PRINTED: 03/03/2017 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES PREFIX THG SUMMARY STATEMENT OF DEFICIENCIES SUPPLETE F 242 483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including) sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record review, the facility failed to offer showers as scheduled for 2 of 3 (Resident #59 and Resident #26) reviewed for choices. Findings included: 1. Resident #59 was admitted 2/9/16 with cumulative diagnoses of rheumatoid arthritis, atrial fibrillation and coronary artery disease. The annual Minimum Data Set (MDS) dated 11/18/16 indicated Resident \$69 was cognitively intact with no behaviors. She was coded as requiring extensive assistance for her hygiene and bathing. The MDS was coded that a choice between a shower or bed bath was very important to her. The Care Area Assessment Workshew (CAA) dated 11/18/16 indicated Resident 459 was cognitively intact and no refusal of the activities of daily living (ADLs) were mentioned. Resident #59 was cognitively intact and no refusal of the rectivities of daily living (ADLs) were mentioned. Resident #59 was cognitively intact and no refusal of the rectivities of daily living (ADLs) were mentioned. Resident #59 was cognitively intact and no refusal o		DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE			345532	B. WING _			01/2	20/2017
DATE	NAME OF PE	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-0.2011
CAH D	I IREDTY (COMMONS NSG AND PE	HAR CTP OF LEE COUNTY		31	0 COMMERCE DRIVE		
F242 48.3.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to make choices about aspects of his or her life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record review, the facility failed to offer showers as scheduled for 2 of 3 (Resident #99 and Resident #26) reviewed for choices. Findings included: 1. Resident #59 was admitted 2/9/16 with cumulative diagnoses of rheumatoid arthritis, atrial fibrillation and coronary artery disease. The annual Minimum Data Set (MDS) dated 11/18/16 indicated Resident #59 was cognitively intact with no behaviors. She was coded as requiring extensive assistance for her hygiene and bathing. The MDS was coded that a choice between a shower or bed bath was very important to her. The Care Area Assessment Worksheet (CAA) dated 11/18/16 indicated Resident #59 was cognitively intact and no refusal of her activities of daily living (ADI.2) were mentioned. Resident #59 was cognitively intact and no refusal of her activities of daily living (ADI.2) were mentioned. Resident #59 was cognitively intact and no refusal of her activities of daily living (ADI.2) were mentioned. Resident #59 was cognitively intact and no refusal of her activities of daily living (ADI.2) were mentioned. Resident	LIDLINITY	COMMONS NSG AND IN	CHAB CIR OF ELE COUNTY		S	ANFORD, NC 27330		
(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This RECUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record review, the facility failed to offer showers as scheduled for 2 of 3 (Resident #59 and Resident #26) reviewed for choices. Findings included: 1. Resident #26) reviewed for choices. Findings included: 1. Resident #359 was admitted 2/9/16 with cumulative diagnoses of rheumatoid arthritis, attrial fibrillation and coronary artery disease. The annual Minimum Data Set (MDS) dated 11/18/16 indicated Resident #59 was cognitively intact with no behaviors. She was coded that a choice between a shower or bed bath was very important to her. The Care Area Assessment Worksheet (CAA) dated 11/18/16 indicated Resident #59 was cognitively intact and no refusal of her activities of daily living (ADLs) were mentioned. Resident #59	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record review, the facility failed to offer showers as scheduled for 2 of 3 (Resident #59 and Resident #26) reviewed for choices. Findings included: 1. Resident #59 was admitted 2/9/16 with cumulative diagnoses of rheumatoid arthritis, atrial fibrillation and coronary artery disease. The annual Minimum Data Set (MDS) dated 11/18/16 indicated Resident #59 was cognitively intact with no behaviors. She was coded that a choice between a shower or bed bath was very important to her. The Care Area Assessment Worksheet (CAA) dated 11/18/16 indicated Resident #59 was cognitively intact and no refusal of her activities of daily living (ADLs) were mentioned. Resident #59		(f)(1) The resident has schedules (including shealth care and provictonsistent with his or and plan of care and of this part. (f)(2) The resident has about aspects of his care significant to the resident has members of the community activities in the co	s a right to choose activities, sleeping and waking times), ders of health care services her interests, assessments, other applicable provisions a right to make choices or her life in the facility that resident.	F2	242			2/10/17
		This REQUIREMENT by: Based on resident, fa and record review, the showers as scheduler and Resident #26) resincluded: 1. Resident #59 was a cumulative diagnoses atrial fibrillation and cannual Minimum Data indicated Resident #5 no behaviors. She was extensive assistance. The MDS was coded shower or bed bath with Care Area Asses dated 11/18/16 indicated cognitively intact and daily living (ADLs) were	amily and staff interviews e facility failed to offer d for 2 of 3 (Resident #59 viewed for choices. Findings admitted 2/9/16 with of rheumatoid arthritis, oronary artery disease. The a Set (MDS) dated 11/18/16 by was cognitively intact with as coded as requiring for her hygiene and bathing. that a choice between a as very important to her. sment Worksheet (CAA) ted Resident #59 was no refusal of her activities of tre mentioned. Resident #59			Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federa 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 sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F242 SS=D 483.10(f)(1)-(3) SELF DETERMINATION SIGHT TO MAKE CHOICES	al	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

02/10/2017

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345532	B. WING		0.	1/20/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	'	
				310 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AN	D REHAB CTR OF LEE COUNTY		SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 242	Continued From p	page 1	F 24	12		
	·	stance with her ADLs and no				
	refusal of shower			Resident # 59 was immedia	tely offered a	
		0 0. 00. / 12 20.		shower on 1/18/2017 by Ce	-	
	A review of Resid	ent #59 Bedside Kardex Report		Assistant (C.N.A.) and refus	•	
		sion dated 2/9/16 and no date		was offered another shower		
	of last reviewed of	f revised indicated she required		Certified Nursing Assistant ((C.N.A.) on	
	staff of assistance	e of one person for bathing.		1/21/2017 and accepted. O		
				resident #59 was interviewe	•	
		1/17/17 at 11:51 AM, Resident		Minimum Data Set (MDS) N		
		as not offered showers on her		stated she preferred whirpo		
		r days of Wednesdays and		Wednesdays and Saturday		
	was important to	ent #59 stated having showers		Residents care plan and kall updated on 2/3/17 by the M		
	was important to	ner.		Set (MDS) Nurse.	IIIIIIUIII Dala	
	In an interview on	1/19/17 at 7:55 AM, Nursing		Oct (MDO) Naise.		
		stated she was assigned on		Resident # 26 was immedia	tely offered a	
	, ,	ated Resident #59 refused		shower on 1/20/2017 by the	-	
	showers in in the	winter time stating the shower		accepted. Resident was int		
		d. NA #1 stated Resident #59		1/24/17 by the MDS Nurse a		
	was scheduled to	have her showers on first shift		she prefers a whirlpool or sh		
		and Saturdays. She stated she		Tuesdays and Fridays betw		
		Resident #59 's refusals but		of 3 PM to□ 11 PM. The ca		
		Resident #59 a bed bath		revised on 2/6/2017 by the I		
		ated Resident #59 received a		Set (MDS) Nurse to indicate	e these	
		ay rather than a shower but she		preferences stated above.		
		e offered Resident #59 a		Corrective Action for Decide	ent Detentially	
	1	v. NA #1 stated she was		Corrective Action for Reside Affected:	ent Potentially	
	supposed to repo	rt any refusals to the nurse.		Allected.		
	In an interview on	1/19/17 at 8:10 AM, NA #2		All residents have the poten	itial to be	
		nented when Resident #59		affected by this practice. Al		
		er on shower schedule sheet		and/or responsible party we		
	and reported refu	sal to the nurse.		between 1/23/2017 through		
				bathing preferences (Whirlp		
		nower schedule for Resident #59		or Bed Bath or bath of choice		
		resent indicated no refusals but		preferences relating to date	•	
		owers on the following days:		the administrative staff to in-		
	10/1/16-Shower			Social Worker, the Medical		
	10/5/16-Shower			Health Information Manager	r (HIM), The	

Facility ID: 980156

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345532	B. WING		01/20/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	ヿ
				310 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND F	REHAB CTR OF LEE COUNTY		SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE COMPLETION HE APPROPRIATE DATE	,
F 242	Continued From pag	ge 2	F 2	42		
1 242	10/8/16-Shower 10/9/16-Shower 12/14/16-Shower 1/14/17-Shower In another interview Resident #59 she w yesterday. In another interview #2 stated she did no document Resident she knew she report In an interview on 1/ nurse stated she oft nurse and she had r refuse her showers. #59 was refusing he would have care pla refusal. In an interview on 1/ who worked with Re 1/18/17 stated no st Resident #59 refuse stated if she was ma refusing a shower of treatments, she wou nursing notes. A rev	on 1/19/17 at 10:10 AM, as not offered a shower on 1/19/17 at 11:40 AM, NA at know why she failed to #59 's shower refusal but ted the refusals to the nurse. 19/17 at 2:55 PM, the MDS en also worked as a floor never known Resident #59 to The MDS stated if Resident r showers, she stated she nned Resident #59 for the 20/17at 8:20 AM Nurse #2 sident #59 on Wednesday aff reported to her that d her shower. Nurse #2 ade aware of Resident #59	F 24	Rehabilitation Director (RD) Dietary Manager, the Direct (DoN), the Minimum Data S Nurse, and the Business Of (BOM). 64 updates were m plans and Karedex s have to reflect changes in resider conducted between 1/23/20 as of 2/9/2017 by the MDS Director of Nursing. Systemic Changes: Nursing Staff to include full and prn, licensed and unlice (Registered Nurses (RN), L Practical Nurses (LPN), and Nursing Assistants (C.N.A.) in-serviced 1/20/17 by the E Nursing through 2/10/2017 Activities of Daily Living (AE (Showers) giving showers a the care plan, honoring choices/preferences, docum refusal(s) of care and alertin changes/refusals of care. T information has been integr standard orientation training required in-service refreshe all employees and will be re Quality Assurance (QA) Pro	time, part time ensed staff icensed d Certified) were Director of regarding DL) Care according to the nurse of This and in the g and in the recovered with were viewed by the	
	#59 refusing her sho In an interview on 1/ Director of Nursing (expectation that Res showers as schedul staff should attempt			that the change has been s Quality Assurance: The Director of Nursing (Do the Certified Nursing Assist documentation of Activities	ustained. N) will monitor ant (C.N.A.)	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SUI COMPLET	
		345532	B. WING _		01/20/	2017
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY	,	STREET ADDRESS, CITY, STATE, ZIP C 310 COMMERCE DRIVE SANFORD, NC 27330	•	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 242	aide document the 2. Resident #26 wa 1/16/16 with multiple chronic kidney dise behavioral disturba The admission Min assessment dated #26 was cognitively the assessment. Ir and Activities section indicated it was ver between a tub bath bath. The comprehensive 1/28/16, indicated for Daily Living (ADI deficit related to im The plan of care for identified any issue The quarterly MDS Resident #26 had s She was assessed rejection of care. F physical help of one A review of the med #26 was scheduled The shower docum 1/17/17 was review received 16 of 31 s 109 day timeframe.	e nurses and the nurses and refusal. s admitted to the facility on e diagnoses that included ase and dementia without	F 2	(ADL) Care to include bath weekly using the Quality Astrool for Monitoring Shower completed on a minimum of during weekly Quality of Lift Meeting x 4 weeks. Then scompleted monthly x 3 moresolved by the Quality Ass. Committee. Any concerns immediately addressed with Nursing Home Administrate (NHA)/Director of Nursing Reports will be presented the Quality Assurance (QA) con Nursing Home Administrate Director of Nursing (DoN) of authorized Designee to enaction initiated as appropriated to a support and weekly Quality Assurance. The weekly Quality Assurance The we	ssurance (QA) ss. This will be sof 3 residents fe (QoL) this audit will be on this or until surance (QA) identified will be sh/by the fr (DON). To the weekly mmittee by the for (NHA), the for the sure corrective fate. fied and freviewed at the fr (QA) Meeting. fince (QA) Director of frese, Minimum for/Nurse, fron Director for Health for Certified for diministrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		345532	B. WING	 	01/20/2017	
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 242	Continued From page		F 24	12		
	#26 on 1/17/17 at 3	as conducted for Resident 40 PM. The interview 26 had not received showers				
	Nursing (DON) on 1 showers were docu Medical Record (EM (NAs). She reporte copy shower schedu which residents wer The DON stated that	Inducted with the Director of 1/18/17. She indicated mented in the Electronic IR) by Nursing Assistants d that the facility utilized hard ules for the NAs to identify e scheduled for showers. It the EMR was the primary ation for showers, bed baths, wers.				
	1/19/17 at 1:51 PM. familiar with Reside sometimes Residen she was provided walternative. She stathe correct process showers. NA #2 repstaff to pick one opt selected bed bath raccepted the bed ballooked in the EMR to	she indicated she was not #26. She reported that t #26 refused her shower and ith a bed bath as an ted that she was not sure of for documenting refusals of corted that the EMR required ion for bathing and she had ather than refusal if a resident eath. She revealed that if you here was no way to identify if yided because the resident				
	1/19/17 at 2:27 PM. familiar with Reside Resident #26 refuse provided her with a NA #3 reported that pick one option for the second residual residu	nducted with NA #3 on She indicated she was Int #26. She reported that is Indicated that is Int #26. She reported that is Int #26 her shower that she Int bed bath as an alternative. Inthe EMR required staff to Interest to be at the shear that she had selected in refusal if Resident #26 had				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		345532	B. WING			01/20/2017
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27330	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 242 F 278 SS=D	1/19/17 at 3:45 PM. 3 resident refused a shas an alternative. Na required staff to pick she had selected bed resident had accepted. An interview was consuming (DON) on 1/2 indicated her expects offered and provided. She additionally state of shower refusals shaddressed in the resident had accurately reflew. (g) Accuracy of Assemust accurately reflew. (h) Coordination A registered nurse meach assessment with participation of health (i) Certification (1) A registered nurse the assessment is consumer.	anducted with NA #4 on She reported that if a shower she offered a bed bath A #4 reported that the EMR one option for bathing and d bath rather than refusal if a sed a bed bath. Inducted with the Director of 20/17 at 9:42 AM. She ation was for showers to be to residents as scheduled. Bed that if there was a pattern the expected it to be ident's plan of care. SMENT DINATION/CERTIFIED sesments. The assessment are the resident's status. Inducted with the Director of 20/17 at 9:42 AM. She ation was for showers to be to residents as scheduled. Bed that if there was a pattern the expected it to be ident's plan of care. SMENT DINATION/CERTIFIED sesments. The assessment are the resident's status. Inducted with the Director of 20/17 at 9:42 AM. She ation was for showers to be to residents as scheduled. See that if there was a pattern the expected it to be ident's plan of care. SMENT DINATION/CERTIFIED sesments. The assessment are the professionals.	F 2			2/10/17
	(j) Penalty for Falsific	cation				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	E SURVEY IPLETED	
		345532	B. WING	 	0.	//20/2017
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY	•	STREET ADDRESS, CITY, STATE, ZIP CO 310 COMMERCE DRIVE SANFORD, NC 27330	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 278	who willfully and ke (i) Certifies a mate resident assessme penalty of not more assessment; or (ii) Causes anothe	e and Medicaid, an individual	F 27	78		
	\$5,000 for each as (2) Clinical disagre material and false This REQUIREME by: Based on record of facility failed to acc Set (MDS) for preshospice, life expect (Resident #26), and Coding errors were assessments for for residents. The findings included 1. Resident #40 was multiple diagnoses vascular disease, mellitus, chronic kithe knee amputation A wound report dad Resident #40 had of the admission of 12/10/16 indicated admitted with two selft heel. Review of the wound report was the self heel.	ement does not constitute a statement. NT is not met as evidenced eview and staff interviews, the curately code Minimum Data sure ulcers (Resident #40), tancy (Resident # 81), falls d diagnosis (Resident #81). e discovered in the MDS our of the eighteen sampled ed: as admitted on 12/9/16 with that included peripheral pressure ulcers, diabetes dney disease, and right below		The statements made on the Correction are not an admiss not constitute an agreement alleged deficiencies. To remain in compliance with and State Regulations the fataken or will take the actions this Plan of Correction. The Correction constitutes the farallegation of compliance such alleged deficiencies cited hawill be corrected by the date indicated. F278 Corrective Action for Resider On 1/18/17, the following Minset (MDS) Assessments that surveyor sample list were constituted.	sion to and do with the n all Federal acility has a set forth in Plan of cility s th that all ve been or or dates ant Affected: nimum Data tt were in the	

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F 278 Continued From page 7 wound physician, revealed that Resident #40 had the other was to the bottom surface of the left heel. The admission comprehensive Minimum Data Set (MDS) assessment dated 12/16/16 indicated Resident #40 had one stage III pressure ulcer coded in section M of the assessment. A review of the medical record of Resident #40 revealed wound reports for two independent stage III pressure ulcers. An interview that was conducted with two independent stage III pressure ulcers. An interview that Resident #40 was admitted with two stage III pressure ulcers to the left heel that Resident #40 was admitted with two stage III pressure ulcers to the left heel that were PREFIX CROSS-REFERENCECED TO THE APPROPRIATE DATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 278 modifications to reflect accurate resident issues that had been inaccurately coded on the MDS Assessments. Those in the resident #40), hospice, life expectancy (resident # 40), hospice, life expectancy (resident # 41), falls (resident # 26) and diagnosis to reflect depression (resident # 23). These MDS assessments modifications were completed by the MDS Coordinator/Nurse on 2/10/17 and transmitted. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this practice. On 1/18/17 through 2/10/17, Six residents who had		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Wound physician, revealed that Resident #40 had the other was to the bottom surface of the left heel. The admission comprehensive Minimum Data Set (MDS) assessment dated 12/16/16 indicated Resident #40 had one stage III pressure ulcers coded in section M of the assessment. A review of the medical record of Resident #40 revealed wound reports for two independent stage III pressure ulcers. An interview that was conducted with the facility wound physician, on 1/18/17 at 11:03 AM, revealed that Resident #40 was admitted with two stage III pressure ulcers to the left heel, each dated 12/16/16. Each report documented that Resident #40 had been admitted with two independent stage III pressure ulcers. An interview that was conducted with the facility wound physician, on 1/18/17 at 11:03 AM, revealed that Resident #40 was admitted with two stage III pressure ulcers to the left heel that were			345532	B. WING			04/	20/2047
CAJ ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG PR	NAME OF P	ROVIDER OR SUPPLIER	0.0002		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	20/2017
F 278 Continued From page 7 wound physician, revealed that Resident #40 had the other was to the patron sheel. The admission comprehensive Minimum Data Set (MDS) assessment dated 12/16/16 indicated Resident #40 had one stage III pressure ulcer coded in section M of the assessment. A review of the medical record of Resident #40 revealed wound reports for two independent stage III pressure ulcers. An interview that was conducted with two stage III pressure ulcers. An interview that was conducted with the other was to the left heel that Resident #40 was admitted with two stage III pressure ulcers to the left heel that were PREFIX TAG REACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 278 Modifications to reflect accurate resident issues that had been inaccurately coded on the MDS Assessments. Those in the resident #40), hospice, life expectancy (resident #40), hospice, life expectancy (re	LIBERTY	COMMONS NSG AND F	REHAB CTR OF LEE COUNTY					
wound physician, revealed that Resident #40 had two independent stage III pressure ulcers. One ulcer was to the rear surface of the left heel and the other was to the bottom surface of the left heel. The admission comprehensive Minimum Data Set (MDS) assessment dated 12/16/16 indicated Resident #40 had one stage III pressure ulcer coded in section M of the assessment. A review of the medical record of Resident #40 revealed wound reports for two independent stage III pressure ulcers to the left heel, each dated 12/16/16. Each report documented that Resident #40 had been admitted with two independent stage III pressure ulcers. An interview that was conducted with the facility wound physician, on 1/18/17 at 11:03 AM, revealed that Resident #40 was admitted with two stage III pressure ulcers to the left heel that were modifications to reflect accurate resident issues that had been inaccurately coded on the MDS Assessments. Those in the resident #40, hospice, life expectancy (resident #81), falls (resident #26) and diagnosis to reflect accurate resident issues that had been inaccurately coded on the MDS Assessments. Those in the resident sample included; Pressure ulcers (resident #81), falls (resident #26) and diagnosis to reflect depression (resident # 26) and diagnosis to reflect depression (resident # 81), falls (resident # 26) and diagnosis to reflect depression (resident # 81), falls (resident # 26) and diagnosis to reflect depression (resident # 26) and transmitted. Coordinator/Nurse on 2/10/17 and transmitted. Corrective Action for Resident Potentially Affected: All residents have the potential to be affected by this practice. On 1/18/17 through 2/10/17, Six residents who had	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
not conjoined. An interview that was conducted with the MDS Nurse on 1/19/17 at 2:49 PM revealed that she was responsible for coding Section M of the MDS assessments. She indicated she coded the assessment for Resident #40 after she had received and reviewed the wound report. The wound nurse stated that there must have been only one stage III pressure ulcer on the wound report. The wound nurse reviewed the wound report and acknowledged that the wound report had documented that Resident #40 had two stage III pressure ulcers and that the error in coding one stage III pressure ulcers in Section M of the MDS dated 12/16/16 for Resident #40 must have been an oversight. An interview was conducted with the MDS A minterview that was conducted with the MDS 3 months, two hospice residents that had been diagnosed with life expectancy of 6 months of less to live, and 51 residents who were on psychoactive medications were reassessed and their most recent Omnibus Budget Reconciliation Act (OBRA)/Minimum Data Set (MDS) assessments reviewed for accurate coding by the Registered Nurse/Minimum Data Set (MDS) Coordinator and the Minimum Data Set (MDS) Nurse Consultant. Three residents that were found to have coding errors were corrected via modifications by 2/10/17 by the MDS Coordinator.	F 278	wound physician, re two independent staulcer was to the rea the other was to the heel. The admission com Set (MDS) assessmed Resident #40 had o coded in section Moder A review of the med revealed wound repstage III pressure uld dated 12/16/16. Ea Resident #40 had be independent stage IA ninterview that was wound physician, or revealed that Residestage III pressure uld not conjoined. An interview that was wound physician, or revealed that Residestage III pressure uld not conjoined. An interview that was responsible for assessments. She assessment for Residestage III pressure uld not conjoined and review wound nurse stated only one stage III preport. The wound wound report and are report had document two stage III pressure uld dated 12/16/16 for Fan oversight.	vealed that Resident #40 had age III pressure ulcers. One in surface of the left heel and abottom surface of the left heel assessment. A sical record of Resident #40 and are ulcers to the left heel, each and and the left heel, each and and the left heel and and the left heel and and the left heel that were as conducted with the facility in 1/18/17 at 11:03 AM, and the left heel that were as conducted with the MDS and a second and the left heel that were as conducted with the MDS and and the left heel that were as conducted with the MDS and and the left heel that were as conducted with the MDS and the left heel that were as conducted with the MDS and the left heel that were as conducted with the MDS and the left heel that were as conducted that she coded the left heel that were as conducted that the wound and the left heel that were as and that the wound and the left had the error in pressure ulcer instead of two cers in Section M of the MDS are left and that he error in pressure ulcer instead of two cers in Section M of the MDS are left and that he error in pressure ulcer instead of two cers in Section M of the MDS are left and the left heel that heel that heel and the left heel that heel and the left heel that he	F 2	278	issues that had been inaccurately code on the MDS Assessments. Those in the resident sample included; Pressure ulderesident # 40), hospice, life expectance (resident # 81), falls (resident # 26) and diagnosis to reflect depression (resident 23). These MDS assessments modifications were completed by the MC Coordinator/Nurse on 2/10/17 and transmitted. Corrective Action for Resident Potential Affected: All residents have the potential to be affected by this practice. On 1/18/17 through 2/10/17, Six residents who had pressure ulcers, 52 who had fallen in p3 months, two hospice residents that had been diagnosed with life expectancy of months of less to live, and 51 residents who were on psychoactive medications were reassessed and their most recent Omnibus Budget Reconciliation Act (OBRA)/Minimum Data Set (MDS) assessments reviewed for accurate coding by the Registered Nurse/Minimum Data Set (MDS) Coordinator and the Minimum Data Set (MDS) Nurse Consultant. Three residents that were found to have coding errors were corrected via modifications by 2/10/17	ed eed eecers ey d int # IDS Illy d ast ad f 6 s s t t um	

Facility ID: 980156

PRINTED: 03/03/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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F 278	Continued From pa	nge 8	F 27	8		
	was that MDS be c	oded accurately.				
	2. Resident #81 wa	as initially admitted to the		On 1/20/17 through 2/10/17, the licensed nurses (both Registe (RN) and Licensed Practical N (LPN) to include fulltime, particular section (LPN) to include full sect	red Nurses Iurses	
	facility on 10/30/14 included lung canon	with multiple diagnoses that er.		PRN Nurses were in-serviced importance of notifying the Re Nurse/Minimum Data Set (MD	gistered	
	•	e plan of care for Resident #81 area of hospice care was		Coordinator and the facility Dir Nursing (DoN) on any new res changes/incidents/new orders including any refusals for care	rector of sident /behaviors	
	#81 was recertified 10/2/16 with a certi	dical record indicated Resident for hospice services on fication period that extended		treatment(s). This in-service w by the Director of Nursing (Do	/as provided N).	
	assessment dated #81 was cognitively Conditions section,	nimum Data Set (MDS) 11/2/16 indicated Resident v intact. Section J, the Health had not indicated Resident ctancy of six months or less		On 2/7/17 the Registered Nurs (RN)/Minimum Data Set (MDS) Coordinator and the facility Dir Nursing (DoN) were both provere-education on accurate MDS the facility nurse consultant ar Data Set (MDS) Nurse Consultants in-service included areas to as documentation that needs to be	s) rector of rided with s coding by and Minimum Itant. The ssess,	
	on 1/19/17 at 2:40 responsible for cod assessments. Sec 10/24/16 for Reside was no prognosis of reviewed with the Marcord documentat was on hospice can	onducted with the MDS Nurse PM. She stated she was ing Section J of the MDS tion J of the MDS dated ent #81 that indicated there of 6 months or less was MDS Nurse. The medical ion that indicated Resident #81 re at the time of the 10/24/16 I with the MDS Nurse. She		communication required betwee facility staff (Certified Nurse At (CNA), Registered Nurses (RN Practical Nurses (LPN)and the administrative staff) as well as Director (MD)/Physician so to accurate Minimum Data Set (N which should be maintained at Minimum Data Set (MDS) Cook	een the ssistants N), Licensed to the Medical ensure MDS) coding t all times.	
	revealed the MDS this was an oversig going to be comple	was inaccurate. She indicated ht and a modification was		ensure that questions relating resident s life expectancy and status, all falls, presence of pr ulcers and diagnosis are accu on the Omnibus Budget Reco	to a d hospice essure rately coded	

Facility ID: 980156

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345532	B. WING _			01/	20/2017
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LIDEDTY				3′	10 COMMERCE DRIVE		
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F 278	Continued From page	e 9	F 2	278			
		20/17 at 9:00 AM. She ed the MDS to be coded			(OBRA)/Minimum Data Set (MDS) assessments as appropriate and the resident Care Plan accurately updated within 24 to 48 hours of change.		
	Resident #81 was co the Special Treatmer Programs section, ind not received hospice facility (Question Oo' An interview was con on 1/19/17 at 2:40 Pt responsible for codin	dicated Resident #81 had care while a resident at the			This information has been integrated in the routine in service(s) for Registered Nurse (RN) Minimum Data Set (MDS) Coordinator/MDS support nurse and in the required in-service refresher cours for all employees and will be reviewed the Quality Assurance (QA)Process to verify that the change is maintained.	ı es by	
	not received hospice facility was reviewed medical record docur Resident #81 was on the 10/24/16 MDS was Nurse. She revealed indicated this was an was going to be com	t #81 that indicated he had care while a resident at the with the MDS Nurse. The mentation that indicated hospice care at the time of as reviewed with the MDS MDS was inaccurate. She oversight and a modification pleted.			Quality Assurance: The facility Director of Nursing (DON) audit a minimum of two residents Minimum Data Set (MDS) comprehens assessments for accuracy of the variou identified areas per week for 4 weeks, then monthly for 3 months or until resolved by Quality Assurance (QA) Committee. Reports will be presented the weekly Quality Assurance (QA)	sive us	
	1/20/17 at 9:00 AM. the MDS to be coded 3. Resident #26 was	She indicated she expected accurately. admitted on 1/16/16 with at included a history of			committee by the Administrator or Dire of Nursing (DoN) to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at monthly Quality Assurance (QA) Meeting is attended by the Director of	the	
	The quarterly Minimu	0/24/16 indicated Resident significantly impaired.			Nursing (DoN), Minimum Data Set (ME Coordinator, Support Nurse, Rehabilitation Director (RD) or Therapy designee, Health Information Manager (HIM), Certified Dietary Manager and t	y	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 278	Continued From page	e 10	F 278			
		26 had no falls since the sment (7/24/16 quarterly		Administrator.		
	WIBO).			Compliance date: 2/10/2017		
		cal record indicated Resident inor injury on 8/10/16.		·		
		Resident #26 was updated ew focus area of an actual er falls.				
	on 1/19/17 at 2:40 PM responsible for coding assessments. She in incident log in the elecode the MDS for fall dated 10/24/16 for Reshe had no falls since assessment (7/24/16 reviewed with the MD record documentation a minor injury on 8/10 MDS Nurse. She revinaccurately. She state An interview was con 1/20/17 at 9:00 AM. the MDS to be coded 4. Resident #23 was	quarterly assessment) was DS Nurse. The medical of the first of the fi				
	12/16/16 with multiple Depression. The admission Minim assessment dated 12 Resident #23 had red medication during the	e diagnoses including num Data Set (MDS) 2/23/16 indicated that ceived an antidepressant e assessment period. The indicated that Resident #23				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345532	B. WING		01/20/2017
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F 278	Continued From pag	e 11	F 27	3	
F 279 SS=D	The orders included 50 milligrams (mgs.) On 1/19/17 at 2:48 P interviewed. The ME she missed to code I on the quarterly MDS On 1/20/17 at 9:00 A (DON) was interview expected the MDS to 483.20(d);483.21(b)(COMPREHENSIVE 483.20 (d) Use. A facility me assessments complemenths in the resider results of the assess	M, the MDS Nurse was DS Nurse acknowledged that Depression under diagnoses S assessment. M, the Director of Nursing ed. The DON stated that she b be accurate. 1) DEVELOP	F 279		2/10/17
	comprehensive persite each resident, consists set forth at §483.10(concludes measurable to meet a resident's reand psychosocial necomprehensive assecare plan must description of the comprehensive assecare plan must description.	develop and implement a con-centered care plan for stent with the resident rights c)(2) and §483.10(c)(3), that objectives and timeframes medical, nursing, and mental eds that are identified in the ssment. The comprehensive			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY IPLETED
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	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27330	•	
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F 279	or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, include treatment under §483. (iii) Any specialized some rehabilitative services provide as a result of recommendations. If findings of the PASAI rationale in the resident's representational of the resident's representation of the resident's representation of the resident's prefuture discharge. Factorial physical properties of the resident's prefuture discharge.	ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). ervices or specialized is the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. th the resident and the	F 2'	79		
	local contact agencie entities, for this purpo (C) Discharge plans in plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on record revisacility failed to accur	ssed and any referrals to s and/or other appropriate ose. In the comprehensive care in accordance with the in paragraph (c) of this is not met as evidenced iew and staff interviews the ately develop a care plan for oled residents for pressure		The statements made on this Correction are not an admission of constitute an agreement w	on to and do	

PRINTED: 03/03/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			E SURVEY IPLETED
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F 279	Continued From pag	ge 13	F 279	9		
	multiple diagnoses ti vascular disease, primellitus, chronic kidrithe knee amputation. A review of the admidated 12/10/16 indicadmitted with two states and the following insufficiency related hypertension, diabet right below the knee pressure ulcer to the pressure ulcer was tigns of healing and	dmitted on 12/9/16 with hat included peripheral essure ulcers, diabetes ney disease, and right below is ssion nursing assessment ated that Resident #40 was age III pressure ulcers to the #40's care plan that was 16 revealed that Resident g focus areas: renal to chronic kidney disease, amputation, and a stage III eleft heel. The goal for the hat the pressure would show remain free from infection		alleged deficiencies. To remain in compliance with a and State Regulations the facilitaken or will take the actions so this Plan of Correction. The Plan of Correction constitutes the faciliallegation of compliance such alleged deficiencies cited have will be corrected by the date or indicated. F279 Corrective Action for Resident On 1/18/17, Resident # 40 so was reviewed and updated to it current pressure ulcers and int This was completed by the Mir	lity has et forth in lan of ity s that all e been or r dates Affected: care plan include terventions.	
	information in the capressure ulcer. Review of the wound #40 dated 12/14/16, wound physician, retwo independent staulcer was to the rear the other was to the heel. There were acnotes from Resident detailing two separa heel on 12/21/16, 12 A review of the wour indicated that reside ulcers. A further revrevealed that Reside stage III pressure ulcers.	d progress notes for Resident as documented by the facility wealed that Resident #40 had ge III pressure ulcers. One surface of the left heel and bottom surface of the left diditional wound progress #40 's wound physician te pressure ulcers on the left 2/28/16, and on 1/4/16. In the professional wound progress with 40 had two pressure iew of the wound reports ent #40 had two independent cer reports for the left heel, in Each report documented		Set (MDS) Coordinator. Corrective Action for Resident Affected: All residents have the potentia affected by this practice. On 1/through 2/10/17 Six residents or pressure ulcers were reassess their care plans were reviewed accuracy of wounds and woun interventions by the Registered (RN) Minimum Data Set (MDS Coordinator and the Minimum (MDS) Nurse Consultant. All sicare plans were accurate and pressure ulcer interventions. The Plan review completed by MDS	I to be /18/17 who had sed and I for d care d Nurse) Data Set ix identified included Fhis Care	

Facility ID: 980156

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	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION (X3) DATE COMP		SURVEY LETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE		(X5) COMPLETION DATE
F 279	independent stage III A dressing change ar was completed of the foot of Resident #40. The dressing to the le removed by Nurse #1 physician. There were resident 's left foot. The wound nurse. The measured one pressure to the wound nurse. The measured one pressure 2.4 centimeters by centimeter depth. The 3.3 centimeters by 2. was not measured duskin. An interview that was wound physician, on revealed that Resider stage III pressure ulc not conjoined. An interview that was Nurse on 1/19/17 at 2 was responsible for in care plans in regards indicated she had init Resident #40 with on care plan had been in acknowledged that RIII pressure ulcers an care plan so that both addressed in the care An interview conduct.	d been admitted with two pressure ulcers. Ind wound care observation a pressure areas on left the on 01/18/17 at 10:41 AM. Beft heel and foot was a in front of the wound care are two pressure ulcers on the The wound was cleansed by the wound care physician are ulcer on the left foot to a 1.7 centimeters and 0.1 are other was measured to be to centimeters and the depth are to the condition of the conducted with the facility 1/18/17 at 11:03 AM, and #40 was admitted with two ers to the left heal that were a conducted with the MDS 2:49 PM revealed that she initiating and updating the to pressure ulcers. She intended the care plan for the pressure ulcer and that the correct. The wound nurse esident #40 had two stage d that she would correct the pressure ulcers would be a plan. The wound had the expectation was that the accurate when	F	279	Coordinator on 2/10/2017. Systemic Changes: On 1/18/17,the facility licensed nurs (both Registered Nurses (RN) and Licensed Practical Nurses (LPN)), t include full time, part time, and PRN nurses were in-serviced on the importance of notifying the Register Nurse (RN)/Minimum Data Set (MD Coordinator and the facility Director Nursing (DoN) on any new resident changes / new wounds/incidents / r orders /behaviors including any refu for care or treatment(s) by the DON On 2/7/17 the Registered Nurse (RN)/MDS Coordinator and the faci Director of Nursing (DoN) were both provided with re-education on accu Minimum Data Set (MDS) coding/u care plans by the Minimum Data Set (MDS) Nurse Consultant. The in se included areas to assess, document that needs to be reviewed, commun required between the facility staff (Certified Nursing Assistants (CNA) nurses (both Registered Nurses (RLicensed Practical Nurses (LPN)) a administrative staff) as well as the Noirector (MD) so to ensure accurate Minimum Data Set (MDS) coding a updating care plans which should be maintained at all times. Minimum Data Set (MDS) Coordinated the set of th	red os) r of t new usals I. lility h rate pdat et ervice intation icat Medie end oe	ting e on tion nd he ical	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION IG		(X3) DATE COMP	
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F 279	Continued From pag	e 15	F	resident s li status, all fa ulcers and d on the Omni (OBRA)/Min assessment resident Car within 24 to dithin	questions relating to a ife expectancy and hospicalls, presence of pressure liagnosis are accurately co ibus Budget Reconciliation imum Data Set (MDS) is as appropriate and the re Plan accurately updated 48 hours of change. Attion has been integrated in service(s) for Registered Minimum Data Set (MDS) /MDS support nurse and in in-service refresher course yees and will be reviewed assurance (QA) Process to be change is maintained. Director of Nursing (DoN) where the various eas. This will be done were keen the monthly for three ntil resolved by Quality QA) Committee. Reports of the weekly Quality QA) committee by the Nursistrator (NHA) or Director N) to ensure corrective act appropriate. Compliance with a composition of the monthly Quality QA) Meeting. The monthly is attended by the Director of the process of the monthly Quality QA) Meeting. The monthly is attended by the Director of the process of the monthly Quality QA) Meeting. The monthly is attended by the Director of the process of the monthly Quality QA) Meeting. The monthly is attended by the Director of the process of the process of the monthly Quality QA) Meeting. The monthly is attended by the Director of the process of the p	nto nes by ntiles ekly will sing of tion ill ity	

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COVIDER OR SUPPLIER	HAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27330	
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Continued From page	: 16	F 27	Nursing (DoN), Minimum Data Secondinator, Support Nurse, Rehabilitation Director (RD) or The designee, Health Information Man (HIM), Certified Dietary Manager a Nursing Home Administrator (NHA	erapy lager and the
PARTICIPATE PLANN 483.10 (c)(2) The right to par and implementation o plan of care, including (i) The right to particip including the right to i be included in the pla request meetings and revisions to the perso (ii) The right to particip expected goals and o amount, frequency, a other factors related t plan of care. (iv) The right to receiv included in the plan o (v) The right to see th right to sign after sign of care.	ticipate in the development f his or her person-centered to but not limited to: Date in the planning process, dentify individuals or roles to mining process, the right to the right to request in-centered plan of care. Date in establishing the sutcomes of care, the type, and duration of care, and any to the effectiveness of the rethe services and/or items of care. The true the services and/or items of care. The true the services and/or items of care care plan, including the ifficant changes to the plan	F 28	Compliance date: 2/10/2017	2/10/17
	CONTIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page 483.10 (c)(2)(i-ii,iv,v)(3 PARTICIPATE PLANN 483.10 (c)(2) The right to participe including the right to included in the plarequest meetings and revisions to the perso (ii) The right to participe including the right to included in the plarequest meetings and revisions to the perso (iii) The right to participe including the right to include in the plarequest meetings and revisions to the perso (iv) The right to receive included in the plan of care. (v) The right to see the right to sign after sign of care. (c)(3) The facility shall	CORRECTION 345532 COVIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 483.10 (c)(2) (The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan	A BUILDING 345532 COVIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 F 27 483.10 (c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the	CONTINUED TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2)(-ii,iv,v)(3).483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to sea the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345532	B. WING		01/20/2017
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	:	STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27330	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 280	Continued From pag	e 17	F 280		
	shall support the resi planning process mu	dent in this right. The st			
	(i) Facilitate the inclu resident representati	sion of the resident and/or ve.			
	(ii) Include an assess strengths and needs	sment of the resident's			
		esident's personal and in developing goals of care.			
	483.21 (b) Comprehensive (Care Plans			
	(2) A comprehensive	care plan must be-			
	(i) Developed within the comprehensive a	7 days after completion of assessment.			
	(ii) Prepared by an ir includes but is not lin	terdisciplinary team, that nited to			
	(A) The attending ph	ysician.			
	(B) A registered nurs resident.	e with responsibility for the			
	(C) A nurse aide with resident.	responsibility for the			
	(D) A member of foo	d and nutrition services staff.			
	the resident and the An explanation must medical record if the	cticable, the participation of resident's representative(s). be included in a resident's participation of the resident presentative is determined			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	` `cc		SURVEY LETED
		345532	B. WING _			01/2	20/2017
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	•	STREET ADDRESS, CITY, STATE, ZIP CO 310 COMMERCE DRIVE SANFORD, NC 27330	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI IE APPROPRIA		(X5) COMPLETION DATE
F 280	resident's care plan. (F) Other appropriate disciplines as determor as requested by the contraction of the plant of the p	e staff or professionals in nined by the resident's needs he resident. evised by the interdisciplinary essment, including both the quarterly review T is not met as evidenced on, staff and resident review, the facility failed to usal of wearing a right hand of for 1 of 3 residents reviewed ROM). Findings included: dmitted 12/9/15 with es of cerebral vascular iplegia (paralysis of one side and depression. The oata Set (MDS) dated evere cognitive impairment esident #72 was coded for ewith her activities of daily having impairment on one sident #72 last care plan of where she was to wear a purs daily for her right hand ician orders indicated the ed on 9/16/16 with no orders Resident's right hand splint is daily. Check skin integrity	F2	The statements made on th Correction are not an admiss not constitute an agreement alleged deficiencies. To remain in compliance with and State Regulations the fataken or will take the actions this Plan of Correction. The Correction constitutes the fatallegation of compliance such alleged deficiencies cited hawill be corrected by the date indicated. F280 Corrective Action for Resider on 1/23/17, Resident # 72 was revised and updated to resident regident	sion to and with the hall Federa acility has set forth in Plan of cility set that all we been or or dates Int Affected searce plan reflect the and refusal n was	al n : :	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	, ,	E SURVEY MPLETED
		345532	B. WING			1/20/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				310 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND F	REHAB CTR OF LEE COUNTY		SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 280	Continued From pag	ge 19	F 280			
	observed sitting in h	AM, Resident #72 was er recliner not wearing a right t hand was resting in her lap		Corrective Action for Resident Po Affected:	tentially	
	with her fingers cont Resident #72 was a perform ROM to her able to fully extend h painful. When asked she stated she once use it anymore. In a second observa Resident #72 was o without a right hand resting in her lap wit to her palm. In an observation or Resident #72 was si wearing a right hand resting in her lap wit to her palm. Nursing room. She stated she #72 had a right hand	racted over to her palm. ble to take her left hand and right hand but she was not her fingers. She stated it was I about her right hand splint, had a splint but she did not tion on 1/17/17 at 2:00 PM, bserved sitting in her doorway splint. Her right hand was h her fingers contracted over I 1/18/17 at 9:30 AM, tting up in her recliner not I splint. Her right hand was h her fingers contracted over assistant (NA) #1 was in the e was not aware Resident d splint but she was able to		All residents have the potential to affected by this practice. On 1/19, 2/7/17, education was provided by Director of Nursing (DoN) to the notation staff full time, part time, and prn, I and unlicensed staff (Certified Nu Assistants (CNA), Licensed Pract Nurses (LPN), and Registered Nu (RN)) to ensure that they commun with the Minimum Data Set (MDS Coordinator and facility Director of Nursing (DON) and other administance to care in-terms of Actionally Living (ADL), refusal for carrincluding showers or splints as identication to the sure those incidents such as falls, current presulcers, diagnosis and diagnosis of life expectancy r/t hospice care and	y the pursing licensed ursing sical urses nicate e who refusals, ivities of e entified.	
	In an interview on 1/ Rehabilitation Direct turned over to restor splinting 10/13/15. H assessed quarterly thand contracture but any changes. He star Resident #72 was re-	18/17 at 12:20 PM, the or stated Resident #72 was rative nursing for right hand le stated Resident #72 was for worsening of her right to she had not experienced ated he was not aware that efusing her right hand splint.		reported. Sixty-one residents ider have these issues. Twenty out of Sixty-one Care Plans reviewed w updated accordingly. The twenty included two residents refusals of showers at times and eighteen re preference related to showers. The Plans and Cardexes were updated these identified twenty residents of 2/10/2017 by the MDS Nurse. The plans were also updated immediated following the completion of the comprehensive assessment(s). A residents were re-assessed by the	the vere updates sidents he Care d for on he care ately	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	I' ') DATE SURVEY COMPLETED
		345532	B. WING			01/20/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LIDEDTY	COMMONE NEC AND E	SELIAB CER OF LEE COUNTY		310 COMMERCE DRIVE		
LIBERTY	COMINIONS NSG AND R	EHAB CTR OF LEE COUNTY		SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	and Resident #72 to 2 hours daily had be plan. A review of Resident documentation report when the care plan with the care plan	refuse her right hand splint wear her right hand splint for en removed from the care	F 2	Registered Nurse (RN) Minimal (MDS) Coordinator, Registere (RN) Director of Nursing (DON Minimum Data Set (MDS) Cor Nurse Consultant for Care Pla appropriate updates to ensure focus/ problem, goals and intervere identified and appropriat documented on the Care Plan resident Care Plans that were compliance were corrected by the MDS Nurse.	d Nurse N) and porate In that proper rventions ely s. Twenty found out of	
	nurse stated she revised she did not care plar her right hand splint she was not wearing ordered. The MDS in have reviewed the K because she would lead to applying the splin nurse stated the Direct have revised the car Resident #72's chosplint. In an interview on 1/ stated she revised R today to include her DON stated she plar reassess Resident # The DON stated it will plan would have been she right as he would have been she did not applying the splin nurse stated the Direct have revised the car Resident #72's chosplint.	18/17 at 2:10 PM, the MDS riewed the care plan with the ssessment 12/19/16 and a Resident #72's refusal of because she was not aware at the right hand splint as urse stated she must not fardex documentation have noted the aides were not as ordered. The MDS rector of Nursing (DON) may be plan earlier today to include se to refuse the right hand 18/17 at 2:20 PM, the DON resident #72's care plan refusals of the splint. The need to have therapy refused to address her uarterly MDS assessment		Systemic Changes: On 2/7/17, the Minimum Data Coordinator and facility Direct Nursing (DON) were both proveducation that addressed appoare planning and updating of plan as appropriate to reflect tresident(s) current medical standard Education was provided by the Data Set (MDS) Corporate Renurse (RN) Consultant. All full time, and prn nursing to include unlicensed and licensed staff Nursing Assistants (CNA), Lice Practical Nurses (LPN), and Renurses (RN) were in serviced adequately communicate with Registered Nurse (RN) Minimum (MDS) Coordinator, the facility Nursing (DON) and other admistaff including the Nursing Holadministrator (NHA) on any cuincidents such as falls, new princidents.	or of vided with ropriate the care he atus. e Minimum egistered I time, part the both (Certified ensed tegistered to the um Data Set v Director of inistrative me urrent	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	, ,	
		345532	B. WING _			01/20/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 280	Continued From page done 12/19/16.	e 21	F 2	ulcers, refusal of wearing spl of Daily Living (ADL) care an different approaches/redirect Minimum Data Set (MDS) Corensure that Care Plans are a updated each and every time interventions are determined basis by the inter-disciplinary said interventions will be transident(s) Care Plan within hours of said meeting. This any intervention for falls, any resistant to care which include refusals, refusals for splints, hospice status / life expectar pressure ulcers, that may en resident squality of life or producine based upon an incide condition or direct observation. This information has been in the routine in service(s) for Rurse (RN) Minimum Data Scoordinator / Minimum Data Scoordinator / Minimum Data Support nurse and in the requin-service refresher courses employees and will be review Quality Assurance Process to the change is maintained. Quality Assurance: The Director of Nursing (DOI minimum of two residents of accuracy and current update that the care plans are update current incident occurrence as	and offering ting residents or appropriately enew of an ally y team. The asferred to the 24 to 48 would includ y resident des shower current and appropriately enew of a shower current and appropriately energy current for and appropriately energy ener	s. ill ne de er in o

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345532	B. WING _			01/20/2017
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, 2 310 COMMERCE DRIVE SANFORD, NC 27330	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE EIENCY)	(X5) COMPLETION DATE
F 280	Continued From page	e 22	F2	completion of the comp Omnibus Budget Recor (OBRA) Minimum Data Assessment(s) as appr be done weekly for four monthly for three month by Quality Assurance (OR Reports will be present Quality Assurance (QA) Nursing Home Administ Director of Nursing (DC corrective action initiate Compliance will be mor ongoing auditing progra monthly Quality Assura The monthly Quality Assura The monthly Quality As Meeting is attended by Nursing (DON), Minimu Coordinator, Support N Rehabilitation Director (designee, Health Inform (HIM), Certified Dietary Nursing Home Administ	nciliation Act Set (MDS) ropriate. This will r weeks, then hs or until resolved QA) Committee. ed to the weekly) committee by the trator (NHA) or DN) to ensure ed as appropriate. hitored and am reviewed at the nce (QA) Meeting. ssurance (QA) the Director of um Data Set (MDS) lurse, (RD) or Therapy nation Manager Manager and the	
F 282 SS=D	PERSONS/PER CAF (b)(3) Comprehensive	e Care Plans	F 2	Compliance date: 2/10/	/17	2/13/17
	as outlined by the cormust- (ii) Be provided by quaccordance with each care.	d or arranged by the facility, imprehensive care plan, alified persons in a resident's written plan of				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTR		(X3) DATE COMP	SURVEY
		345532	B. WING _			01/	20/2017
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		310 COMM	DDRESS, CITY, STATE, ZIP CODE MERCE DRIVE D, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	interview, the facility the care plan for splin 3 sampled residents (Resident #26) of 3 s Findings included: 1. Resident #83 was facility on 4/25/16 with including hypertension. The quarterly Minimulassessment dated 17 Resident #83 had may problems and had im (ROM) on one side. Resident #83's care was last reviewed on of the care plan problems and the care plan problems and problems and problems and had im (ROM) on one side. Resident #83's care was last reviewed on of the care plan problems and problems and had im (ROM) on one side. Resident #83's care was last reviewed on of the care plan problems and problems and problems application of the care plan problems application of the care plan problems application of broobserve my skin und redness, irritation, etchnurse to review my problems are to review my problems.	iew, observation and staff failed to consistently follow niting for 1 (Resident #83) of reviewed and for falls for 1 ampled residents reviewed. originally admitted to the h multiple diagnoses on and cerebral infarction. Im Data Set (MDS)	F2	The second content of the second seco	ective Action for Resident Affecter 19/17, Resident # 83 s left hand was applied per Physician/MD as and Residents # 26 s reacher of in resident s room. Resident # 26 care plans were reviewed are sues were identified. The splint a ner were issued for residents # 85 f 26 by the Director of Nursing.	d do ral in or d: was # 83 id ind in 3	
	His left hand was cor splint or brace obser- On 1/19/17 at 9:30 A was interviewed. NA assigned to Resident splint for Resident #8	Resident #83 was observed. Intracted and there was no wed. M, NA (nursing assistant) #6 If the stated that she was to the stated that the stat		affect 2/7/17 provid nursir	sidents have the potential to be ted by this practice. On 1/19/17 a 7, education by the DON was ded to full time, part time, and pring staff on all shifts (Certified ing Assistants (CNA), Licensed		

Facility ID: 980156

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345532	B. WING			01/	20/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	20/2017
					10 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY			ANFORD, NC 27330		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
F 282	Continued From pag	e 24	F	282			
	the nurses did not in	form her to start applying the			Practical Nurses both licensed and		
	splint so she had not				unlicensed (LPN, and Registered Nurs	es	
		AM, the Director of Nursing			(RN) to ensure that they are aware of t		
		ed. The DON indicated that			residents care plan to ensure all reside		
		storative NAs or restorative			needs including adaptive equipment,		
	nurse. The NAs wor	king on the floor were			splints, reachers, etc. Also to report or	1	
	responsible for apply	ring the splints. She stated			those who have portrayed any behavio	rs	
	that splint application	was documented on the			of refusals, resistance to care in-terms	of	
	activity of daily living				Activities of Daily Living (ADL), refusal	for	
		flow sheets were reviewed.			care including showers or splints as		
	•	If flow sheet indicated that the			identified. Two out of Three residents		
		d on 9/1, 9/2, 9/3, 9/4, 9/5,			identified to have these issues have ha	ıd	
		d 9/15/16. There was no flow			their care plans reviewed and updated		
		16 to indicate that the splint			accordingly by the MDS Nurse on		
		ovember 2016 flow sheet			2/10/2017. All current residents were		
		int was not applied on 11/1,			re-assessed by the Registered Nurse		
		7, 11/6, 11/7, 11/8, 11/12,			(RN) Minimum Data Set (MDS)	r of	
		3016. The January 2017 flow the splint was not applied on			Coordinator, Registered Nurse Director Nursing (DON) and Minimum Data Set		
	1/4, 1/5, 1/6 and 1/17				(MDS) Corporate Nurse Consultant for		
	174, 175, 175 and 1717				Care Plan appropriate updates to ensu		
	On 1/19/17 at 2:35 P	M, NA #3 was interviewed.			that proper focus/ problem, goals and	.	
		nad been assigned to			interventions were identified and		
		stated that Resident #83 was			appropriately documented on the Care		
	not wearing his splin	ts for a long time now. His			Plans. Two Resident Care Plans that		
	splint was stopped d	ue to the sore on his wrist			were found out of compliance were		
	and she was not info	rmed by the nurses to			corrected by 2/10/17 by the MDS Nurs	e.	
	resume applying the	splint.					
	On 1/20/17 at 9:00 A	M, the DON was					
	interviewed. The DO	N stated that she expected					
		ed consistently as care			Systemic Changes:		
	1 -	ed that the facility had no					
		o will monitor the splint			On 2/7/17, the Minimum Data Set (MD	S)	
		will evaluate the progress of			Coordinator and facility Director of		
	the residents on splir	nts.			Nursing (DON) were both provided with	ו	
	0.0.1.4.400				education that addressed appropriate		
		admitted to the facility on			care planning and updating of the care		
		diagnoses that included a			plan as appropriate to reflect the		
	nistory of failing and	dementia without behavioral			resident(s) current medical status to		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345532	B. WING		0.	1/20/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	72072017
LIBERTY	COMMONE NEC AND D	FUAR CTR OF LEE COUNTY		310 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	Continued From pag	e 25	F 28	2		
	disturbance.			include the possession of a deas a reacher.	evice such	
	included the focus an initiated on 1/28/16. The quarterly MDS of Resident #26's cogn impaired. She requibed mobility. Reside assistance with transpersonal hygiene. Swalking in room, wal on unit, and locomot utilized a walker. A review of the medi	plan of care for Resident #26 rea of the risk for falls lated 10/24/16 indicated ition was significantly red extensive assistance with ent #26 required limited sfers, dressing, toileting and he required supervision with king in corridor, locomotion ion off unit. Resident #26 cal record revealed Resident /17. The fall report indicated		This education was provided to Minimim Data Set (MDS) Corp. Consultant. All nursing staff win-serviced between 1/20/17-2 the Director of Nursing to adec communicate with the Register (RN) Minimum Data Set (MDS) Coordinator, the facility Director Nursing (DON) and other admistaff including the Nursing Hol Administrator (NHA) on any continuity such as falls, new producers, adaptive equipment, spreachers, etc. Staff was additive ducated on the use of the Elector Consultation.	porate Nurse vere 2/10/2017 by quately ered Nurse S) or of hinistrative me urrent ressure plints, ionally	
	Resident #26 had tri- the floor and had slic fall investigation indi- Resident #26 reaching the floor. The fall into	ed to pick up something from I off the side of her bed. The cated the fall was due to ng to pick up an object from erventions indicated a		Kardex/Bedside Kardex, wher information pertaining to the u resident specific devices can learn is integrated with new hire	e tilization of oe found e orientation.	
	assist with the retrieve her reach.	provided for Resident #26 to val of items that were not in		This information has been into the routine in service(s) for Re Nurse (RN) Minimum Data Se Coordinator/MDS support nurs	egistered et (MDS)	
	was updated on 1/6/	ted to falls for Resident #26 17 with an addition of the e me with a reacher to pick		the required in-service refresh for all employees and will be r the Quality Assurance (QA) Poverify that the change is maint	eviewed by rocess to	
	conducted on 1/19/1	esident #26's room was 7 at 9:50 AM. There was no Resident #26 ' s room.		Quality Assurance:		
	Assistant (NA) #3 on	nducted with Nursing 1/29/17 at 2:27 PM. She miliar with Resident #26.		The Director of Nursing will au minimum of two residents ka accuracy and current updates that the care plans for devices	ardex□ for to ensure	

Facility ID: 980156

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345532	B. WING		01/20/2017
NAME OF P	ROVIDER OR SUPPLIER	1	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/20/2017
				310 COMMERCE DRIVE	
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		SANFORD, NC 27330	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 282	Continued From page	e 26	F 28	2	
	She reported Reside indicated Resident #2 reacher to minimize the An observation of Reson 1/19/17 at 3:00 Pl sleeping in her bed. observed in Resident An interview was con 1/19/17 at 3:45 PM. familiar with Resident Resident #26 was at Resident #26 had no minimize the risk of fahad a reacher it was resident was able to An interview was con 1/19/17 at 4:05 PM. familiar with Resident Resident was able to An interview was con 1/19/17 at 4:05 PM. familiar with Resident	nt #26 was a fall risk. NA #3 26 had no intervention of a the risk of falls. sident #26 was conducted M. Resident #26 was There was no reacher t #26's room. ducted with NA #4 on She indicated she was t #26. She reported fall risk. NA #4 revealed intervention of a reacher to alls. She stated if a resident kept near their bed so the access it easily. ducted with NA #5 on She indicated she was t #26 and she was assigned		equipment to include splints and are being carried out for accuracy indicated on the resident kardex be done weekly for one month the monthly for three months or untiled by Quality Assurance Committee Support nurse, the Supervisory Registered Nurse or the License Practical Nurse Lead will conduct random audits (one per shift and must be on a weekend) for the five weeks, then monthly for three muntil resolved by the Quality Ass Committee beginning the week of 2/13/2017. Reports will be presented to the Quality Assurance (QA) committed Nursing Home Administrator (NE) Director of Nursing (DON) to ensecorrective action initiated as approximated.	cy as . This will nen I resolved e. The ed ct three d one irst four conths or urance of weekly tee by the HA) or sure propriate.
F 318	was a fall risk. NA #8 no intervention of a ro of falls. She stated if it would have been keindicated there was room on 1/19/17. An interview was con Nursing (DON) on 1/2 indicated her expects to be followed.		F 31	Compliance will be monitored ar ongoing auditing program review monthly Quality Assurance (QA) The monthly Quality Assurance Meeting is attended by the Direct Nursing (DON), Minimum Data St. Coordinator, Support Nurse, Rehabilitation Director (RD) or Tt. designee, Health Information Material (HIM), Certified Dietary Manage Nursing Home Administrator. Compliance date: 2/13/17	ved at the) Meeting. (QA) ctor of Set (MDS) Therapy anager
SS=D	DECREASE IN RAN	GE OF MOTION			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345532	B. WING _		0.	1/20/2017
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CO	DE	
LIBERTY	COMMONS NSG AND	REHAB CTR OF LEE COUNTY		SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 318	receives appropriatincrease range of mecrease in range of the decrease of the d	imited range of motion the treatment and services to notion and/or to prevent further of motion. Imited mobility receives to, equipment, and assistance to be mobility with the maximum dence unless a reduction in rably unavoidable. In it is not met as evidenced In it is not me	F3		is Plan of sion to and do with the ain in and State aken or will his Plan of rection gation of ged or will be as indicated.	
	A review of the phy following was order to discontinue:	sician orders indicated the ed on 9/16/16 with no orders : Resident's right hand splint		Resident Number # 72 was of splint on 9/16/16, the care place on 1/23/17 by the MI Coordinator to include Passi Motion (ROM) to be provided	an was DS ve Range of	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			01/	20/2017	
	ROVIDER OR SUPPLIER COMMONS NSG AND	REHAB CTR OF LEE COUNTY	•	31	TREET ADDRESS, CITY, STATE, ZIP CODE 10 COMMERCE DRIVE ANFORD, NC 27330	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 318	is to be worn 2 hou daily before applyir On 1/17/17 at 9:20 observed sitting in hand splint. Her rig with her fingers cor Resident #72 was a perform ROM to he able to fully extend painful. When aske she stated she oncuse it anymore. In a second observe Resident #72 was a without a right hand resting in her lap we to her palm. In an observation of Resident #72 was a wearing a right hand resting in her lap we to her palm. Nursin room. She stated se #72 had a right har	rs daily. Check skin integrity	F3	318	of 10 reps to my right hand. It was also revised to include resident right hand splint is to be worn 2 hours daily. Cheskin integrity daily before applying splint. Clean forearm and hand prior to application with soap and water. Pass ROM to be provided daily. 2 sets of 10 reps for 15 minutes. NA Splint. Care palso has been revised to include I make my choice to refuse splint at times, and may refuse to wear my splint at times at if I refuse, please notify my nurse. (Conference to F280). Resident Number # 83 On 1/18/2017, resident # 83 was ordered a splint. On 1/18/2017, the care plan for Resident # was revised by the MDS Coordinator to include assistance with splint: before donning splint, clean and dry left upper extremity for good hygiene. Perform passive range of motion (ROM) exercise for left upper extremity all planes 2 set 10 once a day for 15 minutes. Left upper extremity apply and remove □ tolerate to 2 hours: apply at 10 AM and remove 12 PM. (Cross reference to F280)	ck ive) plan ie d I and oss		
	Rehabilitation Direct was turned over to hand splinting 10/1 was assessed qual hand contracture b any changes. He st Resident #72 was it	I/18/17 at 12:20 PM, the ctor (RD) stated Resident #72 restorative nursing for right 3/15. He stated Resident #72 terly for worsening of her right ut she had not experienced tated he was not aware that refusing her right hand splint portioned to his knowledge. The			Identification of other residents who make involved with this practice: All other current residents were assess by the Rehabilitation Director and Director Nursing on 1/23/17 for splinting. The found that there were no other resident in need of splinting/splinting devices as 1/23/2017.	sed ctor ey ts		

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING		01/20/2017
NAME OF PI	ROVIDER OR SUPPLIER	L	<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/20/2011
				310 COMMERCE DRIVE	
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		SANFORD, NC 27330	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 318	Continued From pag	e 29	F 318	3	
	RD stated it should b	e applied as ordered.		Systemic Changes:	
	nurse stated she rev last quarterly MDS a she did not care plan her right hand splint she was not wearing ordered. The MDS n up on the Kardex for morning when it was stated it was her und was also the treatmes splints since she did would note or if any sthe splints. A review of Resident documentation report indicated staff were to the Resident #72 wo 1-2 hours daily each medications and that	t from 10/1/16 to present o initial off on day shift that re her right hand splint for morning after her morning Resident #72 could remove		Facility Nursing Staff to include full part time and prn licensed and unlice staff (Registered Nurses (RN), Lice Practical Nurses (LPN), and Certifice Nursing Assistants (CNA)) were in-serviced 1/20/2017 through 2/10 on application and refusal of splinting device(s) by the Director of Nursing (Registered Nurse). Nursing Staff I above were educated to document refusals in the Point of Care (within Click Care), utilizing the Alert Tool, notify the nurse if a resident has refused The Minimum Data Set (MDS) Coordinator was educated by the Minimum Data Set (MDS) Corporated Registered Nurse (RN) consultant of Resident Assessment Instrument (I Process (care planning process) or 2/7/17.	censed ensed ensed ed //2017 ng disted I Point and fused. te on the RAI)
	where staff had atter splint or documented In an interview on 1/2 stated there was no	18/17 2:30 PM, Nurse #1 one person responsible for		Nursing and Rehabilitation will re-e and update for need, and changes splinting needs, and d/c of splinting device(s) during quarterly review.	in
	have a formal restora Resident #72 was kn splint and the aide m to apply the splint.	nd that the facility did not ative program. She stated nown to refuse the right hand ust have just stopped trying		Monitoring: To ensure compliance, Director of Now will monitor for decline for range of during weekly Quality of Life (QoL)	motion
		1/19/17 8:00 AM, Resident kfast and not wearing her		utilizing Quality Assurance (QA) To Splinting for the first four weeks and monthly for three months. Splinting included on the care plan audit (cro	d then g will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345532	B. WING		0.	1/20/2017
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27330		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 318	Resident #72 was in recliner wearing her #72 stated she did reapplying the right. In an interview on 1/stated she was not at to have a right hand stated she had seen Kardex but she had Resident #72's roo worked at the facility and had worked with occasions. In an interview on 1/stated it was her expected to the substance of t	on on 1/19/17 at 10:05 AM, her room sitting in her right hand splint. Resident ot know why the staff started	F 313	referenced to F280) and monitor splints are applied as ordered as refusals once weekly for four withen monthly for three month or resolved by Quality Assurance Committee. The weekly Quality (QoL) Meeting is attended by the of Nursing (DON), Minimum Date (MDS) Coordinator, Support Note Rehabilitation Director or Therest designee, Health Information Note (HIM), Certified Dietary Manag Nursing Home Administrator. Date of Compliance: 2/10/16	and monitor veeks and r until (QA) v of Life he Director ata Set urse, apy	
	facility on 4/25/16 w including hypertensi. The quarterly Minim assessment dated 1 Resident #83 had m problems and had ir (ROM) on one side. indicated that Resident that	s originally admitted to the ith multiple diagnoses on and cerebral infarction. um Data Set (MDS) 1/1/16 indicated that emory and decision making apairment in range of motion. The assessment also ent #83 was not receiving program for range of motion waluated and treated by the bist (OT) for the left hand 9/16 through 8/4/16. The OT in dated 8/17/16 was for				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			01/20/2017	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	·	STREET ADDRESS, CITY, STATE, ZIF 310 COMMERCE DRIVE SANFORD, NC 27330	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 318	ROM exercises. On again evaluated by the recommended to commursing program for a motion (PROM) exer rescreened the reside and indicated that "would not benefit from the care plan probrestorative nursing for splinting/brace application will wear splint/brace hours per day in orded decline in ROM to make the care plan probrestorative nursing for splinting/brace application of the care plan probrestorative nursing for splinting/brace application will wear splint/brace hours per day in orded decline in ROM to make the community of the care plan probrestorative nursing for splinting/brace application of the care plan probrestorative nursing for splinting/brace application of the care plan probrestorative may be application of the care plan probress of the care plan p	with the splint schedule and 10/14/16, Resident #83 was the OT and OT had bettinue with restorative splints and passive range of cises. The OT had then on 12/9/16 and 1/11/17 patient is at baseline and the skilled OT at this time. " I plan initiated on 8/4/16 and 1/11/17 was reviewed. One alterns was "I am on the or left upper extremity for 2 for to minimize risk for further by left extremity x (times) 90 hes included "assist me acce according to schedule, the erneath splint/brace for concentration of the contracted and there was not be wed. M. NA (nursing assistant) #6 with the stated that she was the stated that the stated that the start applying the stated that form her to start applying the	F3	318			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345532	B. WING		01/20/2017
	ROVIDER OR SUPPLIER	HAB CTR OF LEE COUNTY	3	STREET ADDRESS, CITY, STATE, ZIP CODE B10 COMMERCE DRIVE SANFORD, NC 27330	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 318	responsible for applying that splint application activity of daily living Resident #83's ADL fl. The September 2016 splint was not applied 9/6, 9/7, 9/9, 9/14 and sheet for October 20'd was applied. The No indicated that the splint 11/2, 11/3, 11/4, 11/5, 11/25, 11/26 and 11/3 sheet indicated that the 1/4, 1/5, 1/6 and 1/17 On 1/19/17 at 2:35 Pl. She stated that she h. Resident #83. She sinot wearing his splint splint was stopped duand she was not infor resume applying the 1/19/17 at 2:40 PM, in conducted. She stated that the splint was dis She indicated that NA the splint every day. During a continued in AM, the DON stated to be applied consisted indicated that the facility who will monitor the sevaluate the progress	ng the splints. She stated was documented on the (ADL) flow sheets. ow sheets were reviewed. flow sheet indicated that the on 9/1, 9/2, 9/3, 9/4, 9/5, d 9/15/16. There was no flow 6 to indicate that the splint wember 2016 flow sheet int was not applied on 11/1, 11/6, 11/7, 11/8, 11/12, 016. The January 2017 flow the splint was not applied on 1/17. M, NA #3 was interviewed. and been assigned to sated that Resident #83 was as for a long time now. His the to the sore on his wrist med by the nurses to splint. Interview with Nurse #3 was and that she was not aware continued for Resident #83. Its were supposed to apply the service of the splint application and who will to of the residents on splints.	F 318		2/10/17
F 334 SS=D	PNEUMOCOCCAL IN	MMUNIZATIONS	F 334		2/10/17
		umococcal immunizations ility must develop policies			

ION NI IMBED:	,		(X3) DATE SURVEY COMPLETED	
345532 B.	. WING		01/20/2017	
EE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27330		
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esentative enefits and ation; enza erch 31 emedically edready been enefits and cludes enefits a expresentative enebenefits a expresentative enebenefits a emedications or elity must ensure that-levesident's egarding the	F 33	4		
	TION NUMBER:	A. BUILDING B. WING EE COUNTY CIENCIES EDED BY FULL INFORMATION) F 33 A. BUILDING B. WING PREFIX TAG F 33 F 33 A. BUILDING B. WING PREFIX TAG F 33 A. BUILDING B. WING PREFIX TAG F 34 A. BUILDING B. WING PREFIX TAG F 34 A. BUILDING B. WING PREFIX TAG F 34 A. BUILDING B. WING PREFIX TAG F 33 A. BUILDING B. WING PREFIX TAG F 34 A. BUILDING B. WING PREFIX TAG F 34 A. BUILDING B. WING PREFIX TAG F 34 F 35 F 36 A. BUILDING B. WING PREFIX TAG F 36 F 37 F 38 F 38	A BUILDING 345532 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27330 CIENCIES DED BY FULL NFORMATION) F 334 DEFICIENCY D	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
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	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27330		0 COMMERCE DRIVE		
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F 334	Continued From page	e 34	F3	334			
	immunization, unless	ated or the resident has					
		e resident's representative o refuse immunization; and					
	· '	edical record includes adicates, at a minimum, the					
	was provided educat	or resident's representative on regarding the benefits ects of pneumococcal					
	the pneumococcal im contraindication or re	nization or did not receive munization due to medical					
	Based on observation review, the facility fail influenza vaccine and pneumonia vaccine for #26 and Resident #44. A review of the facility Annual Resident Vaccine and the influenza vaccine with an 5 years lapse singiven.	or 2 of 5 residents (Resident 3. Findings included: 7 policy entitled: " New and cination " updated 9/2014 ocine would be offered ned or contraindicated. The yould be offered if greater nee the vaccine was last			The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or witake the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicate	II f d.	
		admitted to the facility diagnoses that included			F334 SS=D 483.80(d)(1)(2) INFLUEN AND PNEUMOCOCCAL IMMUNIZATI		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/20/2011
		3	310 COMMERCE DRIVE	
COMMONS NSG AND	REHAB CTR OF LEE COUNTY			
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Continued From pa	ge 35	F 334		
disease, hyperlipide behavioral disturbal Data Set (MDS) dat Resident #26 had s and required extens of her activities of d There was a signed Influenza and pneuronic medical representation of the electronic medical representation of the stated she administ today but was not as	emia and dementia without nce. The quarterly Minimum ted 10/24/16 indicated evere cognitive impairment sive assistance with her most aily living (ADLs). I consent for both the monia vaccine dated 9/30/16. Wed the Influenza vaccine on pneumonia vaccine. The ecord indicated the was administered 1/19/17. I 19/17 at 4:00 PM, Nurse #1 ered the pneumonia vaccine ble to offer an explanation as		Corrective Action: On 9/30/16 consent was received Influenza and the Pneumococcal of for resident # 26. The resident received the Influenza Vaccine on 10/7/201 administered by LPN Staff Nurse. Consent was confirmed again on 1/19/2017 for the Pneumonia Vaccine on 1/19/2017. On 11/18/2016, consent was received vaccine on 1/19/2017. On 11/18/2016, consent was received the Influenza Vaccine and the Pneumovaccine for Resident # 43. The received the Influenza Vaccine on 1/19/2019.	Vaccine ceived 16 cine. ed the ived the ococcal esident d the
given. In an interview on 1 Director of Nursing facility infection con expectation that all vaccines be admini- unless contraindica 2. Resident #43 wa multiple diagnoses renal insufficiency a MDS dated 11/22/1 moderate cognitive extensive assistance There was a signed influenza and the pi	/20/17 at 12:00 PM, the (DON) stated she was the trol nurse and it was her ordered and consented stered at the time of consent ted. s admitted 11/22/16 with of coronary artery disease, and diabetes. The admission 6 indicated Resident #43 had impairment and required the with most of his ADLs.		Identification of other residents who be involved with this practice: All residents have the potential to affected by the alleged practice. Health Information Manager Compan Audit on 1/27/17 to ensure that or declination was received and the residents who consented received immunizations. We found that the 10 additional long term care reside who consented to receive the Pneumococcal vaccine and had no received the vaccine. We found the were a total of 1 additional resider consented to receive the Influenzations.	be The pleted t consent nose I their ere were ents ot hat there nt(s) who
	COMMONS NSG AND I SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From pa history of falling, bra disease, hyperlipide behavioral disturban Data Set (MDS) dat Resident #26 had s and required extens of her activities of d There was a signed Influenza and pneu Resident #26 receiv 10/7/16 but not the electronic medical r pneumonia vaccine In an interview on 1 stated she administ today but was not a to why Resident #2 pneumonia vaccine given. In an interview on 1 Director of Nursing facility infection con expectation that all vaccines be adminis unless contraindica 2. Resident #43 wa multiple diagnoses renal insufficiency a MDS dated 11/22/1 moderate cognitive extensive assistance There was a signed influenza and the pi	ROVIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 35 history of falling, bradycardia, chronic kidney disease, hyperlipidemia and dementia without behavioral disturbance. The quarterly Minimum Data Set (MDS) dated 10/24/16 indicated Resident #26 had severe cognitive impairment and required extensive assistance with her most of her activities of daily living (ADLs). There was a signed consent for both the Influenza and pneumonia vaccine dated 9/30/16. Resident #26 received the Influenza vaccine on 10/7/16 but not the pneumonia vaccine. The electronic medical record indicated the pneumonia vaccine was administered 1/19/17. In an interview on 1/19/17 at 4:00 PM, Nurse #1 stated she administered the pneumonia vaccine today but was not able to offer an explanation as to why Resident #26 did not receive the pneumonia vaccine at the time consent was	ROVIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 35 history of falling, bradycardia, chronic kidney disease, hyperlipidemia and dementia without behavioral disturbance. The quarterly Minimum Data Set (MDS) dated 10/24/16 indicated Resident #26 had severe cognitive impairment and required extensive assistance with her most of her activities of daily living (ADLs). There was a signed consent for both the Influenza and pneumonia vaccine dated 9/30/16. Resident #26 received the Influenza vaccine on 10/7/16 but not the pneumonia vaccine. The electronic medical record indicated the pneumonia vaccine was administered 1/19/17. In an interview on 1/19/17 at 4:00 PM, Nurse #1 stated she administered the pneumonia vaccine today but was not able to offer an explanation as to why Resident #26 did not receive the pneumonia vaccine at the time consent was given. In an interview on 1/20/17 at 12:00 PM, the Director of Nursing (DON) stated she was the facility infection control nurse and it was her expectation that all ordered and consented vaccines be administered at the time of consent unless contraindicated. 2. Resident #43 was admitted 11/22/16 with multiple diagnoses of coronary artery disease, renal insufficiency and diabetes. The admission MDS dated 11/22/16 indicated Resident #43 had moderate cognitive impairment and required extensive assistance with most of his ADLs. There was a signed consent for both the influenza and the pneumonia vaccine dated	ROVIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH OBFICIENCY MUST BE PRECEDED BY FULL REDULATORY OR LSC IDENTIFYMO INFORMATION) Continued From page 35 Initroly of falling, bradvaardia, chronic kidney disease, hyperlipidemia and dementia without behavioral disturbance. The quarterly Minimum Data Set (MDS) dated 10/24/16 indicated Resident #26 bad severe cognitive impairment and required extensive assistance with her most of hir an interview on 1/19/17 at 4:00 PM, Nurse #1 stated she administered and pneumonia vaccine today but was not able to offer an explanation as to why Resident #26 did not receive the pneumonia vaccine at the time consent was given. In an interview on 1/20/17 at 12:00 PM, the Director of Nursing (DON) stated she was the facility infection control nurse and it was her expectation that all ordered and consented vaccines be administered at the time of consent unless contraindicated. 2. Resident #43 was admitted 11/12/16 with multiple diagnoses of coronary artery disease, renal insufficiency and diabetes. The admission MDS dated 11/12/16 indianated for both the influenze and the pneumonia vaccine and the consent unless contraindicated. 2. Resident #43 was admitted 11/12/16 with multiple diagnoses of coronary artery disease, renal insufficiency and diabetes. The admission MDS dated 11/12/16 impairment and required extensive assistance with most of his ADLs.

Facility ID: 980156

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345532	B. WING			01	/20/2017	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		31	STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 334	pneumonia vaccine vaccine vaccine vaccident #43 on 1/19 In an interview on 1/19 stated she administed the pneumonia vaccio offer an explanation and receive the influe at the time consent value of time consent value of the time consent value of time consent	n the influenza and the were administered to 9/17. 19/17 at 4:00 PM, Nurse #1 red both the influenza and ne today but was not able to as to why Resident #43 did enza and pneumonia vaccine was given. 20/17 at 12:00 PM, the DON) stated she was the rol nurse and it was her redered and consented tered at the time of consent	F	3334	one new admission since who has consented to both the influenza and the pneumococcal vaccine and received it 2/6/17. The support nurse has administered all immunizations 2/8/17 those consenting residents). Systemic Changes: Influenza and Pneumococcal Vaccines are addressed in the admissions process within the first 72 hours upon arrival. Of 1/23/17 the Administrator in-serviced new Admissions and Marketing Coordinator, Support Nurse and the Health Information Manager regarding admissions process regarding vaccines. The admissions and marketing coordinator, upon endorsement by the resident, responsible party or the Pow Attorney will provide the consent or declination to the support nurse to obtain order from the physician and administer the vaccines as appropriate	t on (for seess On d the ses. er of		
					Monitoring: To ensure compliance, Health Informa Manager (HIM) will monitor this issue weekly through an admission/resident audit. This will be monitored on a minimum of two admissions (if there a 0-1 admissions, then the Health Information Manager (HIM) will conduct an audit on a combination of new admissions and current residents) weefor four weeks and then monthly for the	re ct ekly		

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345532	B. WING _	B. WING		20/2017
	ROVIDER OR SUPPLIER COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27330	•	
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F 334	Continued From page		F 3	months for new admissions/current residents and reported in the weekly Quality of Life (QoL) meeting and the Quarterly Quality Assurance Meeting. The weekly Quality Assurance (QA) Meeting is attended by the Director of Nursing (DON), Minimum Data Set (M Coordinator, Support Nurse, Rehabilitation Director (RD) or Therap designee, Health Information Manager (HIM), Certified Dietary Manager and the Nursing Home Administrator.	у	2/9/17
SS=E	(i)(1) - Procure food for considered satisfactor authorities. (i) This may include for from local producers, and local laws or regulation of the food in the food	rom sources approved or ary by federal, state or local cood items obtained directly subject to applicable State culations. es not prohibit or prevent roduce grown in facility compliance with applicable				

T' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE : COMPL		
		345532	B. WING_		01/2	01/20/2017	
NAME OF P	ROVIDER OR SUPPLIER	•	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 371	Continued From pag	e 38	F3	371			
	(i)(3) Have a policy refoods brought to resivisitors to ensure saft handling, and consult This REQUIREMENT by: Based on observation interviews the facility food items in the nourefrigerator. The fact expired food. The factlean ten of nineteer two of two handles of door handles. The factive equipment in manner. One of two handles were broker were in disrepair on twenty-eight wheels	egarding use and storage of dents by family and other is and sanitary storage, imption. To is not met as evidenced on, policy review and staff failed to seal, label and date wishment room freezer of the dility failed to dispose of cility failed to thoroughly a knobs on appliances and in the walk in cooler/freezer acility failed to maintain food a clean and unbroken walk in cooler/freezer door a and four of four wheels the steamer. Twenty of on food service equipment		The statements made on this Correction are not an admission not constitute an agreement walleged deficiencies. To remai compliance with all Federal ar Regulations the facility has taltake the actions set forth in this Correction. The Plan of Correctionstitutes the facility alleg compliance such that all alleged deficiencies cited have been corrected by the date or dates	on to and do vith the n in nd State ken or will s Plan of ection ation of ed or will be		
	1/17/2017 at 10:26 A	as conducted of the kitchen M and 1/19/2017 at 11:52 52 AM, and on 1/20/2017 at		F371 SS=E Corrective Action for Resident A. Dietary staff immediately cl following during the dates of 1/17/17-1/20/17:			
	a. The knobs on two of two of the flat top griddle and the oven and six of six knobs on the stove had a buildup of grease, dirt and debris. b. Four of four wheels on the steamer were broken and had buildup of grease, dirt and debris. c. Two of two knobs on the convection oven had buildup of grease, dirt, and debris. d. Four of four wheels on the drink cart had debris on them. e. The door handle on the walk in freezer was broken and the handle had a buildup of grease, dirt and debris. f. The base of the door to the walk in freezer			 Knobs on two of the two flat griddle(s) Convection Oven cleaned im All six stove knobs stove were of grease dirt, and debris Four of the Four wheels on the have been cleaned up of great debris The wheels on the steamer verpaired on 2/9/17. Two of the two knobs on the oven had been cleaned immediately 	nmediately re cleaned he steamer se, dirt, and were convention		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	B. WING _		01/20/2017
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F 371 Continued From p	age 39	F 3	71	
facing the kitchen debris. g. The door har buildup of grease. h. The frame of and dirt on it. i. There was fo behind the stove, An interview that 10:13 AM with the following: a. Her expectati and handles be of grease, dirt, and ob. The Dietary More broken equipment food service equipment food service equipment needer cleaning. B. An observation 1/20/2017 at 10:5 a. There were 1 covers on a red trefrigerator. There indicated the contwasn't a date or that the cups were b. There were the freezer of the refrigered with an experience with at 11:06 AM reveals.	had buildup of grease, dirt, and dle on the walk in cooler had dirt, and debris. the plate cover cart had grease od and other debris on the floor steamer and convection oven. was conducted on 1/20/2017 at Dietary Manager revealed the on was that appliance knobs ean and free from buildup of lebris. Manager was aware of the and her expectation was that oment that was broken needed replaced. On was that food service do to be kept clean during routine on the nourishment kitchen on 2 AM revealed the following: 7 white foam cups with plastic any in the freezer of the awasn't a label on the cup that ents within each cup. Also there a time on the cups or the tray	F3	grease, dirt, and debris Four of the Four wheels on were immediately cleaned Door handle on the walk in had build-up of grease, dirt, a was cleaned immediately A new handle was ordered broken handle on the walk-in 1/20/17 The base of the door to the freezer facing the kitchen tha dirt, and debris was immedia The door handle to the walk that had grease, dirt, and del immediately cleaned The Frame to the plate cowhad grease and dirt on it was cleaned The food and other debris, behind the stove, steamer, a convection oven were immediately cleaned A deep cleaning of the entir was also conducted on 1/30/Certified Dietary Manager and B. Food not properly stored, dated appropriately to include supplements and milk were i disposed of on 1/20/17. Corrective Action for Resider Affected: A. All areas of the kitchen we by the Certified Dietary Manager for	freezer which and debris to replace the freezer on walk-in thad grease, tely cleaned cin cooler oris was er cart that simmediately on the floor and diately e kitchen 2017 by the d Cook. labeled, and e mmediately ont Potentially ere assessed ager. The

Facility ID: 980156

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345532	B. WING _		01/20/2017
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F 371	refrigerator and no	shment shakes into the out the freezer. She stated that who would have placed the	F3	behind/around the Stove/l Fryer, and Steamer and w cleaned by the Certified D	ere immediately ietary Manager,
nourishment shakes in the freezer. The Dietary Manager removed the frozen nourishment shakes and the expired milk and stated that she would dispose of them. The Dietary Manager			the Cook(s), and the Dieta 1/20/2017. B. The kitchen and nouris	hment rooms	
	stated that the dietary staff do not place any products in the freezer and would not have checked the freezer. The Dietary Manager clarified that it was not the dietary department's responsibility to check the freezer for expired product or product that was properly dated and labeled. The Dietary Manager stated that her expectation that food product must be dated and			were assessed on 1/20/17 Dietary Manager and Coo have no more expired and food.	k and found to
				Systemic Changes: A. The Dietary Services D	irector
	disposed of.	xposed product must be		instructed Dietary Staff to equipment and production	clean areas identified
	1/20/2017 at 11:16	he Housekeeping Manager on S AM revealed that the partment was responsible for		during survey. Weekly cle were modified to include of equipment knobs and har	art wheels,
	for the temperature	erator in the nourishment room e, expired product, and gdated or labeled. The		in-serviced by the Certifie Manager regarding chang Cleaning Schedule on 2/7	es to the
	information that the	nager provided further e housekeeping department refrigerator but was not		Certified Dietary Manager in-service on Food Servic all Dietary staff on 2/7/17.	e Sanitation for A Dietary QA
	The housekeeping	er portion of the refrigerator. manager stated that the eartment would check the		Audit tool was put into pla compliance with this polic B. Dietary and Housekeep	y 2/6/17.
	An interview condi- with the Administra expectations were and labeled, that k kitchen be clean, f be clean, and if the	ucted on 1/2/2017 at 10:29 AM ator revealed that her that all food should be dated mobs and handles in the food service equipment needed be equipment was broken it ired or replaced and reported.		in-serviced on 2/7/17 by the Home Administrator regares Storage Practices □ Nour Kitchen. A QA tool for mostorage Practices by Diet Housekeeping Staff has be implemented beginning 2/	ne Nursing ding Food ishment Unit nitoring Food ary and een

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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F 371	Continued From p	page 41	F3	Quality Assurance/Monitorial A. The Dietary Services Dir Dietary Manager will monitor using the Dietary Quality Assurance of the completed 5 days per woone day must include a week months and then weekly for month or until resolved by (QOL)/Quality Assurance (QAny concerns will be address immediately and reported to Home Administrator (NHA) Reports will be given to the of Life (QOL)/Quality Assurance (QOL)/Quality Assurance (QOL)/Quality Assurance (QOL)/Quality Assurance (QOL)/Quality Assurance (DON), Dietary Services Dietary Manager, Minimum (MDS) Nurse, and Support Medical Director will review Quarterly Quality Assurance (DON), The Nursing Administrator (NHA), Direct (DON), Dietary Services Dietary Manager, Minimum (MDS) Nurse, and Support Medical Director will review Quarterly Quality Assurance (Don), This will begin or completed at a minimum of week (at least one day musweekend) for two months a for one additional month or	rector/Certified or this issue ssurance (QA) on 2/6/17 and reek (at least ekend) for two rone additional Quality of Life QA) committee. ssed or the Nursing for follow up. weekly Quality rance (QA) Action initiated by of Life QA) committee are Committee. reekly meeting Home for of Nursing rector/Certified a Data Set Nurse. The reducing the e (QA) Food Storage ousekeeping d beginning in 2/6/17 and be feed to the produce a land then weekly in the second control of the produce and then weekly in the second control of the produce and then weekly in the second control of the produce and then weekly in the second control of the produce and then weekly in the second control of the produce and then weekly in the second control of the produce and then weekly in the produce and the			

PRINTED: 03/03/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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		345532	B. WING _	B. WING		01/20/2017	
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F 412 SS=D	DENTAL SERVICES (b) Nursing Facilities The facility- (b)(1) Must provide or resource, in accordar part, the following derineeds of each resider (i) Routine dental servunder the State plan) (ii) Emergency dental	DUTINE/EMERGENCY IN NFS r obtain from an outside nce with §483.70(g) of this ntal services to meet the nt: vices (to the extent covered ; and	F	by Quality of Life (QOL Assurance (QA) comm will be addressed immoreported to the NHA for Reports will be given to of Life (QOL)/Quality Acommittee and Correct as appropriate. The Q (QOL)/Quality Assurant is the main Quality Assurant is the main Qu	sittee. Any conce ediately and r follow up. to the weekly Quassurance (QA) tive Action initiate uality of Life ce (QA) committed weekly meeting Home Director of Nursing Son	ality ed tee ee. ng g	2/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 412	Continued From pag	e 43	F 41	2	
	(i) In making appoin	tments; and			
	(ii) By arranging for t dental services locat	ransportation to and from the ions;			
	wish to participate to dental services as an under the State plan This REQUIREMEN' by: Based on record reviacility failed to provione of thirty-five resireviewed for mouth of Findings included: Resident #38 was an untiple diagnoses the bipolar disorder and Resident #38's last was an annual asses with an Assessment 2/11/2016. The resident resi	view and staff interviews the de routine dental services for dents (Resident #38) care. dmitted on 1/11/13 with nat included: diabetes, depression. comprehensive assessment sement that was completed Reference Date of dent was coded as having no infragment(s) (edentulous). Int's care area assessment documented: Resident #38 and did not wear dentures. The dent was coded as having or on a mechanically altered recent MDS assessment the assessment date was #38 was coded as having no ing full or partial dentures aving no mouth or facial pain, by with chewing. Resident		The statements made on this Plan of Correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or we take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicate. F 412 Routine/ Emergency Dental Services In NFS Corrective Action: On January 25, 2017, Resident #38 refused to see the dentist. Resident we offered again by the Facility Social We on 1/26/17 and 2/2/17 with much position encouragement; and the resident continued to refuse see dentist on bot occasions. Resident # 38 denies any dental pain, chewing problems and	vill of eed. vas orker tive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345532	B. WING			01/	20/2017	
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F 412	assessment dated 1 Resident # 38 had a had potential for ora having no natural te goal was listed as: T infection, pain or ble by/through review da listed were: Consult chewing/swallowing Coordinate arranger transportation as ne Monitor/document/re for signs and sympto needing attention: P palate), Abscess, De or bleeding, Teeth m eroded, decayed, To inflamed, white, smo Lesions. Provide m daily living (ADL's) An interview that wa #38 on 1/17/2017 at resident could not re seen the dentist sino nursing home in 201 that she had her tee was going to get der clarified that she had receive dentures. An interview conduct worker on 1/19/17 a Resident #38 had no any dental services worker also stated th procedure was that routinely by the dent oral/dental issue.	wed after the quarterly MDS 1/13/2017 revealed that I focus area of: The resident I health problems related to eth and no dentures. The The resident would be free of reding in the oral cavity ate. The Interventions/Tasks with dietitian and change if problems are noted. ments for dental care, eded/as ordered. eport to the doctor as needed oms of oral/dental problems ain (gums, toothache, ebris in mouth, Lips cracked hissing, loose, broken, ongue (black, coated, both), sores in mouth, outh care as per activities of	F	412	continues to not display any weight los concerns. Facility Social Worker will continue to offer dental services and provide upon resident services and provide upon resident services. Identification of other residents who make involved with this practice: All residents have the potential to be affected by the alleged practice. On January 23, 2017-Jan 27, 2017 all curr residents were assessed and offered to see a dentist by the Facility Social Worker, Health Information Manager (HIM), Rehabilitation Director (RD), Certified Dietary Manager, Director of Nursing, Minimum Data Set (MDS) Nurand the Business Office Manager (BOI Facility Social Worker made arrangements with Senior Dental Care in-house services for residents. Senior Dental Care provided services to 13/60 residents on January 31, 2017 and plat return on 6 February 2017. Arrangements were been scheduled for quarterly rout visits/exams, and dental hygiene every other month by Senior Dental Care for residents for dental services. New admissions will be assessed for any dental needs and will be placed for Ser Dental Care services for next schedule visits, unless emergency dental arises. emergency dental needs will be addressed immediately and residents of an individual basis.	ent o rse, M). for on to ents ine d All		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ING _	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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F 412 Continued From page 45 at 9:00 AM revealed that her expectation all residents, including Resident #38, ede or with teeth, be provided routine dental.	was that entulous	412	Systemic Changes: On Jan 23, 2017 the Administrator in serviced the Social Worker and Director of Nursing on the following: 1. Arranging dental services for identification residents that needed to see the dentise 2. Coordinating routine dental services for residents 3. Establishing dental services for new residents 4. Assisting with emergency dental services as needed 5. Educating nursing staff to communicate to lead nurse/DON/NHA/SW if resident is identified with any dental needs and/or voices dental needs 6. Establishing a process within facility with BSW of coordinating dental service for residents in facility 7. Importance of notifying Administration/Director of Nursing (DOI of any resident with dental needs/refusion The facility Nursing Home Administrator (NHA) and Social Worker has establish routine services with Senior Dental Carfor Quarterly dental services (exams) and dental hygiene every other month (cleanings) for residents. All emergency dental needs will be addressed immediately and residents will be sent an outside dental provider on an individuals. Monitoring:	ed t : es N) als r ed en nd			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 412	Continued From page	<u>+</u> 46	F 4	12			
				To ensure compliance, Nursing Hor Administrator (NHA) or Social Work monitor this issue using the Quality Assurance (QA) survey tool for Der Services. Facility will monitor comp of monitoring dental needs. This wi done on weekly basis for 4 weeks, monthly for 3 months by the Social Worker. Reports will be presented weekly Quality Assurance (QA) Committee by the Nursing Home Administrator or designee to assure corrective action initiated as appropant Any immediate concerns will be brothe Nursing Home Administrator for appropriate action. Compliance will monitored and ongoing auditing proreviewed at the Weekly Quality Ass (QA) Committee meeting is attended the Nursing Home Administrator (No Director of Nursing (DON), Minimus Set (MDS) Coordinator, Support No Rehabilitation Director (RD), Health Information Manager (HIM), Certifice Dietary Manager, and/or Activity Director Manager, and/or Activity Director Manager, and/or Activity Director (Manager)	ser will Intal Iliance Il be Ithen to the Priate. Pr		
F 431 SS=D	483.45(b)(2)(3)(g)(h) LABEL/STORE DRU		F 43	Date of Compliance: 2/10/17		2/10/17	
	drugs and biologicals them under an agree §483.70(g) of this par	t. The facility may permit to administer drugs if State					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 431	that assure the accurdispensing, and admitiologicals) to meet (b) Service Consultate employ or obtain the pharmacist who (2) Establishes a systisposition of all condetail to enable an account of all maintained and periodical and biological abeled in accordance professional principle appropriate accessor instructions, and the applicable. (h) Storage of Drugs (1) In accordance with the facility must storlocked compartment.	acility must provide ices (including procedures irate acquiring, receiving, ninistering of all drugs and the needs of each resident. Ation. The facility must eservices of a licensed it is serviced at incurate reconciliation; and drug records are in order and ill controlled drugs is podically reconciled. As and Biologicals. Its used in the facility must be be with currently accepted es, and include the bry and cautionary expiration date when its and Biologicals. Ith State and Federal laws, established all drugs and biologicals in its under proper temperature only authorized personnel to	F 4	31		
	permanently affixed	provide separately locked, compartments for storage of ed in Schedule II of the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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				310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		SANFORD, NC 27330			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 431	Continued From pag	e 48	F 43	31			
	Control Act of 1976 a abuse, except when package drug distrib quantity stored is min be readily detected. This REQUIREMEN' by: Based on observation record review, the fareplace an expired in injection used to treat The facility also faile open vial of injectabl for 2 of 3 medication medication storage. 1. In an observation cart on 1/19/17 at 4:4 dose of glucagon 1 models abuse of glucagon 2 mod			The statements made on this Plan Correction are not an admission to not constitute an agreement with the alleged deficiencies. To remain in compliance with all Fe and State Regulations the facility has taken or will take the actions set for this Plan of Correction. The Plan of Correction constitutes the facility sallegation of compliance such that a alleged deficiencies cited have been will be corrected by the date or date indicated. F 431 Drug Records, Label/Store D	and do ele ederal as tth in f s all en or		
	On 1/20/17 at 9:45 A (DON) stated the phomedication carts ran were responsible to at least weekly. It was expired glucagon injureplaced at the end of 2. The facility's policy	y on medication storage		On 1/19/17 the expired glucagon or 100 hall medication cart was remove from the medication cart and discart Also, on 1/19/17 the opened unlabed vial of lidocaine on the 300 hall medication.	oted: n the ved rded. eled dication		
	that all injections mu sticker attached and the sticker. The poli	wed. The policy indicated st have a date opened the date must be written on cy also indicated that all for 30 days in refrigerator if .		cart was removed from the medicat cart and discarded immediately. Bo nurses were provided just in time education on the facility policy of ch for expiration dates and on labeling when opened by the Registered Nu	oth necking ı vials		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345532	B. WING	B. WING		01/20/2017	
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE			
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE			
			SANFORD, NC 27330				
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F 431	F 431 Continued From page 49		F 43	31			
	cart was observed. T	M, the 300 hall medication There was an opened/used idocaine 1% (200		(RN) Director of Nursing (DoN)).		
	multiple dose vial of Lidocaine 1% (200 milligrams per 20 milliliter) vial with no date of opening. On 1/19/17 at 4:45 PM, Nurse #3 was interviewed. She stated that the Lidocaine vial should have been dated when opened and stored in the refrigerator. She added that the opened vial of Lidocaine was good for 30 days after opening. Nurse #1 was observed to discard the opened vial of Lidocaine. On 1/20/17 at 9:00 AM, the Director of Nursing (DON) was interviewed. The DON stated that the nurse who opened the Lidocaine vial should have dated it and stored it in the refrigerator after opening. She added that Lidocaine injections were good for 30 days after opening. She also indicated that she expected the nurses to follow the facility's policy on medication storage.			Corrective Action for Resident Affected:	Potentially		
				All residents have the potential affected by this practice. On 1/medication carts, medications medication storage rooms were for any further expired medicat opened vials that were not date they were opened. This audit were opened by the Registered Norector of Nursing (DON) on 11/27/17, and 2/3/147 and did no further expired medications and of concerns were identified. Systemic Changes: On January 28, 2017 the Direct Nursing in serviced the full times.	rooms and e assessed cions and ed when vas lurse (RN) 1/19/17, not yield d no areas ctor of e, part time		
				and prn Nursing staff (Licensed Nurses (LPN) and Registered I (RN) on the process of discard medications and dating vials ware opened. This information hintegrated into the standard ori training and in the required inserfresher courses for all emplowill be reviewed by the Quality Process to verify that the chanbeen sustained. Quality Assurance:	Nurses ling expired when they las been lentation service yees and Assurance		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	DING		(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			01/	20/2017
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		31	TREET ADDRESS, CITY, STATE, ZIP CODE 10 COMMERCE DRIVE ANFORD, NC 27330		
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F 431	Continued From page	÷ 50	F4	431	The Director of Nursing will monitor this issue using the Quality Assurance (QA Survey Tool for monitoring Storage of Drugs & Biologicals observing for any expired medications and any opened with that are not dated. Any issues will be reported to the Nursing Home Administrator (NHA). This will be done weekly for one month and then monthly for 3 months. Reports will be presented to the weekly Quality Assurance (QA)committee by the Nursing Home Administrator (NHA) or the Director of Nursing (DON) to ensure corrective acconstituted as appropriate. Compliance where the monitored and ongoing auditing program reviewed at the weekly Quality Assurance (QA) Meeting. The weekly Quality Assurance (QA) Meeting is attended by the Director of Nursing (DON), Minimum Data Set (MDS) Coordinator, Support Nurse, Rehabilitation Director or Therapy Designee, Health Information Manager (HIM), Certified Dietary Manager and the Nursing Home Administrator (NHA).	rials rials rials rials	
F 520 SS=D	COMMITTEE-MEMB QUARTERLY/PLANS	ERS/MEET	F	520	Compliance date: 2/10/17		2/10/17
	(g) Quality assessme(1) A facility must mai and assurance comm minimum of:	ntain a quality assessment					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		01/20/2017
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F 520	Continued From pa	ge 51	F 520		
	(i) The director of nu	irsing services;			
	(ii) The Medical Dire	ector or his/her designee;			
	staff, at least one of	r, a board member or other			
	(g)(2) The quality as committee must :	sessment and assurance			
	coordinate and eval identifying issues wi	rterly and as needed to uate activities such as th respect to which quality surance activities are			
		lement appropriate plans of ntified quality deficiencies;			
	Secretary may not r records of such com such disclosure is re	ormation. A State or the equire disclosure of the amittee except in so far as elated to the compliance of a the requirements of this			
	committee to identify deficiencies will not sanctions. This REQUIREMEN	faith attempts by the y and correct quality be used as a basis for			
	interviews, the facility Assurance (QAA) C	view, observations, and staff ty's Quality Assessment and ommittee failed to maintain dures and monitor these		The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in	do

NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY (A) (1) (A)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		TE SURVEY MPLETED
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TEIDSALOI WEADOLA DODI DADO SOUDI TOTAL EN ANTICO EN TRANSPORTADO EN TRANSPORT					shower on Tuesdays and Frida		
An interview was conducted with the the times of 3 PM \Box to 11 PM. The care		•	•		-	•	
Administrator on 1/20/2017 at 10:29 AM. The plan was revised by the Minimum Data							

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345532	B. WING _			01/:	20/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	•	
LIBERTY (COMMONS NSG AND RE	HAB CTR OF LEE COUNTY			0 COMMERCE DRIVE		
				S	ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page Administrator stated the Assessment and Assist Committee. The QAA Director of Nursing, a members of the facility Administrator. The Quarterly and that the issues that required quassurance activities, that failing to provide right to participate in plan were repeat defirecertification survey. QAA committee had and showers had been Administrator further schedules and provide specifically discussed The administrator states.	chat the facility had Quality purance (QAA) Review A committee consisted of the physician, at least 3 other by staff and the part of the physician and the part of the physician and the part of the provided puality assessment and the Administrator stated showers/whirlpool baths and planning care-revise care ciencies from the previous. She stated that the facility conducted resident reviews an part of the review. The clarified that shower ing showers were not a in the QAA committee. It in the QAA committee.	F 5	520		te of of ved for er, y ed ed eg	
					Kardex-s to reflect changes in resident preferences conducted between 1/23/2017-1/27/2017 by the Minimum Data Set (MDS) Nurse and DON as of 2/9/2017.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SU COMPLE			
		345532	B. WING _	B. WING		01/20/2017
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, Z 310 COMMERCE DRIVE SANFORD, NC 27330	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 520	Continued From page	ge 54	F5	On 1/19/17 and 2/7/17, provided to the staff (Lic Unlicensed)by the DON (Certified Nursing Assis Licensed Practical Nurse Registered Nurses (RN and part time and PRN communicate with the M (MDS) Coordinator and Nursing (DON) and othe staff about any resident have portrayed any beh resistance to care in-ter Daily Living (ADL), refusincluding showers or sp This education was prove Minimum Data Set (MD Registered Nurse (RN) Twenty of the Sixty-one Karedex shave been used the changes in resident pre 2/9/2017. The care plant Minimum Data Set (MD 2/9/2017. (Cross reference Tag F Systemic Changes: Nursing Staff (full time, both licensed and unlice Nursing Assistants (CN Practical Nurses (LPN), Nurses (RN)) were in-set	censed and I on all shifts stants (CNA), ses (LPN), and i)including full time to ensure that they winimum Data Set I facility Director of er administrative is on those who naviors of refusals, rms of Activities of sal for care olints as identified. vided by the vision corrected by vided by vided by the vision corrected by vided by vided by the vision corrected by vided by vi	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			X3) DATE SURVEY COMPLETED	
		345532	B. WING _			01/20/2017	
NAME OF P	ROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE,	ZIP CODE		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE			
LIBERT	OGMINIONO NOO AND N	INAS OTR OF LEE GOORT		SANFORD, NC 27330			
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F 520	Continued From page	e 55	F 5	through 2/10/2017 by regarding Activities of Care (Showers) giving to the care plan, honor choices/preferences, defensel (s) of care and a changes/refusals of care (Showers) giving to the care plan, honor choices/preferences, defensel (s) of care and a changes/refusals of care and a changes/refusals of care and integrated into the orientation training and inservice refresher comployees and will be Quality Assurance (QA that the change has been and the change has been appropriate to resident(s) current mere and the change and upd plan as appropriate to resident(s) current mere and propriate to resident(s) and propriate to resident so that the change and propriate to resident so the construction of the propriate to the propr	Daily Living (ADL) showers according locumenting alerting the nurse of the provided with the care reflect the dical status. All full time, part o include both and Registered to ate with the part of the provided with the care reflect the dical status. All full time, part o include both and Registered to ate with the part of the p	g of t et	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		01/20/2017
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	;	STREET ADDRESS, CITY, STATE, ZIP CODE 810 COMMERCE DRIVE SANFORD, NC 27330	,
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION
F 520	Continued From pag	e 56	F 520	of Daily Living (ADL) care and offerind different approaches/redirecting residual minimum Data Set (MDS) Coordinate ensure that Care Plans are appropriately updated with interventions on an as needed basis by the inter-disciplinary team (IDT). This information has been integrated into the routine in service (Registered Nurse (RN) Minimum Data (MDS) Coordinator / Minimum Data (MDS) support nurse and in the requin-service refresher courses for all employees and will be reviewed by the Quality Assurance (QA) Process to withat the change is maintained. A facility must maintain a quality assessment and assurance committee consisting of the director of nursing (services; a physician designated by facility; and at least 3 other members the facility's staff. The quality assess and assurance committee meets at liquarterly to identify issues with respectively and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary not require disclosure of the records such committee except insofar as surficiencies. A State or the compliance such committee with the requirement this section. Good faith attempts by the committee to identify and correct qualify deficiencies will not be used as a bas sanctions.	dents. or will ately y en s) for ta Set Set ired he erify ee DON) the s of ment east ect to ance os y may of ch ce of ts of he ality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			01/2	20/2017
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	•	STREET ADDRESS, CITY, STATE, 3 310 COMMERCE DRIVE SANFORD, NC 27330	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATION (CIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	e 57	F 5	(Cross reference Tag F	242 and F 280)		
				Monitoring: To ensure compliance, monitor this issue using Assurance (QA) Compl Nursing Home Adminis compliance of monitorin of 100 percent audits p minimum of two resider surveys and a minimum number of care plans. Weekly x 4 weeks. There on a monthly basis for Nursing Home Adminis be presented to the Qu (QA) Committee by the Administrator or Director to assure corrective act appropriate. Any immediate brought to the Direct Administrator for approcemble Compliance will be monongoing auditing progra Quarterly Quality of Life Quality Assurance (QA meeting is attended by Administrator (NHA), D (DoN), Minimum Data S Coordinator, Support N Rehabilitation Director Designee, Health Inforr (HIM), Certified Dietary Nursing Home Adminis	g the Quality liance survey too strator will monito ng the completion erformed, a nt satisfactions n of two sampled This will be done n this will be done n this will be done strator. Reports we refore Nursing (Do tion initiated as diate concerns we stor of Nursing or priate action. nitored and am reviewed at the e (QoL) Meeting. Committee Nursing Home or (MDS) lurse, or Therapy mation Manager Manager, and the strator (NHA).	or n I e will oN) vill	

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		345532	B. WING			01/20/2017	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520				520			