STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 09/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166 SS=E	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166		10/6/17

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

Electronically Signed | 10/07/2017

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conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 166	Continued From page 2 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interview and record review the facility failed to make prompt efforts to resolve grievances received from 1 of 1 residents (Resident # 5). Findings included: Review of the Quarterly Minimum Data Set dated 06/19/17 revealed Resident #5 was admitted to the facility on 11/19/15 with diagnoses of Paraplegia, Idiopathic Chronic Gout, and Essential Hypertension. Resident #5 was cognitively intact, had no wounds, and needed extensive assist for all activities of daily living except for eating which required supervision only. The plan of care for Resident #5 dated 09/19/17 was reviewed with no concerns. Review of the Grievance Log for the past three months revealed no grievances had been recorded for Resident #5. Record review of copies of emails provided by Resident #5 revealed that he had sent the facility administrator a total of thirty-one (31) grievances via email during the months of July, August and September of 2017.	F 166	F 166 A corrective action for Affected Resident has been accomplished by: For Resident # 5, the Administrator responded to resident on 10/6 by email (Attachment 166-A) to address past concerns that had not been addressed through the formal grievance process. Administrator, DON and Dietary Director also met with the resident on 10/6/17 to discuss any outstanding grievances the resident had. All concerns were resolved and it was established that they would meet with the resident on a weekly basis until resident felt that it was not necessary to meet that often and meeting less often would be sufficient. The resident was informed that he may still express any grievance at any time in writing, orally or by email. All current residents who have a grievance have the potential to be affected by the alleged deficient practice. On 10/2/2017, the Administrator reviewed all other grievances received from	

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F 166	Continued From page 3 In an interview conducted with Resident #5 on 09/14/17 at 4:00 PM he reported that he sends grievances to the administrator via email from his I Pad. He said the administrator had advised him to send his concerns to him in this manner. He stated that the administrator had responded to him telling him that he had delegated the concerns to his staff. Resident #5 said that no one came to resolve his concerns. In an interview with the facility administrator on 09/15/17 at 4:34 PM he revealed that the grievances he received via email from Resident #5 were so frequent that he had started handling them on an individual basis. He said that the Dietary Manager or Director of Nursing met with the resident weekly to discuss and resolve concerns. He reported that most of the grievances were personal preference with 90% concerned with dietary and 10% concerned with nursing. In an interview conducted with the Dietary Manager on 09/15/17 at 4:39 PM she reported that she had received forwarded grievance emails from the administrator originated by Resident #5. She stated that it had been about 4 months since anything had been brought to her attention. She said she could not remember the last time she discussed a grievance or met with Resident #5. She also said that she had never provided a written resolution for a grievance to the resident. In an interview with the Director of Nursing on 09/15/17 at 4:52 PM she revealed that she investigates complaints and based on the results the facility would put something in place to fix the problem. She said that she dealt with clinical problems. She reported that she received	F 166	09/01/2017 through 10/01/2017 to identify any grievance that were not completely addressed, followed up, and resolved. There were no other grievances for that period. Systemic changes made were: In-service education was completed by the Clinical Nurse Consultant to the Administrator, Business Office Manager, and Director of Nursing on the grievance resolution process. (Attachment 166-B) The in-service topics included: • Prompt resolution of all grievances • Facility procedure and time line for addressing grievances This information has been integrated into the standard orientation training and in the required in-service refresher courses for Administrator and Director of Nursing and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Business Office Manager (BOM) will monitor this issue using the Quality Assurance for monitoring grievance resolution (Attachment 166-C). The monitoring will include auditing 100% of all grievances for two weeks to ensure the grievance was promptly addressed according to facility policy. Then the BOM will monitor 5 grievances monthly for 3	

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F 166	Continued From page 4 complaints from Resident #5 once or twice a week. She stated that after she had received a few complaints she would let him know what the facility was able to do. She stated that she had met with Resident #5 about three weeks ago. She revealed that she had never provided the resident with a written resolution to a grievance. She acknowledged that an email titled "Grievance" was indeed a grievance and should be handled as such.	F 166	months for prompt resolution. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 242 SS=E	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 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 REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to allow residents the choice to dine in a dining room setting versus eating in their rooms due to insufficient staffing for 1 of 1 sampled residents interviewed for choices (Resident #6).	F 242	F 242 A corrective action for Affected Resident has been accomplished by: Resident # 6 was interviewed by the	10/6/17

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F 242	Continued From page 5 Findings included: Observations of the lunchtime meal on 09/14/17, 09/15/17, and 09/16/17 revealed no concerns. Residents were seated in the dining room on each occasion. Staff were helping residents who required assistance. Food was handled appropriately by staff and looked appealing. The dining room was homelike. A review of the Daily Staffing schedule dated 08/05/17 revealed that, on day shift, two nurse aides had called off with no replacement. Review of the facility's Grievance Log for the past three months revealed no grievances had been logged for Resident #6. Review of the Quarterly Minimum Data Set dated 08/31/17 revealed that Resident #6 had intact cognition and was independent with activities of daily living. In an interview with Resident #6 on 09/16/17 at 10:20 AM she revealed that she was the Resident Council President. She said that sometimes residents had to eat in their rooms on the weekends and that it upset her. She stated that she preferred to eat in the dining room. She said that she felt it was very important for all residents to be able to go to the dining room for meals because of the interaction with each other. She revealed that when she had complained she had been told that the dining room had been closed because staff had called out and there were not enough nurse aides. She could not remember who she voiced a complaint to when she had to eat in her room.	F 242	Social Worker for preference regarding eating in the dining room. Once the resident's preferences was determined the MDS Coordinator updated resident # 6 kardex and care plan in Point Click Care (PCC). All current residents who desire to go to the dining room for their meals have the potential to be affected by the alleged deficient practice. On 10/2/17, the Social Worker began discussing with all cognitively intact residents their preferences for eating meals in the dining room or their room on the hall way. For residents not cognitively intact, the responsible party was contacted by the Support Nurse and discussed meal preference for eating in the dining room or their room on the hall way. This was completed by 10/6/17. Once preferences were determined, the MDS Coordinator updated each resident's kardex and care plan in PCC with the preference. This was completed by 10/6/17. Systemic changes made were: In-service education (Attachment 242-A) began on 10/2/17 by the Director of Nursing for all RNs, LPNs, Med Tech's, Med Aides, and CNAs, FT, PT, and PRN. The in-service topics included: • Where to locate dining preferences in the kardex • Honoring resident preferences for	

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F 242	Continued From page 6 In an interview with the Nurse #1 (Unit Manager/Scheduler) on 09/15/17 at 10:50 AM she reported that in July and August of this year the facility lost a lot of staff and that they were trying to hire more aides at this time. She stated if there was a staff call out that it was a problem. In an interview with the Dietary Manager on 09/15/17 at 4:39 PM she revealed that about twice a month, meals had to be sent to the halls because there was not enough staff in the building to open the dining room. She said that when this happened the dining room was closed and everyone had to eat in their rooms. In a second interview conducted on 09/16/17 at 12:35 PM the Dietary Manager said that the last time her staff called her and told her all meals had to be delivered to the halls was one week ago. She revealed that the dining room was closed due to lack of staff. She said it must have been on the weekend because she was at home and had to be called. She stated that she did not work weekends. In an interview with nurse aide #2 on 9/16/17 at 11:15 AM she stated that she worked as a nurse aide on the weekends. She said that staff often worked short on the weekends but that she was able to complete her work because she stayed over to get everything done. She revealed that she had worked when the dining room was closed and there were only four nurse aides in the building. In an interview conducted on 09/16/17 at 12:35 PM with nurse aide #1 she revealed that she remembered August 5, 2017 well. She said that the nurse aides were working short staffed. She	F 242	dining. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training by 10/04/2017 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing or Administrator in their absence will monitor this issue using the Quality Assurance for monitoring meal preference (Attachment 242-B). The monitoring will include observing 10 residents eating meals 3 times a week across various shifts including weekends for preference being honored. The observations will be compared to the care plan to ensure preferences are being honored. The tool will be completed weekly for 4 weeks then monthly times 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA	

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F 242	Continued From page 7 said she had all of 100 hall by herself minus one room (rooms #102, #103, #104, #105, #106, #107, #108, #109, #110, #111, #112, #113, #114 and #115). She stated that she only had time to get the residents up in wheelchairs to be fed. Residents could not go to the dining room to eat because there was not enough staff to monitor the dining room. It was closed. She stated that all residents in the facility either ate or were fed in their rooms. She revealed that about three times a month the dining room was closed on the weekends because there was not enough staff to monitor the residents and the residents had to eat in their rooms. In an interview conducted with the Director of Nursing on 09/16/17 at 11:45 AM she revealed that she expected staff to take residents to the dining room if they did not wish to eat in their rooms unless an event was happening or the area was under construction. She stated that she did not work on the weekends. She also said that during the trial of an alternative scheduling method that she noticed that the aides did not have time in the mornings to get people up in time to go to the dining room for breakfast.	F 242	Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 353		10/6/17

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F 353	Continued From page 8 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the	F 353	F 353	

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F 353	Continued From page 9 facility failed to provide sufficient nursing staff which resulted in the inability to serve resident meals in the dining rooom. Findings included: A random sample review of Daily Staffing Schedules was conducted for the following dates: 07/07/17, 07/08/17, 07/09/17, 07/28/17, 08/04/17, 08/05/17, 08/06/17, 08/05/17, 08/25/17, 08/26/17, 08/27/17, 09/16/17, and 09/15/17. The review revealed that there had been several call outs with schedule adjustments on various dates. The Daily Staffing schedule dated 08/05/17 revealed that on day shift two nurse aides had called off with no replacement. In an interview with the Nurse Unit Manger/Scheduler on 09/15/17 at 10:50 AM she reported that in July and August of this year the facility lost a lot of staff and that they were trying to hire more aides at this time. She reported that scheduling of staffing was dependent on the facility census. Normal staffing for day shift was 6-8 aides, second shift was 5-7 aides, and third shift was 4 aides. She said that the plan to cover call outs was to cover the shift with facility staff first and if unable to reach out to agency staff. She stated that nurses had worked as aides to cover call outs in the past. She revealed that at this time if there was a call out that it was a problem. In an interview with the Dietary Manager on 09/15/17 at 4:39 PM she revealed that about twice a month meals had to be sent to the halls because there was not enough staff in the building to open the dining room. In a second interview conducted on 09/16/17 at 12:35 PM she	F 353	A corrective action for Affected Resident has been accomplished by: Resident # 6 was interviewed by the Social Worker for preference regarding eating in the dining room. Once the resident's preferences was determined the MDS Coordinator updated resident # 6 kardex and care plan in Point Click Care (PCC). The nursing staff schedule was reviewed by the Director of Nursing and the Administrator on 09/28/2017 to ensure adequate staff to meet resident dining preferences. Review showed adequate staffing scheduled. All current residents who desire to go to the dining room for their meals have the potential to be affected by the alleged deficient practice. On 10/2/17, the Social Worker began discussing with all cognitively intact residents their preferences for eating meals in the dining room or their room on the hall way. For residents not cognitively intact, the responsible party was contacted by the Support Nurse and discussed meal preference for eating in the dining room or their room on the hall. This was completed by 10/6/17. Once preferences were determined, the MDS Coordinator updated each resident's kardex and care plan in PCC with the preference. This was completed by 10/6/17. Also, a list by meal of all	

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said that the last time her staff called her and told her all meals had to be delivered to the halls because there was not enough staff to open the dining room was one week ago.

In an interview with Resident #6 on 09/16/17 at 10:20 AM she revealed that she was the Resident Council President. She said that sometimes residents had to eat in their rooms on the weekends and that it upset her. She stated that she preferred to eat in the dining room. She said that she felt it was very important for all residents to be able to go to the dining room for meals because of the interaction with each other. She revealed that she had been told that the dining room had been closed because staff had called out and there were not enough nurse aides in the building to monitor the dining room.

In an interview with nurse aide #2 on 9/16/17 at 11:15 AM she stated that she transported during the weekdays and then worked as a nurse aide on the weekends. She said that staff often worked short on the weekends but that she was able to complete her work because she stayed over to get everything done. She revealed that she had worked when there were only four nurse aides in the building on day shift.

In an interview conducted on 09/16/17 at 12:35 PM with nurse aide #1 she revealed that she remembered August 5th well. She said that the nurse aides were working short staffed. She said she had all of 100 hall by herself minus one room. She stated that she only had time to get the "feeders" up to wheelchairs to be fed but that no residents could go to the dining room to eat because there was not enough staff to monitor the dining room. She revealed that about three residents preferring to eat in the Dining Room was compiled and implemented for reference by both dietary and nursing staff.

Systemic changes made were:

In-service education (Attachment 242-A) began on 10/2/17 for all RNs, LPNs, Med Tech's, Med Aides, and CNAs, FT, PT, and PRN. The in-service topics included:

- Where to locate dining preferences in the kardex
- Honoring resident preferences for dining.
- Who to notify and what to do when a call out occurs.
- The dining room cannot be closed without the approval of the Director of Nursing or Administrator and only for the following reasons: a pre-planned facility event, construction, or other reason deemed only by the Administrator.

Effective 09/29/2017, the Director of Nursing and Administrator will review staffing levels and patterns weekly to determine that adequate staff is available to meet resident dining preferences. This process will be completed by reviewing the upcoming 7 days of scheduled nurses and nurse aides to determine that staffing is adequate to meet preferences. This will be completed weekly for 6 weeks to ensure sustained change has occurred.

Agencies that are used for staffing needs were sent the facility specific in-service

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 09/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 11 times a month the dining room was closed on the weekends because there was not enough staff to monitor the residents. In an interview conducted with the Director of Nursing on 09/16/17 at 11:45 AM she revealed that she expected the facility to be staffed appropriately. She said that the facility was in the process of hiring more staff.	F 353	and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training by 10/06/2017 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing or Administrator in their absence will monitor this issue using the Staffing QA Tool (Attachment 242-B) for monitoring staffing is adequate to meet resident preference for dining. Rounds will occurs 3 times a week interviewing at a minimum 5 residents across various shifts and weekends to determine that preferences regarding dining is being met. This tool will be completed weekly x 4weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 353	Continued From page 12	F 353	and the Administrator.	