispose of soiled linen properly during patient care on 2 of 2 residents (Resident #7 and Resident #56) and failed to wear personal protective equipment (gloves) on 1 of 2 residents observed (Resident #7). Findings Included: 1. Resident # 7 was admitted on 5/13/16. Diagnoses included fracture to left tibia, atrial fibrillation, osteoarthritis, stroke, and dementia. The Minimum Data Set (MDS) quarterly assessment dated 10/14/16 revealed the resident	F 441	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 441	

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F 441	Continued From page 36 was cognitively aware. The resident required an extensive assist with assist of two with bed mobility and transfers. Resident #7 did not ambulate and required total dependence with an assist of one staff member with dressing, toileting and personal hygiene. She had an impairment on one side on her lower extremity. The resident was always incontinent of bowel and bladder. A record review of the updated care plan as of 10/8/16 included a plan of care for incontinent care and all activities of daily living (ADLs). All the interventions and goals were appropriate and measurable. An observation of ADL care was done at 9:30 am with Nursing Assistant (NA) #19 and a NA in training. The resident was noted to be lying flat in her bed. NA #19 was not wearing gloves. NA #19 started cleaning the residents face and upper torso and arms. She then proceeded to clean the resident ' s legs and feet. She continued to do care without gloves. The aid rinsed the cloth in the soapy water and then washed the resident ' s perineum area. NA #19 continued to have no gloves applied. The perineum area was cleansed and she proceeded to put the contaminated soiled wash cloth directly on the resident ' s side table. NA #19 used approximately 3 cloths to clean the perineum area and all of the soiled cloths were placed on the side table in a pile. NA #19 completed the care on the resident with drying and dressing the resident. NA #19 and the NA in training changed the resident ' s linen at this time. The soiled linens were put into a plastic bag on the floor. This plastic bag was then placed on top clean linens and clean pillows which were on a chair. The wash clothes remained on the table. NA #19 and the NA in	F 441	A corrective action for Affected Resident has been accomplished by: Resident's # 7 and 56, the involved CNA's were reeducated on infection control practices including glove use, frequency of glove changes, handling of contaminated linen, how what to do when contamination occurs, when to provide hand hygiene, and how to provide personal and perineal care by the Staff Development Coordinator. A corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On 11/18/16 and 11/21/16, the Clinical Nurse Consultant completed an audit on staff practices for proper hand washing techniques; glove use; soiled gloves removed and disposed properly before touching other equipment or patient surroundings; observed for proper precautions used for the disposal of soiled linens; and if linens and laundry are handled in a manner that prevents the spread of infection, and proper perineal care. Systemic changes made were: By 11/25/16, the Staff Development Coordinator in-serviced all current nursing staff (CNA, RN, LPN, Med-Aide) both full time, part time, agency and PRN. In-service topics included: • Glove use • Frequency of glove changes • Handling of contaminated linen	

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F 441	Continued From page 37	F 441		

training finished their care with the resident and began to dispose of the soiled linens on the table in the plastic bag. The side table was not sanitized after removing the soiled linens.

2. Resident #56 was admitted on 1/8/16. Diagnoses included in part quadriplegia, dysfunction of bladder, chronic pain, and dependent on oxygen.

The MDS dated 10/10/16 quarterly assessment revealed the resident was cognitively aware. The resident required an assist with two staff members with bed mobility and transfers. The resident required total dependence with an assist of one staff member for all ADLs and had an impairment with both sides to upper and lower extremities. The resident had a suprapubic catheter and was incontinent of bowel.

A record review of the care plan updated on 10/4/16 revealed a plan of care for ADLs for quadriplegia to include assistance with all ADLs. All the interventions and goals were appropriate and measurable.

An observation of ADL care was observed on this resident on 10/25/16 at 10:00 am with NA #19 and a NA in training. The resident was offered a shave and declined. NA #19 and the NA in training applied gloves and prepared the linens and the wash basin. The bed bath was started as NA #19 began to wash the resident ' s face, chest and arms. NA #19 rinsed the wash cloth and washed the resident ' s legs and feet. A new wash cloth was obtained and used to cleanse the resident ' s perineum area. It was noted to have a small amount of stool smeared on the cloth. Once NA #19 completed cleansing the perineum

- What to do when equipment or adjacent surfaces become contaminated
- When to perform hand hygiene and soap and water verses alcohol based hand gel
- Providing perineal care

This education was provided by an Education Training Packet on infection control practices.

Any in-house staff member who did not receive in-service training by 11/25/2016 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained.

The facility plans to monitor its performance by:
The Staff Development Coordinator/Director of Nursing will monitor this issue using the Infection Control Practices QA Tool for monitoring infection control practices for glove use, hand hygiene, perineal care, and preventing contamination. This will be completed weekly x 4weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the

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F 441	Continued From page 38 area, the soiled wash cloth was placed directly on the resident's side table. The wash cloth and wash basin were removed from the table after all the care had been done. The side table was not sanitized after removing the soiled linens. An interview with NA #19 and the NA in training was conducted at 11:00 am on 10/25/16. NA #19 reported that she forgot to put gloves on while doing care on Resident #7. NA #19 reported she was not thinking and she was rushing when she placed the soiled wash clothes on Resident #7 and Resident #56 ' s side tables. NA #19 reported that she should not have put the soiled cloth on the table and she should be wearing gloves whenever doing personal care on any resident. NA #19 confirmed that she should not have placed the dirty linens on top of the clean linens. The NA ' s reported they were in serviced about infection control during orientation. An interview with the Staff Development Coordinator (SDC) Nurse on 10/28/16 at 2:45 pm revealed that her expectation of the staff was to dispose of soiled linens properly by using plastic trash bags and disinfecting any contaminated areas. The SDS nurse reported in-services were completed for infection control upon hiring at orientation, yearly and as needed. An interview with the Administrator on 10/28/16 at 5:00 pm revealed her expectation of all staff was to dispose of linens properly and to wear their personal protective equipment when required.	F 441	weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Dietary Manager and the Administrator.	