PRINTED: 01/08/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345503	B. WING			11/	/30/2018
	ROVIDER OR SUPPLIER	ROWA		STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 565 SS=E	and participate in resi (i) The facility must pr group, if one exists, we reasonable steps, with to make residents and upcoming meetings in (ii) Staff, visitors, or or resident group or fame the respective group's (iii) The facility must pr person who is approve group and the facility providing assistance ar requests that result fro (iv) The facility must or resident or family group the grievances and re groups concerning iss in the facility. (A) The facility must be facility must implement request of the resident §483.10(f)(6) The res participate in family group §483.10(f)(7) The res family member(s) or or representative(s) meet families or resident re residents in the facility This REQUIREMENT by:	ident has a right to organize dent groups in the facility. To vide a resident or family with private space; and take the approval of the group, and family members aware of the atimely manner. The guests may attend the group meetings only at a sinvitation. To vide a designated staff the do by the resident or family and who is responsible for and responding to written to me group meetings. To consider the views of a sup and act promptly upon the commendations of such the sues of resident care and life the able to demonstrate their the for such response. The construed to mean that the first as recommended every the or family group. Indent has a right to have other resident the presentative(s) of other	F	565	The statements made on this Plan of		12/28/18
ABODATORY	DIDECTORIS OF PROVINERIS	SUPPLIER REPRESENTATIVE'S SIGNATUR	_		TITI F		(X6) DATE

12/20/2018 **Electronically Signed**

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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				4412 SOUTH MAIN STREET			
LIBERTY	COMMONS NSG & REI	H ROWA		SALISBURY, NC 28147			
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F 565	Continued From pa	ge 1	F 5	665			
	follow up on recurre	interview the facility failed to ent Resident Council concerns not being answered timely in		Correction are not an adr not constitute an agreem alleged deficiencies.			
		dent Council Meeting Minutes.					
	Findings included: Review of the Reside 5/25/18 at 10:45 and continued to mention to be answered. The present during the residual continued to the resent during the research continued to the research	dent Council Minutes dated n revealed residents had on the waits for their call lights ne Activity Director was neeting and recorded the		To remain in compliance and State Regulations the taken or will take the action this Plan of Correction. To Correction constitutes the allegation of compliance alleged deficiencies cited will be corrected by the discourse and state of the correction	e facility has on set forth in The Plan of e facility's such that all I have been or		
	minutes.			indicated.			
	6/22/18 at 10:45 and expressed major condepartment including lights to be answered present during the minutes.	dent Council Minutes dated in revealed residents had incerns with the nursing ig waiting long times for called. The Activity Director was meeting and recorded the		F 0565 Resident/Family Response Address how corrective a accomplished for those rehave been affected by the practice:	action will be esidents found to		
	10:45 am revealed that Nurses are not answer call lights. present during the rminutes. On 8/24/18 at 10:45	cil Minutes dated 7/20/18 at the residents had complained helping the Nurse's Aides The Activity Director was neeting and recorded the am at the Resident Council iced concerns regarding long		On 11/26/2018 the Direct reviewed 100% of all resiminutes for May2018 to 3 and identified concerns. (and 12/13/2018 the Direct completed in-service train time, part-time, and PRN nurse aides on call bell residues.)	ident council September 2018 On 11/26/2018 ctor of Nursing ning for all Full nurses and		
	wait times for call lig entering the room, verturn shortly but do hours later. The mi Nursing was preser	ghts to be answered and staff voice to resident that they will o not return or return several nutes reflected the Director of at at the meeting. The Activity of during the meeting and		Address how the facility versidents having the pote affected by the same defined on 11/30/2018 No other concerns about call bells	will identify other ential to be icient practice:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345503	B. WING			44,	20/2049	
NAME OF D	ROVIDER OR SUPPLIER	0.10000		ς.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	30/2018	
NAME OF T	TOVIDER OR GOLT EIER				412 SOUTH MAIN STREET			
LIBERTY	COMMONS NSG & REH	ROWA						
				<u> </u>	ALISBURY, NC 28147		ı	
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F 565	Continued From page	e 2	F	565				
		ent Council Meeting Minutes			and 12/13/2018 the Director of Nursing	1		
		am revealed multiple council			completed in-service training for all Ful	•		
		cerns regarding staff not			time, part-time, and PRN nurses and	•		
		timely and staff turning off			nurse aides on call bell response			
		rning. The minutes reflected			/communication with residents. On			
	the Director of Nursin	•			November 30, 2018 the administrator v	vas		
	meeting. The Activity	Director was present during			invited and attended Resident council			
	the meeting and reco	rded the minutes.			meeting and there were no other			
					concerns of slow call bell response we	re		
	_	vith the Resident Council on			noted.			
		several members of the						
		ced concerns that they had			Address what measures will be put into)		
		mes for their call lights being			place or systemic changes made to			
		s Resident Council Meetings			ensure that the deficient practice will n	ot		
		n. They stated they had			recur:			
		the previous Resident had not had any resolution			On December 17, 2018 the			
	_	uncil Meeting on 10/26/18.			administrator in-served the Director of			
		ers stated they had not felt			Nursing and Activity Director on timely			
	like their concerns we				response to Resident Council Concern	S		
	into tron correction we	ore being addressed.			and creating a notebook and storage of			
	An interview with the	Activity Director on 11/28/18			follow up documents to assure safe	•		
		the residents had been			keeping. After the meeting the Activity			
	complaining about the	e call lights not being			Director is to provide the Administrator	the		
		ough. She stated when a			meeting minutes for review and determ			
	concern is brought up	o in Resident Council			the assigned person responsible for fo	low		
	Meeting she will usua	ally get the manager for the			up. Follow up documentation is to be			
		ns and have them come to			returned to the Administrator or design	ee		
	_	uncil agrees to have them			by the next Resident council meeting.			
		she had asked the Director						
	_	he meeting each time the			Indicate how the facility plans to monitor	or		
	_	not being answered timely			its performance to make sure that			
	had come up.				solutions are sustained; and Include da when corrective action will be complete			
	_	vith the Director of Nursing						
		m the Resident Council			Beginning after December 28, 2018 (n	ext		
	_	e reviewed. The Director of			monthly council meeting) the			
	_	id not follow up on the			Administrator and or designee will beg	n a		
	i Resident Council Cor	ncerns for long wait times for	1		monthly review of Resident council		1	

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345503	B. WING _			11/	30/2018	
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F 565 F 584 SS=D	off and not returning f 6/22/18, 7/20/18, 8/24 She stated her expect answer call lights time. An interview with the 70:55 am revealed her follow up on each comand then send it to hir stated he believed that up on, but the information He stated his expectate concern would be add Safe/Clean/Comfortal CFR(s): 483.10(i) (1)-(\$483.10(i) Safe Environment of the facility must proving the facility shall extended the facili	and staff turning call lights or the concerns voiced on 1/18, 9/28/18 and 10/26/18. Itation is that all staff would ely. Administrator on 11/30/18 at a expected the Managers to be cern from their department on to be signed off. He at the issues were followed ation was just misplaced. Ition was that any resident dressed immediately. Die/Homelike Environment (7) Comment. If to a safe, clean, elike environment, including iving treatment and g safely.	F 5		minutes and concern /complaint responsing a QA audit tool. The QA audit towill be completed after the monthly Resident council meeting, to assure the concerns ae addressed. The findings of the audit will be reviewed in the month QA meeting which is attended by the Administrator, Director of Nursing, Unimanager, MDS co -coordinator, Environmental Director, Dietary manage Heath information Manager, Social Services Director, This audit will be completed monthly withen randomly thereafter.	ol at of ly t	12/28/18	

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F 584	Continued From pag		F 5	584			
	and comfortable inte	ior;					
	§483.10(i)(3) Clean to in good condition;	ped and bath linens that are					
	§483.10(i)(4) Private resident room, as spo	closet space in each ecified in §483.90 (e)(2)(iv);					
	§483.10(i)(5) Adequa	ate and comfortable lighting					
	levels. Facilities initia	table and safe temperature lly certified after October 1, a temperature range of 71 to					
	sound levels.	maintenance of comfortable					
	Based on observation facility failed to (1) la bedpans, urinals, and manner in 3 of 4 halls clean bathroom free liquid on the floor, dri	d bath basins in a sanitary s and failed to (2) provide a of dark yellow stain and ed stains on the edge of the			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 Federa		
	resident bathrooms of	mell of urine for 1 of 5 observed on the 100 Hall.			and State Regulations the facility has taken or will take the action set forth in this Plan of Correction. The Plan of		
	8:31 am revealed an handrail in the bathro The two urinals were	of the 100 Hall on 11/29/18 at uncovered urinal on the for rooms 104 and 110. not labeled to designate and both 104 and 110 were			Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.		
	semiprivate rooms w				F-0584 Safe/Clean/Comfortable/Homelike Environment		

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TAG	,	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE	
F 584	Continued From page	e 5	F s	584				
	8:45 am revealed a b	ed pan on the floor in the						
	I .	3 that was not covered or			Address how corrective action will be			
	labeled. Room 203 is	s a semiprivate room with			accomplished for those residents foun	d to		
	two residents.	·			have been affected by the deficient practice:			
	An observation of the	300 Hall on 11/29/18 at			process.			
	9:10 am revealed und	covered and unlabeled bath			On 11/30/2018 the Director of Nursin	g		
	pans in the bathroom	s for room 301, 304, 305,			and Environmental Services Manager	•		
	306, and 309; and an	uncovered and unlabeled			cleaned, covered and labeled the ur	inals		
	urinal in the bathroon	n for room 303. Rooms 301,			for resident □s for residents in rooms 1	04		
	303, 304, 305, 306 ai	nd 309 were semiprivate			and 110.			
	rooms with two reside	ents.			On 11/30/2018 the Director of Nursing and Environmental Services Manager			
	An interview with Nur	se Aide #2 on 11/29/18 at			cleaned, covered and labeled the			
		bed pans and bath pans			bedpans for room 203. On 11/30/2018			
	I .	he bathroom in clear bags			date the Director of Nursing removed			
		resident's room numbers on			bath pans and urinals, obtained new			
	them. She stated she	e had an in-service and was			equipment for residents in rooms 301,			
	told how to store the	bed pans, bath pans, and			304, 305, 306, 309, 303.			
	urinals but did not rer	nember when she had the			On 11/30/2018 the Environmental			
	in-service.				Services Director cleaned the			
					floor/toilet/bathroom in room 111 remo	ving		
	During an interview w				the yellow stain.			
	I .	she stated the bed pans,			On 14/20/2010 the constitution at the constitution			
		s should be covered with a			On 11/30/2018 the environmental serv			
	, .	d in the residents' bathrooms			director posted the on call schedule th			
		let. She stated they should			lists the environmental services staff a			
	also de labeled with t	he residents' room numbers.			contact telephone number for off hours	5		
	During on interview w	vith Nurse Aide #4 on			and weekend environmental and			
	During an interview w				housekeeping services needs.			
	I .	she stated the bed pans cleaned after each use and			Address how the facility will identify ot	her		
		g in the residents' bathroom			residents having the potential to be	IGI		
	1 5	let; and the bath pans			affected by the same deficient practice	٠.		
		fter each use, placed in a			ancolou by the same denote it practice	••		
		d in the residents' closet.			On 11/30/2018 the Environmental			
	piastic bay and store	a in the residents closet.			Services Manager completed a 100%			
	An interview with Nur	se Aide #5 on 11/29/18 at			audit of all resident bath rooms areas.	The		
		ne was not aware there was			findings were that there were no other			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		DOW!		4	412 SOUTH MAIN STREET		
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F 584	Continued From page	e 6	F	584			
	a bed pan on the floo	or in bathroom of room 203.			issues identified.		
		an should be in a plastic bag					
	on the back of the toi	let. She stated she had an			Address what measures will be put into)	
	in-service recently ar	nd knew the bed pans and			place or systemic changes made to		
	urinals should be clea	aned and covered with a			ensure that the deficient practice will no	ot .	
		hroom on the back of the			recur:		
		ins should be cleaned and					
	covered with a plastic	c bag in the resident's closet.			On Nov.30th, 2018 the Director of Nurs	sing	
	0 0 44/00/40 -+ 0)04			and Environmental Services Manager		
		3::31 am an observation of			began in serving all Fulltime , Part time	٠,	
	I .	12 inch by 21 inch dark athroom floor in front of the			and PRN nurses, aides, and housekeeping staff on : providing a a		
	1 =	ins to the edges of the			safe, clean homelike environment and		
	commode; and a stro				ensure that personal belongings are la	hel	
	Commode, and a sire	ong odor of drine.			and care for appropriately. Housekeep		
	An interview with Nur	rse Aide #2 on 11/29/18 at			services maintain a sanitary and order	-	
	9:56 am revealed she				comfortable interior and that all resider	-	
		11 had stains on the toilet			have clean linens and clean bathrooms		
		on the floor with dark yellow			which to live. If Areas are found that ne	ed	
	liquid. She stated sh				additional attention, the staff is to notify	/	
	assignment before ar	nd was not accustomed to			housekeeping services. After 8pm the		
	the resident. She sta	ated when there was a spill			staff will contact the on call		
	they called housekee	eping to clean it up.			maintenance/environmental staff to		
					address the issue. This in-service train	ing	
	_	vith the house keeper on			was completed on Dec. 21st, 2018.		
		she stated she cleaned					
	I .	8 in the morning but had not			lasticate because 6, 200		
	1	e stated it would be at least 1			Indicate how the facility plans to monito	or	
		could clean room 111. She ould clean up spills after			its performance to make sure that	atos	
					solutions are sustained; and Include da		
	housekeeping leaves	ο αι 2.30 μπ.			when corrective action will be complete	u.	
	During an interview a	and observation of room 111			Beginning on Dec.24th, 2018 the		
		ouse Keeping Manager on			Environmental Services manager will		
		he stated the floor and toilet			begin a weekly audit of		
		on them and the bathroom			safe/clean/comfortable homelike		
	did need immediate attention and he would get				environment and bathroom /equipment	1	
	someone to clean it is				cleanliness, using a QA audit tool . The		
		ger also stated the evening			QA audit tool will be completed weekly		

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shift la pm and housel 8:00 pi and his the ne: During on 11/3 expect cleane bag and back of should stored bed particulated assign expect the urin called mop the that all enviror and all enviror compared to the series of the series of the series of the series of the urin called mop the series of	d they usually of keepers leave are and then the stansistant are at morning. I an interview was 30/18 at 10:41 attion was the lad after each usual distored in the off the toilet. Shall be cleaned, coin the resident ans, urinals, and with the resident ans, urinals, and with the resident. The Direction was the stans in the bathrohousekeeping are floor. She staff should enter the am revealed hints' environment as needed are hensive Asset): 483.20(b)(1)	s in the building until 8:00 clean up spills after the at 2:30 pm until they leave at a Housekeeping Manager on call after 8:00 pm until with the Director of Nursing am she stated her ped pans and urinals be see, covered with a plastic presidents' bathrooms on the e also stated the bath pans overed in a plastic bag and s' closet. She stated that all d bath pans should be ents' room number and bed ector of Nursing stated her staff should have cleaned up from for room 111 and then staff to clean the toilet and tated her expectation was ansure the residents. Administrator on 11/30/18 at a sexpectation was the ent should be attended to and kept clean. The sessments & Timing (2)(i)(iii)	F 58	then monthly x3 to assure that comae addressed. The findings of the awill be reviewed in the monthly QA meeting which is attended by the Administrator, Director of Nursing, manager, MDS co -coordinator, Environmental Services Manager a Dietary Manger, Heath Information Manager, Social Services Director. Date of compliance will be December 2018. The Administrator is responsible for tags in the Plan of Correction.	unit unit and per 28,	12/28/18	

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345503	B. WING			11/	30/2018
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F 636	A facility must make a assessment of a resident assessment by CMS. The assess the following: (i) Identification and dii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (vi) Mood and behavion (vii) Psychological we (viii) Physical function (ix) Continence. (x) Disease diagnosis (xi) Dental and nutrition (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xvi) Discharge plann (xvii) Discharge plann (xvii) Documentation regarding the addition on the care areas trig the Minimum Data Se (xviiii) Documentation assessment. The assinclude direct observa with the resident, as well incensed and nonlicer members on all shifts §483.20(b)(2) When retimeframes prescribed	ensive Assessments ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ment must include at least demographic information ensions dent and structural problems dent and health conditions dent and procedures dent and procedures dent and procedures dent and procedures dent (MDS) dent (MDS	F	636			

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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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 636	timeframes specified through (iii) of this seprescribed in §413.3 apply to CAHs. (i) Within 14 calenda excluding readmissic significant change in mental condition. (For "readmission" means following a temporary or therapeutic leave. (iii) Not less than one This REQUIREMENT by: Based on medical reinterviews, the facility comprehensive asset Assessments (CAAs months and within 14 admission for 2 of 26 and Resident # 186) comprehensive asset completion. Findings included: 1.Resident # 29 was 10/07/2016 with diag	dent in accordance with the in paragraphs (b)(2)(i) action. The timeframes 43(b) of this chapter do not ar days after admission, one in which there is no the resident's physical or or purposes of this section, are a return to the facility absence for hospitalization (b) are every 12 months. This not met as evidenced accord review and staff a failed to complete assments and Care Area (c) not less than every 12 and calendar days after a residents (Resident # 29 reviewed for completion of ssments and CAA	F 6		s Plan of ion to and do with the in in ind State aken or will his Plan of ection gation of ged or will be s indicated.		
	syndrome, heart failu A comprehensive Midated 10/13/2017 was to the MDS data bas The electronic medic # 29 revealed that qu	nimum Data Set (MDS) as completed and transmitted e on 10/20/2017. al record (EMR) for Resident		Corrective Action: Resident #29. Comprehensiv Assessment, Assessment Re Date (ARD) 11/24/2018. Com Submitted and Accepted on the State QIES system Resident #186 Comprehensiv Assessment, Assessment Resident Res	eference npleted, 12/17/2018 to ve		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345503	B. WING _		11	/30/2018	
NAME OF P	ROVIDER OR SUPPLIER	1	'	STREET ADDRESS, CITY, STATE, ZIP COL	•		
				4412 SOUTH MAIN STREET			
LIBERTY	COMMONS NSG & RE	H ROWA		SALISBURY, NC 28147			
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 636	Continued From pa	ige 10	F 6	336			
	on 01/11/2018, 04/ 08/30/2018.	12/2018, 05/30/2018 and		Date (ARD) 11/14/2018. Con Submitted and Accepted on the State QIES system			
	11/29/2018 reveale was past due and v	ent # 29 reviewed on d that a comprehensive MDS vas to have been completed e EMR had the next		Identification of other resident be involved with this practice	•		
	assessment referer	OS scheduled with an once date (ARD) of 11/24/2018.		All current residents with Cor Minimum Data Set (MDS) as due have the potential to be	sessments affected by		
	conducted with the	:20 AM an interview MDS coordinator revealed alized that a comprehensive		the alleged practice. On 12/1 through 12/17/2018 an audit completed by the MDS Nurse	was		
	notation in the EMF	4/2018 as indicated by a red R had been past due because of the next MDS on the ARD		to ensure that the facility had comprehensive, accurate, sta reproducible assessment of e	andardized		
		completed quarterly MDS		resident⊡s functional capacit 85 current residents, 10 num	ty. Out of the		
		cted with the MDS nurse		residents did not have their comprehensive assessments within 14 calendar days after	•		
	should have been o	dated on or prior to 10/14/2018 nad just been omitted in error.		excluding readmission in whi significant change in the resignificant or mental condition a	ch there is no dent⊡s		
	conducted with the that the expectation	:35 PM an interview facility administrator revealed n was that MDS assessments		number of resident did not hat Annual comprehensive assess completed by timeframes. The	ave their ssments nis		
	Assessment Manua 2. Resident #186 v	rected by the Resident al (RAI). vas admitted to the facility on ent's admission diagnoses		assessments were completed 12/21/2018. Systemic Changes:	d by		
	included: Sepsis (the and possibly system	ne body's reaction to a severe mic (body wide) infection),		On 12/18/2018 The Register			
		lcers, low potassium, ess, cancer, history of stroke, disorder.		(RN) Minimum Data Set (MD Coordinator, Licensed Praction (LPN) Support nurses any of Interdisciplinary team member	cal Nurse her		
		t #186's Minimum Data Set for 11/29/18 revealed the		participates in the MDS asse process was in serviced /edu	ssment		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
	345503	B. WING		11	/30/2018	
NAME OF PROVIDER OR SUPPL	IER		STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
LIBERTY COMMONS NSG	& PEH POWA		4412 SOUTH MAIN STREET			
LIBERTT COMMONS NSG	X REH ROWA		SALISBURY, NC 28147			
PREFIX (EACH DE	MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
and Care Area completed. An interview w conducted on a Coordinator state admission associated Care completed and stay at the faci. An interview w conducted on a Consultant state completed at the late. The MDS Coordinator had caught up soon. An interview w Administrator of Administrator of admission associated Care completed at the late. The MDS Coordinator had caught up soon.	prehensive admission assessment Assessments (CAAs) were not dith the MDS Coordinator was 11/29/18 at 9:21 AM. The MDS ated she was working on the essment for Resident #186 but had it yet. The MDS Coordinator on assessments and the re Area Assessments should be locked by day 14 of the resident's lity. With the MDS Consultant was 11/29/18 at 9:35 AM. The MDS ted the assessment had not been the time of the interview and was 6 Consultant further stated the MDS and gotten behind and would be 11/30/18 at 1:16 PM. The stated it was his expectation for essments to be completed within hission and for the MDS follow the Resident Assessment		MDS nurse consultant. The education focused on: must conduct initially and pocomprehensive, accurate, so reproducible assessment of resident so functional capace OBRA-required comprehen assessments include the coboth the MDS and the CAA well as care planning. Compassessments are completed admission, annually, and work significant change in a resident as occurred or a significant a prior comprehensive assessed required. They consist of: A Assessment, Annual Assessignificant Change in Statute (SCSA) and Significant Corcomprehensive Assessment and Significant Corcomprehensive assessment are turning resident that must completed by the end of dathe date of admission to the as day 1 if: this is the reside in this facility, OR the reside admitted to this facility and discharged return not anticities resident has been admitted and was discharged return within 30 discharge. The Annual assecomprehensive assessment that must be completed on basis (at least every 366 das SCSA or a SCPA has been	eriodically a standardized of each city. Insive completion of a process, as prehensive di upon then a dent status of correction to essment is admission esment, and is Assessment frection to Prior of (SCPA). The state for a new circumstances, as to be eath status of each status of eath status of east eath of a resident an annual easy) unless a		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	C	(X3) DATE SURVEY COMPLETED	
		345503	B. WING _			11/30/2018
	ROVIDER OR SUPPLIER COMMONS NSG & REH	ROWA				
(X4) ID PREFIX TAG	(EACH DEFICIENC	LUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE LATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 636	Continued From page	e 12	F6	assessment was completed completion dates (MDS/depend on the most rece comprehensive and pass ARDs and completion data. This in service was compart time, and PRN) and interdisciplinary team whin-service training will not work until training is cominformation has been into standard orientation train required in-service refres all employees and will be Quality Assurance Proceethe change has been summer Monitoring: To ensure compliance, To ensure cords Minim Set(MDS) assessment the one of the following Comassessments (Admission Annual Assessment, and Change in Status Assess Significant Correction to Comprehensive Assessments (Admission Annual Assessment, and Change in Status Assess Significant Correction to Comprehensive Assessments (Admission Annual Assessment, and Change in Status Assess Significant Correction to Comprehensive Assessments (Admission Annual Assessment, and Change in Status Assess Significant Correction to Comprehensive Assessment the comprehensive Assessment that the Comprehensive Assessment Assessmen	CAA(s)/care planent ent ent tassessments ates. pleted by nurse (full time, d member of the no did not receive to be allowed to npleted. This tegrated into the ning and in the sher courses for e reviewed by th ess to verify that distained. The Director of kly, 5 residents num Data his could be eith nprehensive n Assessment, d Significant sment and prior ment) to ensure assessments are will be done on the weekend for 3 months. Repor weekly QA tor of Nursing DS) Coordinator ion initiated as	e e e e e e e e e e e e e e e e e e e

I ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345503	B. WING	 	11/30/2018	
	ROVIDER OR SUPPLIER	ROWA		STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH C		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
F 636	_	e 13 Least Every 3 Months	F 63	be brought to the Director of Nursin Administrator for appropriate action Compliance will be monitored and ongoing auditing program reviewed Weekly Quality of Life Meeting. We QA Committee meeting is attended Administrator, Director of Nursing, N Coordinator, Unit Manager, Support Nurse, Therapy, HIM(Health Inform Management), Dietary Manager. The Administrator is responsible for tags on the Plan of Correction. Date of Compliance: 12/28/2018	at the ekly by MDS t ation	
SS=D	and approved by CM once every 3 months This REQUIREMENT by: Based on medical reinterviews, the facility assessments not less months for 2 of 26 re Resident #4) reviewe assessments. Findings included: 1. Resident #3 was refacility on 1/3/17 and the facility on 8/5/16.	s a resident using the ument specified by the State S not less frequently than		The statements made on this Plan Correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and Sta Regulations the facility has taken or take the actions set forth in this Plan Correction. The Plan of Correction constitutes the facility allegation compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indic	and do e ate r will n of of	

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
	345503	B. WING _			1/30/2018	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
			4412 SOUTH MAIN STREET			
COMMONS NSG & RI	EH ROWA		SALISBURY, NC 28147			
(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
weakness, difficult depression, and or Review of Resider Data Set (MDS) as quarterly assessment reas having had more The resident was assistance of one daily living (ADLs) assessment revea with an ARD of 7/1 the calculated differ quarterly assessment greater than 3 more An interview with the conducted on 11/2 Coordinator stated assessment 92 da quarterly or compression MDS Coordinator quarterly assessment quarterly assessment quarterly assessment 92 da quarterly or compression management of the province o	by swallowing, anxiety, steoporosis. In #3's most recent Minimum assessments revealed a ent with an Assessment (ARD) of 10/16/18. Review of evealed the resident was coded derately impaired cognition. Coded as having required the fot two people for all activities of a Review of the previous MDS led a quarterly assessment (A/18. Further review revealed erence between the 7/14/18 ent ARD and the 10/16/18 ent ARD was a time span on this or 92 days. The MDS Coordinator was (19/18) at 9:21 AM. The MDS is she scheduled quarterly yes or less from the previous entensive assessment. The stated she was unaware the ents for Resident #3 were	F 6	F 638 QRTLY ASSES LEAST EVERY 3 MONTHS Corrective Action: Resident #4. Quarterly Asse Assessment Reference Date 12/1/2018. Completed, Subr Accepted on 12/20/2018 to t QIES (Quality Improvement Evaluation System) ASAP (Submission and Processing Resident #3 Comprehensive Assessment Reference Date 10/16/2018. Completed, Sub Accepted on 11/21/2018 to t QIES ASAP system. Identification of other resident be involved with this practice All current residents with Que Minimum Data Set (MDS) as due have the potential to be the alleged practice. On 12/1 through 12/17/2018 an audit completed by the MDS Nurs	essment, e (ARD) mitted and the State and Assessment e (ARD) omitted and the State and the State and the State e (ARD) omitted		
An interview with t conducted on 11/2 Consultant stated be completed at 9 previous quarterly assessment. The had been another for Resident #3, brand was closed as	the MDS Consultant was 19/18 at 9:35 AM. The MDS 19/18 at 9:35 AM. The		Quarterly Review assessme resident s. Out of the 85 cu residents, 4 number of resid have their quarterly review a completed within 92days sin the previous OBRA Quarterl Assessment or ARD of previous remarks assessment assessments were completed submitted by 12/21/2018.	ent of each contract		
	COMMONS NSG & RI SUMMARY (EACH DEFICIE REGULATORY) Continued From p weakness, difficult depression, and or Review of Resider Data Set (MDS) as quarterly assessm Reference Date (A the assessment re as having had more The resident was assistance of one daily living (ADLs) assessment revea with an ARD of 7/1 the calculated diffe quarterly assessm quarterly assessm greater than 3 more An interview with t conducted on 11/2 Coordinator stated assessment 92 da quarterly or compr MDS Coordinator quarterly assessm more than 92 days 10/16/18. An interview with t conducted on 11/2 Consultant stated be completed at 92 previous quarterly assessment. The had been another for Resident #3, bi and was closed as	ROVIDER OR SUPPLIER COMMONS NSG & REH ROWA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 weakness, difficulty swallowing, anxiety, depression, and osteoporosis. Review of Resident #3's most recent Minimum Data Set (MDS) assessments revealed a quarterly assessment with an Assessment Reference Date (ARD) of 10/16/18. Review of the assessment revealed the resident was coded as having had moderately impaired cognition. The resident was coded as having required the assistance of one to two people for all activities of daily living (ADLs). Review of the previous MDS assessment revealed a quarterly assessment with an ARD of 7/14/18. Further review revealed the calculated difference between the 7/14/18 quarterly assessment ARD and the 10/16/18 quarterly assessment ARD and the 10/16/18 quarterly assessment ARD was a time span greater than 3 months or 92 days. An interview with the MDS Coordinator was conducted on 11/29/18 at 9:21 AM. The MDS Coordinator stated she scheduled quarterly assessment 92 days or less from the previous quarterly or comprehensive assessment. The MDS Coordinator stated she was unaware the quarterly assessments for Resident #3 were more than 92 days apart from 7/14/18 and	ROVIDER OR SUPPLIER COMMONS NSG & REH ROWA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 weakness, difficulty swallowing, anxiety, depression, and osteoporosis. Review of Resident #3's most recent Minimum Data Set (MDS) assessments revealed a quarterly assessment with an Assessment Reference Date (ARD) of 10/16/18. Review of the assessment revealed the resident was coded as having had moderately impaired cognition. The resident was coded as having required the assistance of one to two people for all activities of daily living (ADLs). Review of the previous MDS assessment revealed a quarterly assessment with an ARD of 7/14/18. Further review revealed the calculated difference between the 7/14/18 quarterly assessment ARD and the 10/16/18 quarterly assessment ARD and the 10/16/18 quarterly assessment ARD was a time span greater than 3 months or 92 days. An interview with the MDS Coordinator was conducted on 11/29/18 at 9:21 AM. The MDS Coordinator stated she scheduled quarterly assessment. The MDS Coordinator stated she was unaware the quarterly assessments for Resident #3 were more than 92 days apart from 7/14/18 and 10/16/18. An interview with the MDS Consultant was conducted on 11/29/18 at 9:35 AM. The MDS Consultant stated quarterly assessments were to be completed at 92 days or less from the previous quarterly or comprehensive assessment were to be completed at 92 days or less from the previous quarterly or comprehensive assessment opened for Resident #3, but it had not been completed and was closed as incomplete. The MDS	ROVIDER OR SUPPLIER COMMONS NSG & REH ROWA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 weakness, difficulty swallowing, anxiety, depression, and osteoporosis. Review of Resident #3's most recent Minimum Data Set (MDS) assessment revealed the resident was coded as having had moderately impaired cognition. The resident was coded as having required the assistance of one to two people for all activities of daily living (ADLs). Review of the previous MDS assessment ARD was a time span greater than 3 months or 92 days. An interview with the MDS Coordinator was conducted on 11/29/18 at 9:21 AM. The MDS Coordinator stated she was unaware the quarterly assessments. The MDS consultant stated quarterly assessment to ensure that the facility assessment to ensure that the facility of province that the facility of the alleged practice. On 12/17/2018 and 10/16/18. An interview with the MDS Consultant was conducted on 11/29/18 at 9:35 AM. The MDS Coordinator stated she was unaware the quarterly assessments for Resident #3 were more than 92 days apart from 7/14/18 and 10/16/18. An interview with the MDS Consultant stated quarterly assessments were to be completed at 92 days or less from the previous quarterly or comprehensive assessment as were to be completed at 92 days or less from the previous quarterly or comprehensive assessment had the previous Quarterly or comprehensive assessment were to be completed at 92 days or less from the previous quarterly or comprehensive assessment seve to be completed at 92 days or less from the previous quarterly or comprehensive assessment as the previous Quarterly or comprehensive assessment as were to evaluate the previous Quarterly assessment were to evaluate the previous Quarterly or comprehensive assessment assessment opened for Resident #3, but it had not been completed and was closed as incomplete. The MDS	ROWIDER OR SUPPLIER COMMONS NSG & REH ROWA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST SE PRECEDED BY FULL REGULATORY OR LSG IDENTIFYING INFORMATION) Continued From page 14 Weakness, difficulty swallowing, anxiety, depression, and osteoprosis. Review of Resident #3's most recent Minimum Data Set (MDS) assessments revealed a quarterly assessment revealed the resident was coded as having head moderately impaired cognition. The resident was coded as having required the assistance of one to two people for all activities of daily living (ADLs). Review of the previous MDS assessment revealed defiference between the 71/4/18 quarterly assessment ARD and the 10/16/18 and accordance of the previous duarterly occomprehensive assessment. The MDS Coordinator stated she scheduled quarterly assessment and 10/16/18. An interview with the MDS Consultant was conducted on 11/29/18 at 9:21 AM. The MDS Consultant stated garrenty assessments to the previous quarterly or comprehensive assessments to the conducted on 11/29/18 at 9:35 AM. The MDS Consultant stated quarterly assessment and the previous quarterly or comprehensive assessments to the completed and 10/16/18. An interview with the MDS Consultant was conducted on 11/29/18 at 9:35 AM. The MDS Consultant stated quarterly assessments to the previous quarterly or comprehensive assessments completed within 92/days since the ARD of the previous quarterly or comprehensive assessments completed within 92/days since the ARD of the previous comprehensive assessment to pend for Resident #3, but it had not been completed and submitted by 12/21/2018.	

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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	
		345503	B. WING			11/	30/2018
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/-	30/2010
					412 SOUTH MAIN STREET		
LIBERTY	COMMONS NSG & REH	ROWA			SALISBURY, NC 28147		
(X4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 638	Continued From page	e 15	F	638			
. 000	· -	nad an ARD which was 94	'	000			
		3 quarterly assessment. The			On 12/18/2018 The Registered Nurse		
		ed the 10/16/18 quarterly			(RN) Minimum Data Set (MDS)		
	assessment was 2 da				Coordinator, Licensed Practical Nurse		
	completed.	yo late, but it was			(LPN) Support nurses any other		
					Interdisciplinary team member that		
	An interview was con	ducted with the			participates in the MDS assessment		
	Administrator on 11/3	0/18 at 1:16 PM. The			process was in serviced /educated by	he	
	Administrator stated i	t was his expectation for			MDS nurse consultant.		
	admission quarterly a	ssessments to be			The education focused on: The facility		
	completed no more th	nan 92 days from the			must conduct initially and periodically a	ı	
	previous quarterly as:	sessment or comprehensive			Quarterly Review Assessment of each		
		he MDS Coordinator to			resident□s functional capacity.		
		ssessment Instrument (RAI)			OBRA-required quarterly review		
	manual.				assessments are to be completed with	n	
	0 5				92days since the ARD of the previous		
		nost recently admitted to the			OBRA Quarterly Review Assessment of	r	
		was originally admitted to The resident's cumulative			ARD of previous comprehensive assessment, or significant Correction to	_	
	diagnoses included: [Prior Quarterly Assessment (ARD of a		
		isease (PVD), glaucoma,			of the mentioned assessments + 92	ııy	
	anxiety, and depressi	` '/ G			calendar days). The MDS completion of	late	
	anxioty, and doproco.	o			(item Z0500B must be no later than	uto	
	Review of Resident #	4's most recent completed			14days after the ARD (ARD + 14 caler	dar	
		1DS) assessments revealed			days).		
		ual assessment with an			This in service was completed by		
		ce Date (ARD) of 7/14/18.			12/21/2018. Any MDS nurse (full time		
	Review of the assess	ment revealed the resident			part time, and PRN) and member of the	Э	
	_	had severely impaired			interdisciplinary team who did not rece		
	_	ent was coded as having			in-service training will not be allowed to)	
		ce of one to two people for			work until training is completed. This		
	-	ving (ADLs). As of the date			information has been integrated into th		
		8 (138 days after the last			standard orientation training and in the		
		t), review of the transmitted			required in-service refresher courses for		
	T	ssessments revealed no			all employees and will be reviewed by		
	record of received as	sessments since 7/14/18.			Quality Assurance Process to verify the the change has been sustained.	il	
	An interview with the	MDS Coordinator was			the change has been sustained.		
		8 at 9:21 AM. The MDS			Monitorina:		

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR MC). 0938-0391_
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345503	B. WING			11/	30/2018
NAME OF PR	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIDEDTY	COMMONS NSG & REH	POWA		44	412 SOUTH MAIN STREET		
LIBERTT	COMMONS NSG & REH	ROWA		S	ALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 638	Continued From page	2 16	F	638			
		e scheduled quarterly					
		or less from the previous			To ensure compliance, The Director of		
	quarterly or comprehe				Nursing will review weekly, 5 residents		
					electronic records Minimum Data		
	An interview with the	MDS Consultant was			Set(MDS) Quarterly assessments to		
		8 at 9:35 AM. The MDS			ensure that the assessments are to be		
		arterly assessments were to			completed within 92days since the AR	D of	
	be completed at 92 days previous quarterly or	-			the previous OBRA Quarterly Review		
		OS consultant stated there			Assessment or ARD of previous comprehensive assessment, or signific	rant	
		comprehensive assessment			Correction to Prior Quarterly Assessment		
		#4, but it had not been			(ARD of any of the mentioned	5110	
	completed and was closed as incomplete. The				assessments + 92 calendar days) and		
	MDS Consultant state	ed due to the annual having			completed timely : the MDS completion	n	
		n closed, it had caused the			date (item Z0500B must be no later the		
	-	rly assessment to be late.			14days after the ARD (ARD + 14 caler		
	The MDS Consultant				days). This will be done on weekly bas		
		eduled but had not been			to include the weekend for 4 weeks the	en	
	•	S Consultant further stated assessment scheduled but			monthly for 3 months. Reports will be presented to the weekly QA Committee	a hv	
	at the time of the inte				the Director of Nursing and/or Mini Date	-	
		Consultant stated there			Set (MDS) Coordinators to ensure	u	
		related to the scheduling			corrective action initiated as appropria	te.	
	software and there ha	•			Any immediate concerns will be broug		
	assessment schedule	ed. The MDS Consultant			the Director of Nursing or Administrato	r	
	stated when the annu				for appropriate action. Compliance will		
		assessment was not			monitored and ongoing auditing progra	am	
		Consultant stated the			reviewed at the Weekly Quality of Life		
		7/14/18 annual assessment mpleted by sometime in			Meeting. Weekly QA Committee meeti is attended by Administrator, Director of		
		Coordinator stated there was			Nursing, MDS Coordinator, Unit Mana		
		nt scheduled but it had not			Support Nurse, Therapy, HIM (Health	901,	
	been completed and it was going to be more than				Information Management), Dietary		
	92 days from the prev	vious assessment which was			Manager.		
		nt with an ARD of 7/14/18.					
	The MDS Consultant				The Administrator is responsible for all		
	quarterly assessment	would be late.			tags in the Plan of Correction.		

An interview was conducted with the

Date of Compliance: 12/28/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	345503	B. WING			11/30/2018	
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & RE	H ROWA		STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
Administrator state admission quarterly completed no more previous quarterly assessment and fo	age 17 1/30/18 at 1:16 PM. The d it was his expectation for y assessments to be e than 92 days from the assessment or comprehensive r the MDS Coordinator to Assessment Instrument (RAI)	F 63	38			
SS=D CFR(s): 483.20(f)(1) §483.20(f) Automar requirement- §483.20(f)(1) Enco a facility completes facility must encode each resident in the (i) Admission asses (ii) Annual assessn (iii) Significant char (iv) Quarterly reviet (v) A subset of item reentry, discharge, (vi) Background (fais no admission asses §483.20(f)(2) Transafter a facility must be compared to the Mistandard record lay and that passes state CMS and the State §483.20(f)(3) Transafter a facility must be compared to the Mistandard record lay and that passes state CMS and the State §483.20(f)(3) Transafter a facility must be compared to the Mistandard record lay and that passes state CMS and the State §483.20(f)(3) Transafter a facility must be compared to the Mistandard record lay and that passes state CMS and the State §483.20(f)(3) Transafter a facility must be compared to the Mistandard record lay and that passes state CMS and the State §483.20(f)(3) Transafter a facility must be compared to the Mistandard record lay and that passes state CMS and the State §483.20(f)(3) Transafter a facility must be compared to the Mistandard record lay and that passes state CMS and the State §483.20(f)(3) Transafter a facility must be compared to the Mistandard record lay and the State §483.20(f)(3) Transafter a facility must be compared to the Mistandard record lay and the State §483.20(f)(3) Transafter a facility must be compared to the Mistandard record lay and the State §483.20(f)(3) Transafter a facility must be compared to the Mistandard record lay and the State §483.20(f)(3) Transafter a facility must be compared to the Mistandard record lay and the State §483.20(f)(3) Transafter a facility must be compared to the Mistandard record lay and the State Mistandard record lay and the State Mistandard record lay and the State Mistandard record lay and the Mistandard record lay and	ding data. Within 7 days after a resident's assessment, a the following information for a facility: ssment. In a resident's assessment and the following information for a facility: ssment. In a resident sassessment and the facility: ssment assessment and updates. In a supon a resident's transfer, and death. In a resident's transfer, and death. In a resident's assessment, and the facility assessment, apable of transmitting to the mation for each resident and the format that conforms to wouts and data dictionaries, and ardized edits defined by	F 64	40		12/28/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345503	B. WING _		1	1/30/2018	
	ROVIDER OR SUPPLIER	ROWA		STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147			
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COR		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 640	the CMS System, ind (i)Admission assessic (ii) Annual assessment (iii) Significant change (iv) Significant correct (v) Significant correct assessment. (vi) Quarterly review (vii) A subset of item reentry, discharge, a (viii) Background (far initial transmission or does not have an ad §483.20(f)(4) Data for transmit data in the f for a State which has by CMS, in the format approved by CMS. This REQUIREMENT by: Based on medical reinterviews, the facility assessment to the CM Medicaid Services (CM after the assessment (Resident #59) review Minimum Data Set (III Findings included: Resident #59 was ac 7/9/18. Review of Resident is Data Set (MDS) assequarterly assessment	and complete MDS data to cluding the following: ment. ent. ge in status assessment. ction of prior full assessment. ction of prior quarterly s upon a resident's transfer, and death. ce-sheet) information, for an f MDS data on resident that mission assessment. cormat. The facility must format specified by CMS or, an alternate RAI approved at specified by the State and at specified by the State and tenters for Medicare & CMS) system within 14 days towas completed for 1 of 26 wed for transmission of MDS) assessments. dmitted to the facility on	F 6	The statements made on the Correction are not an admiss not constitute an agreement alleged deficiencies. To reme compliance with all Federal Regulations the facility has take the actions set forth in a Correction. The Plan of Corrections the facility salled compliance such that all alled deficiencies cited have been corrected by the date or date	sion to and do with the vain in and State taken or will this Plan of rection egation of eged or or will be es indicated. RANSMITTING		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345503	B. WING _				11/30/2018
NAME OF P	ROVIDER OR SUPPLIER	1	<u> </u>	STI	REET ADDRESS, CITY, STATE, ZIP CODE		
				44	12 SOUTH MAIN STREET		
LIBERTY	COMMONS NSG & R	EH ROWA		SA	ALISBURY, NC 28147		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
F 640	Continued From p	age 19	F 6	640			
	of the 9/29/18 qua	irterly assessment revealed it					
		10/13/18. Further review			Resident #59. Significant Change in		
	· ·	ssment was accepted to the			Status Assessment with Assessment		
	Quality Improvement	ent Evaluation System (QIES)			Reference Date 11/27/2018 complete	d on	
	Assessment Subn	nission and Processing (ASAP)			12/11/2018 and Submitted to the state	е	
	System on 10/31/	18 (18 days after completion).			QIES (Quality Improvement and		
					Evaluation System) ASAP (Assessme		
		pleted of the Final Validation			Submission and Processing) system.		
		lity of the transmission of MDS					
		took place on 10/31/18.			Identification of other residents who n	nay	
		ort revealed quarterly			be involved with this practice:		
		esident #59 with an ARD of					
		mitted on 10/31/18. Further			All current residents with Minimum Da	ata	
		rt revealed a warning for			Set (MDS) assessments due to be transmitted to the state QIES ASAP		
		stated, Record Submitted Late:				od	
		ate is more than 14 days after te on this assessment.			system have the potential to be affect by the alleged practice. On 12/14/201		
	the completion da	te on this assessment.			through 12/17/2018 an audit was	0	
	An interview with t	the MDS Coordinator was			completed by the MDS Nurse consult	ant	
		29/18 at 9:21 AM. The MDS			to ensure that the facility had transmi		
		d MDS assessments had to be			a resident assessment for each curre		
		ays or less from the time the			resident to the Centers for Medicare a		
		completed. The MDS			Medicaid Services (CMS) system with		
		d she was unable to transmit the			14days after the assessment was		
	assessment becau	use the QIES system was			completed. Out of the 85 current		
	down. The MDS (Coordinator further stated the			residents, no resident MDS assessme	ent	
	quarterly assessm	ent for Resident #59 was			was found to have been submitted to	the	
	transmitted late be	ecause it was transmitted for			state QIES ASAP system past 14day	S	
	more than 14 days	s after the assessment was			after the MDS assessment was		
	completed.				completed.		
		the MDS Consultant was 29/18 at 9:35 AM. The MDS			Systemic Changes:		
		the QIES system was down			On 12/18/2018 The Registered Nurse	د	
		rdinator was unable to submit			(RN) Minimum Data Set (MDS)	•	
	the MDS for Resid				Coordinator, Licensed Practical Nurse	ج	
	11120 101 110310	ione noo unlory.			(LPN) Support nurses any other	•	
	An interview was	conducted with the			Interdisciplinary team member that		
		1/30/18 at 1:16 PM The			narticinates in the MDS assessment		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	, , ,	(X3) DATE SURVEY COMPLETED		
		345503	B. WING _			11/30/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
LIDEDTY	COMMONE NEC 9 DEU	DOMA		4412 SOUTH MAIN STREET			
LIDERIT	COMMONS NSG & REH	ROWA		SALISBURY, NC 28147			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 640	Continued From page	e 20	F 6	40			
	Administrator stated i	it was his expectation for be transmitted in 14 days of completion and for the follow the Resident		process was in serviced /e MDS nurse consultant. The education focused on must transmit a resident M assessment to the Center and Medicaid Services (Ci within 14days after the ME was completed. Facility m sections of the MDS 3.0 re State-specific instrument, Care Area Assessment (Ci (Section V) and all tracking information. Transmission apply to all MDS 3.0 record both federal and state required to be Comprehensive assessment transmitted electronically with the Care Plan Completion + 14 days). All other MDS must be submitted within MDS Completion Date (ZCi days). For Entry and Deat tracking records, informati transmitted within 14 days Date (A1600 + 14 days for and A2000 + 14 days for Erecords). This in service was completion in service was completion.	a: The facility MDS s for Medicare MS) system DS assessment ust transmit all equired for their including the EAA) Summary g or correction requirements rds used to meet uirements. Care be transmitted. ents must be within 14 days of Date (V0200C2 assessments 14 days of the D500B + 14 th in Facility ion must be s of the Event r Entry records Death in Facility		
				part time, and PRN) and n interdisciplinary team who in-service training will not work until training is comp information has been integ standard orientation training	nember of the old did not receive be allowed to eleted. This grated into the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345503	B. WING _			 11/:	30/2018
	ROVIDER OR SUPPLIER	ROWA	·		ESS, CITY, STATE, ZIP CODE MAIN STREET , NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BI OSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 640	Continued From page	21	Fé	required all emplo Quality A the chan Monitorial To ensur Nursing electronia assessm Tracking to ensur were transystem to basis to then morpresented the Direct Set (MD corrective Any immathe Direct for approximation of the corrective Meeting is attended Nursing, Support Informat Manager	re compliance, The Director of will review weekly, 5 residents ic records Mini Data Set (MDS) ment to include a Comprehensionent, Quarterly Assessment, grassessment (Entry or Dischare that the MDS assessments insmitted to the QIES ASAP timely. This will be done on weinclude the weekend for 4 weekinclude the weekly QA Committed to for initiated as appropriate action initiated as appropriate action. Compliance will be drand ongoing auditing prograd at the Weekly Quality of Life. Weekly QA Committee meeting at the Weekly QA Committee meeting the drand ongoing auditing prograd at the Weekly QA Committee meeting at the Weekly QA Committee meeting the drand ongoing auditing prograd at the Weekly QA Committee meeting the drand ongoing auditing prograd at the Weekly QA Committee meeting the drand ongoing auditing prograd to the Weekly QA Committee meeting the Weekly QA Committee meeting the drand ongoing auditing prograd to the Weekly QA Committee meeting the drand ongoing auditing prograd to the Weekly QA Committee meeting the drand ongoing auditing prograd to the Weekly QA Committee meeting the drand ongoing auditing prograd to the Weekly QA Committee meeting the drand ongoing auditing prograd the Weekly QA Committee meeting the drand ongoing auditing prograd the Weekly QA Committee meeting the drand ongoing auditing prograd the Weekly QA Committee meeting the drand ongoing auditing prograd the Weekly QA Committee meeting the drand ongoing auditing prograd the Weekly QA Committee meeting the drand ongoing auditing prograd the Weekly QA Committee meeting the drand ongoing auditing prograd the Weekly QA Committee the drand ongoing auditing prograd the Weekly QA Committee the drand ongoing auditing prograd the Weekly QA Committee the drand ongoing auditing prograd the drand ongoing auditing prograd the Weekly QA Committee the drand ongoing auditing prograd the	the the at) ve rge) ekly eks I be e by a re. nt to r be im ng of ger,	
F 732 SS=C	Posted Nurse Staffing CFR(s): 483.35(g)(1)-		F 7	tags in the	ninistrator is responsible for all he Plan of Correction.		12/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345503	B. WING			11/30/2018	
	ROVIDER OR SUPPLIER	ROWA		STREET ADDRESS, CITY, STATE, ZIP COD 4412 SOUTH MAIN STREET SALISBURY, NC 28147			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 732	must post the following basis: (i) Facility name. (ii) The current date. (iii) The total number by the following cate unlicensed nursing serident care per shift (A) Registered nurses (B) Licensed practice vocational nurses (a) (C) Certified nurses (a) (C) Certified nurses (iv) Resident census \$483.35(g)(2) Posting (i) The facility must perspecified in paragraphically basis at the begin (ii) Data must be post (A) Clear and readalter.	affing Information. requirements. The facility ng information on a daily and the actual hours worked gories of licensed and staff directly responsible for ft: es. al nurses or licensed s defined under State law). ides. g requirements. boost the nurse staffing data oh (g)(1) of this section on a ginning of each shift. sted as follows: ble format. ace readily accessible to	F 7:		7)		
	staffing data. The fa written request, mak available to the publi exceed the commun §483.35(g)(4) Facilit requirements. The f posted daily nurse so 18 months, or as red is greater.	ic for review at a cost not to ity standard.					

PRINTED: 01/08/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		345503	B. WING _				11/30/2018	
NAME OF P	ROVIDER OR SUPPLIER	L	1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		11/00/2010	
				44	112 SOUTH MAIN STREET			
LIBERTY	COMMONS NSG & RE	EH ROWA		S	ALISBURY, NC 28147			
(X4) ID PREFIX TAG	(EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOUL) TAG CROSS-REFERENCED TO THE APPROF		BE	(X5) COMPLETION DATE			
F 732	Continued From pa	age 23	 F7	732				
F 732	Based on staff inte posted nursing start through 11/29/18, the accurate staffing in nursing staff schedureviewed (11/15/18 resident census for shifts on 3 of the 18 Findings included: Review of the Daily 11/15/18 revealed Assistants (NAs) of and 6.5 NAs on the entire skilled nursing Review of the daily for 11/15/18 revealed NAs on the 7:00 Plon the 3:00 PM to skilled nursing facility. Review of the Daily 11/16/18 revealed (RN) on the schedure 7:00 AM to 3:00 PM to 3:0	erview and review of required ffing sheets dated 11/15/18 the facility failed to post formation as compared to the lule for 15 days of the 15 days through 11/29/18) and post r at least two shifts of three 5 days reviewed. V Nursing Staff Schedule for there were 9 Nursing In the 7:00 AM to 3:00 PM shift a 3:00 PM to 11:00 PM shift for ing facility population. V posted Report of Nursing Staff ed the facility had posted 8 M to 3:00 PM shift and 6 NAs 11:00 PM shift for the entire	F	732	The statements made on this Plan or Correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federand State Regulations the facility has taken or will take the action set forth this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been will be corrected by the date or dates indicated. F-0732 Posted Nurse Staffing Inform Address how corrective action will be accomplished for those residents four have been affected by the deficient practice: On 11/30/2018 the Director of Nursin and staff scheduler reviewed the Dail Nurse staffing sheets, comparing it to actual census and actual number of sworking to assure the Daily staff and census was correct on the Posted Nurse staffing sheets.	eral sin or ation gy by the staff		
	on the 7:00 AM to	e 9 Nursing Assistants (NAs) 3:00 PM shift and 7 NAs on the PM shift for entire skilled ulation.			Staff information. Address how the facility will identify or residents having the potential to be			
	for 11/16/18 reveal hours for RN on sta 3:00 PM shift, and	r posted Report of Nursing Staff ed the facility had posted no aff, 7 NAs on the 7:00 PM to 6 NAs on the 3:00 PM to 11:00 tire skilled nursing facility			All residents have the potential to be affected by the deficient practice. On 11/30/2018 the Director of Nursing assigned the 400 hall Charge Nurse member on 3-11 and 11-7 to review a	staff		

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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	
		345503	B. WING _				11/30/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		11/00/2010	
				4412 SOI	UTH MAIN STREET			
LIBERTY	COMMONS NSG & REH	ROWA			URY, NC 28147			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 732	Continued From page	e 24	F 7		ıst the Daily Staffing and Censu	ıs		
	11/17/18 revealed the Practical Nurses (LPI	Jursing Staff Schedule for ere were 4.5 Licensed Ns) on the schedule on the shift for the entire skilled			et when changes occur for off hekends , and holidays staff postids.			
	7:00 AM to 3:00 PM shift for the entire skilled nursing facility population. Further review revealed there were 7 Nursing Assistants (NAs) on the 7:00 AM to 3:00 PM shift and 7 NAs on the 3:00 PM to 11:00 PM shift for entire skilled nursing facility population.			plac ensu recu		o vill not		
	for 11/17/18 revealed LPNs on the 7:00 AM the 7:00 PM to 3:00 F 3:00 PM to 11:00 PM nursing facility popula revealed there was n entered for the 7:00 A	osted Report of Nursing Staff I the facility had posted 4 I to 3:00 PM shift, 8 NAs on PM shift, and 6 NAs on the shift for the entire skilled ation. Further review o resident census data AM to 3:00 PM shift, 3:00 PM d 11:00 PM to 7:00 AM shift,		Nurs Part Req and disp acce assig holic char	December13,2018 date the Dinsing began in-servicing all Fulltititime, and PRN nurses on the Juired posting of staffing informathe resident census so that it is played in prominent location and essible for all residents. Staff will gned on off hours, weekends, days to update as appropriate winges to assure accuracy.	ime, ation s d ras and with		
	11/18/18 revealed the schedule on the 7:00 entire skilled nursing review revealed there (NAs) on the 7:00 AM on the 3:00 PM to 11 nursing facility popular Review of the daily p	osted Report of Nursing Staff		its p solu whe Begi Dire revie usin will t	cate how the facility plans to moverformance to make sure that ations are sustained; and Includen corrective action will be compaining on December 21, 2018 the ctor of Nursing will begin a weekew of the Daily Nursing Staffing a QA audit tool. The QA audit be completed weekly to monito the part of the staff working and the corrections.	le dates pleted. the ekly g sheet lit tool or the he		
	LPNs on the 7:00 AM the 7:00 PM to 3:00 F 3:00 PM to 11:00 PM nursing facility popula revealed a resident c	I the facility had posted 4 I to 3:00 PM shift, 8 NAs on PM shift, and 6 NAs on the shift for the entire skilled ation. Further review ensus of 78 was entered for PM shift; no census was		char the a QA r Adm man	dent census so that it is update nges occur in the data. The find audit will be reviewed in the momeeting which is attended by thinistrator, Director of Nursing, nager, MDS co -coordinator, ironmental Services Manager,	dings of onthly ne Unit		

` '		IDENTIFICATION NI IMBED:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345503	B. WING			11/	30/2018	
	ROVIDER OR SUPPLIER	ROWA	•	44	TREET ADDRESS, CITY, STATE, ZIP CODE 412 SOUTH MAIN STREET ALISBURY, NC 28147			
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 732	11:00 PM to 7:00 AM Review of the Daily N 11/19/18 revealed the Assistants (NAs) on the for the entire skilled in Review of the daily po for 11/19/18 revealed NAs on the 3:00 PM to on the 11:00 PM to 7: skilled nursing facility Review of the Daily N 11/20/18 revealed the Assistants (NAs) on the and 5 NAs on the 3:00 the entire skilled nurs Review of the daily po for 11/20/18 revealed NAs on the 7:00 PM to on the 3:00 PM to on the 3:00 PM to 11/21/18 revealed the schedule on the 7:00 entire skilled nursing review revealed there (NAs) on the 7:00 AM NAs on the 3:00 PM to entire skilled nursing review revealed there (NAs) on the 7:00 AM NAs on the 3:00 PM to entire skilled nursing review revealed there (NAs) on the 7:00 AM NAs on the 3:00 PM to entire skilled nursing	PM to 11:00 PM shift or the shift. Jursing Staff Schedule for the ere were 7 Nursing the 3:00 PM to 11:00 PM shift the facility population. Dested Report of Nursing Staff the facility had posted 6 to 11:00 PM shift and 4 NAs 100 PM shift for the entire population. Jursing Staff Schedule for the ere were 7 Nursing the 7:00 AM to 3:00 PM shift for the facility population. Dested Report of Nursing Staff the facility had posted 8 to 3:00 PM shift for the entire population. Jursing Staff Schedule for the facility had posted 8 to 3:00 PM shift for the entire population. Jursing Staff Schedule for the facility population. Further the were 8 Nursing Assistants 1 to 3:00 PM shift for the facility population. Dested Report of Nursing Staff Staff Report of Nursing Staff Staff Report of Nursing Staff Staff Report of Nursing Report of Nursing Report of Nu	F	732	manager, Heath information Manager, Social Services The administrator is responsible for the plan of correction.			
		the facility had posted 4 to 3:00 PM shift, 9 NAs on						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		345503	B. WING		11/30/2018		
	ROVIDER OR SUPPLIER COMMONS NSG & REF	H ROWA	44	TREET ADDRESS, CITY, STATE, ZIP CODE 412 SOUTH MAIN STREET ALISBURY, NC 28147	,		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
F 732	the 7:00 PM to 3:00 3:00 PM to 11:00 PM nursing facility popularsing facility popularsing facility popularsing facility popularsing facility popularsing facility popularsing facility for 11/22/18 revealed nursing facility for 11/22/18 revealed NAs on the 7:00 PM on the 3:00 PM to 1 skilled nursing facility for 11/23/18 revealed the Assistants (NAs) on and 5.5 NAs on the the entire skilled nursing facility for 11/23/18 revealed NAs on the 7:00 PM on the 3:00 PM to 1 skilled nursing facility for 11/24/18 revealed the Assistants (NAs) on and 5 NAs on the 3: the entire skilled nursing facility for 11/24/18 revealed the entire skilled nursing facility for 11/24/18 revealed the entire skilled nursing facility for 11/24/18 revealed NAs on the 7:00 PM NAS on the 7:00 PM NAS on the 7:00 PM	PM shift, and 6 NAs on the M shift for the entire skilled dilation. Nursing Staff Schedule for here were 9 Nursing the 7:00 AM to 3:00 PM shift for raing facility population. Posted Report of Nursing Staff and the facility had posted 8 to 3:00 PM shift for the entire ty population. Nursing Staff Schedule for here were 8 Nursing the 7:00 AM to 3:00 PM shift 3:00 PM shift for raing facility population. Nursing Staff Schedule for here were 8 Nursing the 7:00 AM to 3:00 PM shift 3:00 PM to 11:00 PM shift for raing facility had posted 7 to 3:00 PM shift and 6 NAs 1:00 PM shift for the entire ty population. Nursing Staff Schedule for here were 8 Nursing the 7:00 AM to 3:00 PM shift for the entire ty population. Nursing Staff Schedule for here were 8 Nursing the 7:00 AM to 3:00 PM shift for raing facility population. Posted Report of Nursing Staff and the facility had posted 7 to 3:00 PM shift for raing facility had posted 7 to 3:00 PM shift and 6 NAs 1:00 PM shift and 6 NAs 1:00 PM shift for the entire	F 732				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345503	B. WING		11/30/2018		
	ROVIDER OR SUPPLIER	H ROWA	4	STREET ADDRESS, CITY, STATE, ZIP CODE 412 SOUTH MAIN STREET SALISBURY, NC 28147	,		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
F 732	11/25/18 revealed the schedule on the 7:00 entire skilled nursing review revealed the PM to 11:00 PM shiff facility population. Review of the daily for 11/25/18 revealed RNs on the 7:00 ANd on the 3:00 PM to 10 skilled nursing facility revealed there was entered for the 7:00 to 11:00 PM shift, at three of three shifts. Review of the Daily 11/26/18 revealed the entire skilled nursing facility at the entire skilled nursing facility in the part of the paily 11/26/18 revealed the shifts. Review of the daily for 11/26/18 revealed NAs on the 7:00 PN	Nursing Staff Schedule for here was 1 RN on the 10 AM to 3:00 PM shift for the 10 g facility population. Further re were 4.5 NAs on the 3:00 ft for the entire skilled nursing staff ed the facility had posted 0 M to 3:00 PM shift and 6 NAs 1:00 PM shift for the entire ty population. Further review no resident census data 0 AM to 3:00 PM shift, 3:00 PM and 11:00 PM to 7:00 AM shift, Nursing Staff Schedule for here were 9 Nursing the 7:00 AM to 3:00 PM shift for rsing facility population. posted Report of Nursing Staff ed the facility had posted 8 M to 3:00 PM shift and 6 NAs 1:00 PM shift for the entire	F 732	,			
	11/27/18 revealed to Assistants (NAs) or and 6.5 NAs on the the entire skilled nu	Nursing Staff Schedule for here were 8 Nursing the 7:00 AM to 3:00 PM shift 3:00 PM to 11:00 PM shift for rsing facility population. posted Report of Nursing Staffed the facility had posted 7					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345503	B. WING _			11/3	30/2018
	ROVIDER OR SUPPLIER	ROWA		STREET ADDRESS, CITY, STATE, ZIP CO 4412 SOUTH MAIN STREET SALISBURY, NC 28147)DE		
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 732	NAs on the 7:00 PM on the 3:00 PM to 11 skilled nursing facility. Review of the Daily 11/28/18 revealed the Assistants (NAs) on for the entire skilled of 11/28/18 revealed the Assistants (NAs) on 5 NAs on the 3:00 PM entire skilled nursing. Review of the daily profession of the entire skilled nursing. Review of the daily profession of the 11:00 PM entire skilled nursing. Review of the daily profession of the entire skilled nursing. The entire skilled nursing. The entire skilled nursing. The entire skilled nursing. Further review of all nursing Staff sheets revealed no hand-wr printed staffing for Raddition, review of the ochanges to the poshift which would refind discharges.	to 3:00 PM shift and 6 NAs :00 PM shift for the entire / population. Nursing Staff Schedule for ere were 10 Nursing the 7:00 AM to 3:00 PM shift nursing facility population. osted Report of Nursing Staff of the facility had posted 9 to 3:00 PM shift the entire / population. Nursing Staff Schedule for ere were 9 Nursing the 7:00 AM to 3:00 PM shift, M to 11:00 PM shift, and 3 M to 7:00 AM shift for the facility population. osted Report of Nursing Staff of the facility had posted 7 to 3:00 PM shift, 6 NAs on PM shift, and 4 on the 11:00 for the entire skilled nursing 15 daily posted Report of (11/15/18 through 11/29/18, itten adjustments to the Ns, LPNs, and CNAs. In e recorded census revealed osted census from shift to lect admissions and	F 7	32			

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID INC	7. 0930-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345503	B. WING			11/	30/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				44	412 SOUTH MAIN STREET			
LIBERTY	COMMONS NSG & REH	ROWA		S	ALISBURY, NC 28147			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI	X	(EACH CORRECTIVE ACTION SHOULD E	3E	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI	ATE	DATE	
					DEFICIENCY)			
F 732	Continued From page	e 29	F	732				
	scheduler stated she	filled out the daily posted						
	Report of Nursing Sta	aff Monday through Friday						
	when she was at the	facility with the information						
	she got from the Dail	y Nursing Staff schedule						
		made and on the weekend						
		ble for posting and updating						
	_	ne Scheduler stated she did						
		ng on the Report of Nursing						
		nurse or one of the nurses						
	T	affing on the sheet related to						
		ustments in staffing. The						
		census number was not						
		rd shift to reflect the actual						
		the shift. The scheduler						
		nsus on the Report of						
		the 7:00 AM to 3:00 PM shift						
	· ·	mber down for the 3:00 PM						
		11:00 PM to 7:00 AM shift.						
	I .	ved the Report of Nursing						
	· ·	t to the Daily Nursing Staff						
		ered discrepancies for the						
		/18, 11/17/18, 11/18/18,						
		1/21/18, 11/24/18, and						
	11/25/18.							
	An interview was con	ducted with the Director of						
	I .	/30/18 at 1:34 PM. The						
		er expectation for the daily						
		sing Staff sheet to be						
	accurate and comple							
	accurate and comple	ю.						
	An interview was con	ducted with the						
		30/18 at 1:16 PM. The						
		it was his expectation for the						
	I .	of Nursing Staff sheet to be						
	accurate and comple	_						
	a second comple							
	I .		1		I .			