STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(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. §483.10(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. §483.10(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. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to get a resident out of bed when requested for 1 of 4 sampled residents, Resident # 6, reviewed for preferences. The findings included:	F 561	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has take nor will take the action set forth in this Plan of	3/18/19

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

Electronically Signed | 03/14/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 561	Continued From page 1 Resident #6 was admitted to the facility on 12/14/18 with a neuromuscular disease and Pneumonia. Her most recent Minimum Data Set Assessment dated 12/22/18 revealed she was cognitively intact and required extensive assistance of two staff members for transfer to and from the bed. Resident #6's Care Plan dated 12/19/18 revealed she required a mechanical lift for all transfers due to neuromuscular disease. During an interview with Resident #6 on 2/19/19 at 4:45pm she stated Nurse Aide #1 told her she could not get out of bed on Saturday, 2/16/19, and Sunday, 2/17/19, because they did not have enough staff. Resident #6 stated she required a mechanical lift to get out of bed and it required two staff members to transfer her to her motorized wheelchair. She stated they had left her in bed until this morning. Resident #6 stated it upset her that she could not get up, but she had just dealt with it. On 2/20/19 at 12:29 pm Nurse Aide #1 stated she worked Saturday, 2/16/19, and Sunday 2/17/19, and Resident #6 was on her assignment. Nurse Aide #1 stated Resident #6 had asked her on Saturday if she would get her up to her motorized wheelchair. She stated she told Resident #6 she could not get her out of bed because they were short-staffed, and she was told to keep everyone in bed by Nurse Aide #2. Nurse Aide #1 stated she told Nurse #1 she was not getting Resident #6 out of bed because they were short staffed. On 2/20/19 at 5:30 pm an interview with Nurse #1 revealed she was aware Resident #6 was not assisted out of bed on Saturday, 2/16/19, and	F 561	Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated F Tag 0561 Self-Determination Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 3/13/2019 the Director of Nursing discussed resident # 6 preferences on getting out of bed when she chooses. The Resident # 6 care plan was updated on 3/13/2019 by the Minimum Data Set Registered Nurse to reflect the resident choice of getting out of bed in the morning. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 3/13/2019 the Director of Nursing obtained 100% of current residents on 300 hall choice of time range of rising in the morning. On 3/13/2019 the Minimum Data Set Registered nurse care plan was updated to reflect the residents choices of rising in the morning or preference to stay in bed in morning. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 561	Continued From page 2 Sunday, 2/17/19. She stated there had not been enough staff to get everyone out of bed. On 2/19/19 at 2:02 pm the Director of Nursing (DON) stated she was not aware Resident #6 was not out of bed on Saturday, 2/16/19, and Sunday, 2/17/19. The DON stated when the facility was fully staffed there were 9 Nurse Aides on 7 am to 3 pm shift. She stated the staffing had been a challenge, but she had hired some Nurse Aide that were currently in Orientation. The DON stated when the new Nurse Aides were hired they would have enough Nurse Aides to staff appropriately. On 2/20/19 at 6:10 pm the Administrator stated it was a resident's right to be out of bed when they requested and they should be able to get up whenever they requested.	F 561	recur: On3/08/2019 the Director of Nursing began in servicing 100% of Registered nurses, Licensed practical nurses and Nurse aide□s fulltime, part-time, and as needed on Resident Self-determination and Resident Rights that resident have choice will be honored and staff will be available to assist residents with their needs this will be completed on 3/15/2019 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. On 3/19/19 The Director of Nursing/designee will began QA audit of resident interviews on honoring of their preferences on time of rising by asking 5 residents using QA tool Resident Self-determination Audit This audit will be completed weekly x4 then monthly x 3. QA Reports will be presented in the weekly QA meeting by the Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, Minimum Data Set Nurse, Social services director,Dietary Manager, Health information Manager, and Activities Director.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		3/25/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 677	Continued From page 3 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview the facility failed to provide assistance with toileting for 1 of 4 residents, Resident #2, reviewed for assistance with activities of daily living. Findings included: Resident #2 was admitted to the facility on 10/6/17 with diagnoses of heart failure, hypertension, depression, weakness, and slurred speech. A Minimum Data Set Assessment dated 1/18/19 revealed Resident #2 was cognitively intact and required extensive assistance of two staff members for toileting and transfers to and from the bed. The assessment also revealed she was frequently incontinent of bowel and bladder and the facility had not attempted a toileting program for Resident #2. During an interview with Resident #2 on 2/19/19 at 12:10 pm she stated she could not use the toilet without assistance because her legs were too weak. She stated she frequently waited 30 minutes to an hour for someone to answer her call light and assist with toileting. Resident #2 stated on 2/18/19, after she returned from an appointment around 1:00 pm, she waited for 30 minutes for someone to answer her call light for toileting. She stated she tried not to wet herself but had to use her incontinence brief since no one came. She stated waiting a long time for assistance with toileting happened so often she	F 677	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has take nor will take the action set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated F Tag 677 ADL Care Provided for Dependent Residents Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 3-13-2019 the Director of Nursing met with resident # 2 to discuss her care needs and assessment of her toileting needs. Resident's # 2 care plan was updated on 3-13-2019 by the Minimum Data Set Registered Nurse to reflect the resident choice and with toileting intervention. Address how the facility will identify other residents having the potential to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 677	Continued From page 4 was accustomed to waiting. An interview with Resident #2's Family Member on 2/20/19 at 1:05 pm was conducted. He stated he brought Resident #2 back to her room after her appointment on 2/18/19 and left at 1:00 pm. He stated he had not stayed to see if they answered Resident #2's call light. The Family Member stated he had been at the facility many times and had to track down a Nurse Aide because Resident #2 had waited 30 minutes or more for assistance. During an interview with Nurse Aide #2 on 2/20/19 at 2:00 pm she stated Resident #2 arrived back to the facility from her appointment around 1:00 pm on 2/18/19. She stated she was assisting residents that required assistance with feeding at that time and was tied up in a room. She stated it could have been 30 minutes or longer before she was able to answer Resident #2's call light. Nurse Aide #2 stated there was not enough staff to answer call lights during meals. An interview on 2/18/19 at 3:40 pm with Nurse Aide #3 revealed Resident #2 was on her usual assignment. She stated Resident #2 had incontinence but did have continent episodes. Nurse Aide #3 stated it is not possible to get care rounds done every 2 hours and assist residents to the bathroom because they are short staffed. She stated Resident #2 did have to wait at least 30 minutes because she required two staff to transfer her to the toilet. During an interview with the Director of Nursing (DON) on 2/19/19 at 2:02 pm she stated she was not aware the staff were not able to complete personal care as they should. She stated they	F 677	affected by the same deficient practice: On 3/21/2019 the Director of Nursing and Minimum data set registered nurse reviewed 100% of current residents on all halls for toileting needs. On 3/21/2019 the Minimum Data Set Registered nurse reviewed and updated as appropriate resident ADL care plan to reflect the residents toileting needs. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/08/2019 the Director of Nursing began in-servicing 100% of Registered nurses, Licensed practical nurses and Nurse Aides fulltime, part-time and as needed on ADLs provision for dependent residents that included toileting as per residents individualized care plan. This will be completed by 3/15/2019. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. On 3/25/19 The Director of Nursing/designee will begin QA audit of 6 random resident (3) interviews with oriented residents (3) observations of cogitatively impaired residents for completion of their ADL care needs / toileting needs by the staff. This audit will be completed weekly x4 then monthly x 3. QA audits will be presented in the weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 677	Continued From page 5 had been understaffed, mostly on 3:00 pm to 11:00 pm and 11:00 pm to 7:00 am shifts. The DON stated she was not aware residents had waited 30 minutes to an hour to use the toilet. The DON stated she had recently hired several Nurse Aides and they would be through orientation soon and the facility would be staffed on all shifts. An interview with the Administrator on 2/20/19 at 6:10 pm revealed he expected the staff to assist with toileting and answer call lights timely. He stated he expected the nursing department to be staffed to provide man power to ensure all residents' needs are met.	F 677	QA meeting by the Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, Minimum Data Set Nurse, social services director, Dietary Manager, Health information Manager, and Activities Director.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family and staff interviews, and interviews with the physician and the orthopedic surgeon, the facility failed to have an effective plan in place to prevent recurrent falls of a cognitively impaired resident who had a fall with injury before admission. The resident fell three times in the facility within 2 weeks after admission and had a dislocated hip after the second fall. This is evident in 1 of 3 residents reviewed for falls. (Resident #1)	F 689	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has take nor will take the action set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged	3/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 689	Continued From page 6 Findings included: Resident #1 was admitted to the facility on 1/21/19 with diagnoses of fall with fractured right femur, right artificial joint, and dementia. A Care Plan dated 1/22/19 for Resident #1 stated she had an actual fall before admission with risk for further falls due to communication and comprehension and unsteady gait. The goal of the care plan stated the resident would resume usual activities without further incident. Interventions in place were fall mats beside of bed, nonskid socks on resident, frequently used objects in reach, keep call light in reach, and anticipate needs. Review of an admission Minimum Data Set (MDS) assessment dated 2/1/19 revealed she was severely cognitively impaired and required extensive assistance with all activities of daily living, such as, moving about in bed, transferring to and from the bed, toileting, and eating. The assessment also revealed Resident #1 required extensive assistance of two staff members to walk. A review of a Falls Incident Report completed by Nurse #1 dated 1/22/19 at 7:25 am revealed Resident #1 had a fall and was found sitting in the doorway of her room on her buttocks. The report stated Resident #1 stated, "I fell", but was unable to give details of the fall. She was assessed for injuries and none were found; and was assisted to her wheelchair and placed at the nurse's station for closer observation. The report also revealed the Responsible Party and the physician were notified of the fall.	F 689	deficiencies cited have been or will be corrected by the date or dates indicated F Tag 689 Free of Accident Hazards/Supervision/Devices Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 2/18/2019 the Director of Nursing and care plan team meet with resident's daughter to discuss resident's care needs and it was agreed that staff would offer for the resident to get up in reclining chair when restless and offer activity/busy box. Additionally, on 2/28/2019 the Director of Nursing requested the medical provider review resident medications with daughter as to her previous home medication regimen and changes were made. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 3/13/2019 the Director of Nursing reviewed 100% of residents that had fallen in the past fourteen days to ensure they have an effective plan to reduce risk of repeat falls in residents that have cognitive impairment. During review ,three of the residents had a repeat fall in a two week period. On 3/13/2019 the Minimum Data Set Registered nurse reviewed fall care plans for effective fall intervention. Address what measures will be put into	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 689	Continued From page 7 A review of Nurse's Note, written by Nurse #1, dated 1/22/19 at 7:34 am revealed Nurse Aide (NA) #2 walked past Resident #1's room door and found her sitting on the floor on her buttocks with bilateral legs drawn up. Resident #1 stated "I fell on the floor" but was not able to give any details. Resident #1 was assessed and no injuries were found. The note also revealed Nurse #1 notified the Family Member and the Physician of the incident. An interview with Nurse #1 on 2/18/19 at 2:20 pm revealed she was called to Resident #1's room on 1/22/19 by NA #2 when Resident #1 fell on 1/22/19 at 7:34 am. She stated the fall was unwitnessed and Resident #1 was in the bed before the fall and the fall mats were in place at the time of the fall. Resident #1 was not able to tell them what had happened. She stated she assessed her for injuries and then put her in the wheelchair, so she could watch her. She stated she did a lot of one on one with Resident #1 to keep her from falling. Nurse #1 stated Resident #1 did not have any safety awareness. An interview on 2/18/19 at 2:42 pm with NA #2 revealed she was the Nurse Aide that found Resident #1 sitting on the floor in her room on 1/22/19 at 7:34 am. She stated Resident #1 did not appear to be in pain and Nurse #1 assessed her for injuries before they moved her to the wheelchair. She stated the resident did not have non-skid socks on because she had taken them off but her fall mats were in place. Nurse Aide #2 stated the resident was moved to the nurse's station in her wheelchair. She also stated they did not have enough staff to sit with Resident #1, she stated they were usually only 3 Nurse Aides	F 689	place or systemic changes made to ensure that the deficient practice will not recur: On 3/8/2019 the Director of Nursing began in-services for 100% of Registered nurses, Licensed practical nurses, and Nurse aides full-time, part-time, and as needed on Fall Prevention and Fall Intervention. This was completed on 3-17-2019. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. On 3/19/19 the Director of Nursing will begin QA audit of 100% of residents with falls and cognitive impairment using the QA audit tool Accidents and Supervision. This audit will be completed weekly x4 then monthly x 3. QA Reports will be presented in the weekly QA meeting by the Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, Minimum Data Set Nurse, Social services director,Dietary Manager, Health information Manager,and Activities Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 689	Continued From page 8	F 689		

on the Skilled Unit. NA #2 stated she found Resident #1 on the floor shortly after she came on duty and she was making her first round.

A review of the Falls Incident Report completed by Nurse #2 for a fall on 1/24/19 at 5:40 am. The report stated Resident #1 was heard yelling at the nurse's station and was observed lying on her left side on the floor. Nurse #2 wrote she observed the right knee was turned in and right hip was swollen. Nurse #2 wrote Resident #1 started screaming when she touched her right leg and she did not attempt range of motion on the leg or move Resident #1. Nurse #2 called the Nurse Practitioner and received orders to sent Resident #1 to the hospital for evaluation. Interventions added to Resident #1's Care Plan were sent to Emergency Room for evaluation; reinforce safety reminders; observe for possible side effects of medication; and physician to review medications.

A review of the nurse's note written by Nurse #2 on 1/24/19 at 5:40 am revealed she heard Resident #1 yelling at the nurse's station, when she arrived at the nurse's station Resident #1 was lying on her left side on the floor. The note further revealed Resident #1's right knee was turned inward, and her right hip was swollen. Nurse #2 documented she did not move Resident #1 and called the physician on call for orders to send to the hospital for evaluation. The note also revealed she notified the Family Member of what had happened and Resident #1 was being sent to the hospital for evaluation.

During an interview with Nurse #2 on 2/20/19 at 5:15 pm she stated she was Resident #1's nurse on 1/24/19 when she fell at 5:40 am. Nurse #2 stated Resident #1 was brought to the nurse's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 689	Continued From page 9	F 689		

station that night in a reclining wheelchair to watch her more closely. Nurse #2 stated she had the 200 hall and the 400 Hall on 1/24/19 and she was on the 400 Hall on the other side of the facility when Resident #1 fell from the reclining wheelchair. She stated she had gone to the 400 Hall to pass meds and Resident #1 was asleep in her reclining wheelchair when she left, she stated she had left her a few minutes before. Nurse #2 stated she was the last staff to see Resident #1 before she fell. She stated they had only 3 Nurse Aides for the whole building that night, there should have been 4, and they could not monitor Resident #1 closely enough to keep her safe from falls. She stated at the time of the fall the Nurse Aides were all in rooms assisting other residents and the other nurse was on the 300 Hall. Nurse #2 stated she heard Resident #1 yelling and came back to the Nurse's Station and found her on the floor. Nurse #2 stated she did not move Resident #1 because her leg was turned in and she was in a lot of pain. She stated she called the physician on call and received orders to send her to the hospital, and then she called the Family Member to report what had happened.

A review of the hospital Discharge Summary dated 1/25/19 revealed Resident #1 was taken to the Operating Room after reduction of the right hip hemiarthroplasty was unsuccessful in the Emergency Room. Resident #1 was taken to the Operating Room and underwent a closed reduction and the right hip was aligned. After recovering the anesthesia Resident #1 was transferred back to the facility on 1/25/19.

A review of the Fall Incident Report, written by Nurse #3, dated 2/6/19 at 7:45 am revealed Resident #1 was found sitting on the fall mat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 689	Continued From page 10	F 689		

beside her bed, leaning on her left side with her immobilizer in place to her right leg. Resident #1 was assessed for injuries and assisted back to bed and her bed was in lowest position. Resident #1 was not able to state what had happened. Nurse #3 stated in the report she notified the physician on call and obtained an x-ray of the right hip to ensure the hip did not dislocate.

A Nurse's Note dated 2/6/19 at 2:06 pm revealed Nurse #3 had notified the physician on-call and the Family Member of the fall and obtained new orders for an x-ray of Resident #1's right hip.

An interview with Nurse #3 on 2/19/19 at 9:00 am revealed she was working when Resident #1 fell on 2/6/19 at 7:45 am. Nurse #3 stated she was on the 300 hall and a Medication Aide was working on Resident #1's hall when she fell. Nurse #3 stated when she got to the 200 hall Resident #1 was lying on her left side on the floor and her immobilizer was in place to her right leg. She stated she spoke with the Family Member when she came to the facility that morning and told her how Resident #1 was found and she obtained an order for an x-ray of the right hip. Nurse #3 stated the right hip x-ray was negative for new fracture or dislocation. Nurse #3 stated about a week later she was working on the 300 hall and a Medication Aide was on the 200 Hall, and the Family Member came to her and told her Resident #1 needed to be sent out to the hospital because her right hip was dislocated. Nurse #3 stated no one had told her Resident #1 needed to be assessed. Nurse #3 stated with a Medication Aide on the 200 hall and her having the 300 Hall, she could not take care of that many residents. She stated she had spoken with the Director of Nursing last week and told her she could not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 689	Continued From page 11	F 689		

manage that many residents.

An interview with Nurse Aide #2 on 2/18/19 at 2:42 pm indicated she had been getting residents up for breakfast when she walked by Resident #1's room and saw her sitting on the floor mat beside her bed. She stated her immobilizer was in place but she did not have nonskid socks on, she stated Resident #1 would take her nonskid socks off. Nurse Aide #2 stated Resident #1's bed was in the lowest position. Nurse Aide #2 further revealed Resident #1 did not appear to be in any pain.

During an interview with the Medication Aide on 2/18/19 at 3:14 pm she stated she worked the 200 Hall when Resident #1 fell on 2/6/19 at 7:45 am. She stated Resident #1 did not appear to be in pain when she was found on the floor in her room on the fall mat beside her bed. She stated Nurse #3 assessed Resident #1 for injuries and they assisted Resident #1 back to bed. She stated Resident #1 did not grimace or cry out when they moved her back to the bed. She stated she had not been to Resident #1's room that morning and she had arrived at 7:00 am.

Review of Nurse's Note dated 2/13/19 at 12:56 pm revealed the Family Member reported to Nurse #4 that Resident #1's right foot looked like it was turned in and requested an x-ray. Nurse #4 obtained an order for a right hip x-ray.
A review of Nurse's Note dated 2/14/19 at 12:25 am revealed Nurse #5 received an x-ray report which stated Resident #1 had a dislocated right hip prosthesis.

Review of Nurse's Note dated 2/14/19 at 2:15 am revealed Nurse #5 spoke with the Physician and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 689	Continued From page 12	F 689		

reported the right hip x-ray showed the right hip was dislocated. Orders were received to call the surgeon in the morning since Resident #1 was resting quietly and had no signs of pain.

A Nurse's Note dated 2/14/19 at 6:11 am revealed Nurse #5 spoke with Resident #1's Family Member and reported the results of the right hip x-ray, the right hip was dislocated. The Family Member told Nurse #5 that she would call the Orthopedic Surgeon and see if they can do surgery to repair today.

Review of a Nurse's Note dated 2/18/19 at 8:43 am revealed Resident #1 was sent to the hospital by ambulance on 2/15/19 and she was admitted.

Review of the Discharge Summary from the hospital dated 2/18/19 revealed Resident #1 had a removal of the right hip prosthesis on 2/17/19 and she was discharged from the hospital to the facility on 2/18/18.

An observation of Resident #1 on 2/19/19 at 6:20 am revealed she was resting quietly in bed with a sitter at the bedside.

An observation of Resident #1 on 2/20/19 at 12:15 pm revealed she was resting quietly in bed with a sitter at bedside.

An interview with Resident #1's Family Member on 2/19/19 at 8:48 am revealed two family members were staying with Resident #1 from 8:00 am until 7:00 pm and she hired a sitter to sit with her from 7:00 pm until 12:00 am to keep Resident #1 from falling. The Family Member stated they had been sitting with her since the first fall on 1/22/19. The Family Member stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 689	Continued From page 13	F 689		

all she expected was for someone to check on Resident #1. The Family Member stated she felt the facility was very understaffed with Nurse Aides and that had been the reason her mother fell on 1/24/19 and dislocated her hip the first time. She stated there had only been three Nurse Aides that night to care for all the residents.

During a phone interview with the Physician on 2/19/19 at 3:15 pm she stated Resident #1's right hip dislocated because of her age and co-morbidities. She stated due to her age her tendons would likely be looser around the joints and it would cause her to dislocate. She stated she felt Resident #1 should have had a hip replacement when she fell before coming to the facility and she would have had a better outcome. The Physician stated it was not necessarily the falls that cause Resident #1's dislocation, and she could have dislocated by just being turned in the bed. The Physician stated she would not be surprised if Resident #1's right hip dislocated again because of her cognition and behaviors.

A phone interview with the Orthopedic Surgeon on 2/20/19 at 9:00 am revealed he felt it would be difficult to say that Resident #1's right hip dislocated because of a fall because she had so many other co-morbidities. He stated he did know when she had surgery before coming to the facility that Resident #1's hip was in place because he had checked her range of motion to the hip before she left the operating room and the hip was in place. He stated if it had not been in place it would have dislocated with the examination. The Orthopedic Surgeon stated Resident #1's right hip should not have dislocated with her being combative, he stated she would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 689	Continued From page 14	F 689		

have to be extremely strong to dislocate her hip.

During an interview with the Director of Nursing (DON) on 2/19/19 at 2:02 pm she indicated the staffing for Nurse Aides had been very low because she was not getting any applications until recently. She stated she had hired several Nurse Aides but they were still in orientation. She stated on 1/24/19 at 5:40 am when Resident #1 fell there were 3 Nurse Aides on duty on 11:00pm to 7:00am shift, and she indicated there should be 4 Nurse Aides. She further indicated on 2/6/19 at 7:45 am when the resident fell there were 7 Nurse Aides working on the 7:00am to 3:00pm shift and there should have been 9. The DON stated the facility had a clinical meeting each morning and the falls were discussed at the meeting. She stated the MDS Coordinator updates the care plans for each resident with falls. The DON stated Resident #1 had poor cognition and poor safety awareness. She also stated Resident #1 had behaviors of resisting care when she was bathed and provided incontinence care; and she hit, fought, and cursed staff. She stated they had put interventions, such as, anticipating her needs, encouraging her to wear nonskid socks, and observing for possible side effects of medication that may affect balance on admission. She further stated they had added fall mats and bed in lowest position after the fall on 1/24/19. After the fall on 2/6/19 the DON indicated the facility had obtained orders for a right hip x-ray to ensure the hip was not dislocated.

On 2/20/19 at 5:00 pm with the MDS Coordinator she stated the facility meets every morning for a clinical meeting and falls are discussed in that meeting. She stated she updated the care plans

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 689	Continued From page 15 with the interventions that are put into place from any falls and if the interventions in place are working. The MDS Coordinator indicated they had discussed Resident #1 after each fall. She further indicated on 1/22/19 the facility had put an interim care plan into place and interventions were anticipate needs as much as possible; educated resident about safety reminders; encourage to wear non-skid socks when not wearing shoes; keep frequently used objects within reach; and observe for side effects of medications. The MDS Coordinator stated on 1/24/19 the facility added fall mats; keep call light in reach; reinforce safety reminders frequently; and sent to the Emergency Room for evaluation. The MDS Coordinator stated on the 2/6/19 the intervention was the x-ray to determine if Resident #1's hip had dislocated. On 2/20/19 at 6:10 pm an interview with the Administrator revealed he expected staff to take measures to ensure residents were safe from falls and accidents.	F 689		
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		3/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 725	Continued From page 16 §483.35(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. §483.35(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. This REQUIREMENT is not met as evidenced by: Based on record review; staff, resident, and family member; and physician interviews the facility failed to provide enough nursing staff to ensure assistance with activities of daily living, such as, incontinence care for 1 of 4 residents reviewed; failed to honor resident requests when they wanted to get out of bed for 1 of 4 residents reviewed for preferences; and failed to protect 1 of 4 residents, Resident #1, from accidents. Resident #1 fell on 1/24/19 and was sent to the hospital for evaluation and treatment. Resident #1 was diagnosed with a dislocated right hip. The findings included: This tag is cross-referenced to: 1a. F-677: Based on record review, staff and resident interview the facility failed to provide assistance with toileting for 1 of 4 residents, Resident #2, reviewed for assistance with activities of daily living.	F 725	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has take nor will take the action set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated F Tag 725 Sufficient Nursing Staff Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 3/13/2019 the Administrator and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 725	Continued From page 17 1b. F-561: Based on record review and staff and resident interviews the facility failed to get a resident out of bed when requested for 1 of 4 sampled residents, Resident # 6, reviewed for preferences. 1c. F-689 Based on record review, staff interviews, interviews with the physician and the orthopedic surgeon the facility failed to provide adequate supervision to prevent falls that resulted in a hip dislocation in 1 of 3 residents, Resident #1, reviewed for accidents. Resident #1 had a right hip hemiarthroplasty on 1/17/19 before she admitted to the facility. She fell on 1/24/19 and sustained a right hip dislocation and was sent back to the hospital for a closed right hip reduction. Resident #1 had a third dislocation without a fall on 2/15/19 and was discharged to the hospital and on 2/17/19 she had surgery to remove her right hip prothesis. An interview on 2/18/19 at 3:40 pm with Nurse Aide #3 revealed it was not possible for her to provide care rounds every 2 hours and assist residents to the bathroom because she had too many residents due to low staffing. During an interview on 2/18/19 at 3:20 pm with Nurse Aide #7 she stated she usually worked 7:00 am to 3:00 pm shift but she did work overtime on 3:00 pm to 11:00 pm shift. She stated they were very short of staff and the residents suffered. She stated they usually only get two rounds in a shift. She stated she tried to get back to the residents that were more incontinent between rounds. She stated they worked with 4 Nurse Aides for the whole building 5 out of 7 days a week. She stated the staff were exhausted and they called out.	F 725	Director of Nursing discussed staffing needs for sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain highest practical physical, mental, and psychosocial well-being as determined by resident assessments and individualized plans of care and considering the number, acuity and diagnosis of the facility□s resident population in accordance with their facility assessment required. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 3/14/2019 the Administrator and Director of Nursing reviewed the facility assessment and developed a staffing plan to include on call schedule and agency staff availability to ensure that the facility provides sufficient nursing staff, to ensure assistance with activities of daily living, honoring resident requests to arise per preference and follow interventions to reduce risk of falls in cognitively impaired residents. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/14/2019 the Administrator and Director of Nursing began in servicing 100% of Registered nurses, Licensed practical nurses and Nurse aides fulltime, part-time, and as needed on the staffing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 725	Continued From page 18 An interview on 2/18/19 at 3:40 pm with Nurse Aide #8 revealed she worked the 3:00 pm to 11:00 pm shift. She stated they were so short on staff she can assist with incontinence care like they should be, she stated she usually only got two rounds done a shift. She stated the residents also waited a long time for their lights to be answered. Nurse Aide #3 was interviewed on 2/18/19 at 3:42 pm and she stated she usually worked the 7:00 am to 3:00 pm. She stated it was not possible to get more than one round and answer call lights with the low staffing. She stated the incontinent residents were wet longer than they should be and the residents that were not incontinent were waiting at least 30 minutes on staff to assist them. An interview with Nurse #5 on 2/19/19 at 7:25 am revealed the staffing on the 11:00 pm to 7:00 am shift was inadequate. She stated they were usually only able to get two care rounds complete and the care rounds should be every 2 hours or 4 times a shift. During an interview with Nurse #6 on 2/19/19 at 7:37 am she stated the staffing of Nurse Aides was insufficient. She stated they usually got two care rounds done each shift because there were so many residents to each Nurse Aide. She stated there were usually only two Nurse Aides on the Skilled Unit on 11:00 pm to 7:00 am shift. During an interview with Nurse #1 on 2/19/19 at 2:20 pm she stated the facility was so understaffed with Nurse Aides that it made it hard for the nurses to complete their work because they tried to help the Nurse Aides. She indicated	F 725	plan, on call schedule, staffing agency, and staffing agency availability. On 3-15-2019 the Administrator and Director of Nursing meet in special a resident council meeting to share staffing plan to ensure that the facility provides sufficient nursing staff to ensure assistance with activities of daily living , honoring resident requests to arise per preference and follow interventions to reduce risk of falls in cognitively impaired residents. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. On 3/19/19 the Administrator and The Director of Nursing will began QA audit for sufficient staffing and plan implementation and that sufficient number of Registered nurses, licensed practical nurse, and nursing assistants are in the building on a 24 hr. basis to provide nursing care to all residents in accordance with the resident care plan. The Administrator and Director of Nursing will meet with the resident council weekly to discuss staffing and get feedback from the residents. This audit will be completed weekly x4 then monthly x3. QA Reports will be presented in the weekly QA meeting by the Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN STREET SALISBURY, NC 28147

(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 725	Continued From page 19 there were usually 3 Nurse Aides for the skilled unit (100 Hall, 200 Hall, and 300 Hall) for the 7:00 am to 3:00 pm shift and there should be 5. During an interview with the Director of Nursing (DON) on 2/19/19 at 2:02 pm she stated she was not aware the staff were not able to complete personal care, including toileting, as they should. She stated they had been understaffed, mostly on 3:00 pm to 11:00 pm and 11:00 pm to 7:00 am shifts. The DON stated she was aware the Nurse Aides were giving residents bed baths instead of showers, but she was not aware residents had waited 30 minutes to an hour to use the toilet. The DON stated she had recently hired several Nurse Aides and they would be through orientation soon and the facility would be staffed on all shifts. The DON stated when she was fully staffed there were 9 Nurse Aides on 7:00 am to 3:00 pm shift; 6-7 Nurse Aides on the 3:00 pm to 11:00 pm shift; and 4 Nurse Aides on the 11:00 pm to 7:00 am shift. An interview with the Administrator on 2/20/19 at 6:10 pm revealed he expected the staff to assist with toileting and answer call lights timely. He stated he expected the nursing department to be staffed to provide man power to ensure all residents needs were met.	F 725	Minimum Data Set Nurse, Social services director, Dietary Manager, Health information Manager, and Activities Director.	