PRINTED: 11/26/2019 FORM APPROVED OMB NO. 0938-0391

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 7 | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---------------------|---|----------------------------|--|
| | | 345503 | B. WING _ | | 10/24/2019 | |
| | ROVIDER OR SUPPLIER | IAB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE COMPLETION | |
| E 000 | Initial Comments | | E 0 | 00 | | |
| F 636 | conducted on 10/21 found in compliance 483.73, Emergency #4V7G11. | ecertification survey was -24/2019. The facility was with the requirement CFR Preparedness. Event ID | F 6 | 36 | 11/19/19 | |
| SS=F | CFR(s): 483.20(b)(1 | <u> </u> | | 30 | 11/19/19 | |
| | a comprehensive, a | ssessment nduct initially and periodically ccurate, standardized ment of each resident's | | | | |
| | §483.20(b)(1) Resident A facility must make assessment of a resignals, life history and resident assessment by CMS. The assessment by CMS. The assessment following: (i) Identification and (ii) Customary routind (iii) Cognitive pattern (iv) Communication. (v) Vision. (vi) Mood and behave (vii) Psychological we (viii) Physical function (ix) Continence. | ident's needs, strengths, d preferences, using the t instrument (RAI) specified sment must include at least demographic information le. ins. vior patterns. rell-being. oning and structural problems. is and health conditions. cional status. | | | | |
| ADODATODY | DIDECTOR'S OR BROWNER | VSLIPPLIER REPRESENTATIVE'S SIGNATU | DE | TITI E | (X6) DATE | |

11/14/2019

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|--|--|---|----------------------------|--|
| | | 345503 | B. WING | | , | 10/24/2019 | |
| | ROVIDER OR SUPPLIER COMMONS NSG & REI | HAB CTR OF ROWAN COUNTY | STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 636 | regarding the addition the care areas to the Minimum Data S (xviii) Documentation assessment. The aninclude direct obserwith the resident, as licensed and nonlicomembers on all shift §483.20(b)(2) When timeframes prescribed through (iii) of this sprescribed in §413.3 apply to CAHs. (i) Within 14 calend excluding readmiss significant change in mental condition. (For it is a condition of the readmission of a completion of a condition of a | aning. In of summary information In onal assessment performed iggered by the completion of In of participation in In seessment process must Invation and communication In well as communication with It is well as communication with I | F 63 | The statements made on this Correction are not an admission not constitute an agreement walleged deficiencies. To remair compliance with all Federal an Regulations the facility has tak take the actions set forth in this Correction. The Plan of Correctonstitutes the facility's allegated | on to and do ith the n in d State ten or will s Plan of ction | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | 1, , | E SURVEY IPLETED |
|--------------------------|---|---|--|---|---|----------------------------|
| | | 345503 | B. WING _ | B. WING | | 0/24/2019 |
| | ROVIDER OR SUPPLIER | AB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | | OULD BE | (X5) COMPLETION DATE |
| F 636 | 10/17/12 and readmidiagnoses were De Hypertension, Chron Osteoarthritis. A review on 10/23/19 record revealed she Annual Minimum Datwith an ARD (Assess 9/9/19. The assess transmitted. An interview with the 10:48 am revealed s responsibility of Direcontinued as of the Nof 2019. She stated assistance with the Notime and had fallen becompleted or transmided there had also software program and Consultant had instructomplete or transmit notified her due to a An interview with the 5:55 pm revealed his Minimum Data Set Acompleted and trans the direction of the R MDS Nurse had bee Nursing for 6 to 8 were assisted. | admitted to the facility on ted on 8/17/18. Her mentia, Heart Failure, ic Kidney Disease, and Of Resident #8's medical was scheduled to have an ta Set (MDS) Assessment sment Reference Date) of nent was not completed or MDS Nurse on 10/24/19 at he had taken over the ctor of Nursing position and MDS Nurse in June and July she did not have any MDS Assessments during this behind and had not itted Resident #8's Annual th the ARD of 9/9/19. She to been an issue with the MDS d the corporate MDS cucted her by email to not MDS Assessments until she | F | compliance such that all alleged deficiencies cited have been or v corrected by the date or dates in F 636 COMPREHENSIVE ASSESSMENT & TIMING Corrective Action: Resident #8. Annual Comprehent Assessment, Assessment Refere Date (ARD) 9/9/2019. Completed Submitted and Accepted on 10/2 the State Quality Improvement E System QIES system Resident #4. Annual Comprehent Assessment, Assessment Refere Date (ARD) 9/4/2019. Completed Submitted and Accepted on 10/2 the State QIES system Resident #230. Admission Comprehensive Assessment, As Reference Date (ARD) 10/7/2019. Completed, Submitted and Accepted 10/22/2019 to the State QIES system Resident #80. Admission Comprehensive Assessment Refere Date (ARD) 7/1/2019. Completed Submitted and Accepted on 8/13 the State QIES system Resident #5. Annual Comprehent Assessment, Assessment Refere Date (ARD) 09/05/2019. Completed Submitted and Accepted on 10/2 the State QIES system Resident #129. Admission Comprehensive Assessment, As Reference Date (ARD) 9/12/2019. Completed, Submitted and Accepted on 10/2 the State QIES system Resident #129. Admission Comprehensive Assessment, As Reference Date (ARD) 9/12/2019. Completed, Submitted and Accepted on 10/2 the State QIES system Resident #179. Significant Change Comprehensive Assessment. As Reference Date (ARD) 9/12/2019. Completed, Submitted and Accepted on 10/2 the State QIES system Resident #179. Significant Change Comprehensive Assessment. As Reference Date (ARD) 9/12/2019. | dicated. E asive ence d, 29/2019 to evaluation asive ence d, 24/2019 to sessment 9. pted on stem ehensive ence d, 24/2019 to asive ence d, 24/2019 to asive ence ence d, 24/2019 to asive ence ence d, 24/2019 to asive ence ence eted, 24/2019 to asive ence eted, 24/2019 to | |

| 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 _ | | | 10/24/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP C | ODE | |
| LIDEDTY | COMMONG NOC 8 DELL | AR OTR OF ROWAN COUNTY | | 4412 SOUTH MAIN STREET | | |
| LIBERTY | COMMONS NSG & REHA | AB CTR OF ROWAN COUNTY | | SALISBURY, NC 28147 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY) | | | (X5) COMPLETION DATE |
| F 636 | F 636 Continued From page 3 Minimum Data Sets. The Administrator also stated he had received an email from the | | F 6 | Reference Date (ARD) 10/ Completed, Submitted and | Accepted on | |
| | · · | indicated the facility should smit MDS Assessments with or later until notified | | 11/15/2019 to the State QII Resident #38. Admission C Assessment, Assessment Date (ARD) 7/12/2019. Co Submitted and Accepted of | Comprehensiv Reference mpleted, | е |
| | with diagnoses of Hy Hemiplegia, Anxiety, | and Depression. | | the State QIES system Resident #36. Admission C Assessment, Assessment Date (ARD) 7/16/2019. Co | Reference mpleted, | |
| | 10/23/19 revealed ar | #8's medical record on Annual MDS Assessment 9 had not been complete or | | Submitted and Accepted of the State QIES system Identification of other resid | | |
| | MDS Nurse stated sharesponsibilities of ME Nursing in June and did not have any ass fallen behind in the MMDS Nurse stated the with the MDS software corporate MDS Consemail to not complete Assessments until sharesponsible software problem. | sultant had instructed her by e or transmit MDS he notified her due to a | | be involved with this practice. All current residents with C Minimum Data Set (MDS) and the alleged practice. On 11 through 11/14/2019 an auditorial completed by the MDS Nutrong to ensure that the facility has comprehensive, accurate, reproducible assessment of resident's functional capact 84 current residents, 8 nunresidents did not have their comprehensive assessment. | comprehensive assessments be affected by 1/11/2019 dit was rse consultant ad conducted standardized of each eity. Out of the other of rest completed | t a |
| | 5:55 pm revealed his Minimum Data Set As completed and transi the direction of the R MDS Nurse had been Nursing for 6 to 8 we and had not been ab | ssessments should be mitted in a timely manner per Al manual. He stated the n the interim Director of eks in June and July 2019 le to keep up with the The Administrator also | | within 14 calendar days aft excluding readmission in w significant change in the re physical or mental conditio number of resident did not Annual comprehensive ass completed by timeframes. assessments were comple 11/15/2019. Systemic Changes: | which there is resident's on and 4 have their sessments This | |

| B. WING | STREET ADDRESS, CITY, STATE, 2 | 10/24/2019 |
|---|--|--|
| COUNTY | | ZID CODE |
| COUNTY | 4442 COUTH MAIN STREET | LIP CODE |
| 000111 | 4412 SOUTH MAIN STREET | |
| | SALISBURY, NC 28147 | |
| SY FULL PRE | FIX (EACH CORRECTIVE G CROSS-REFERENCED | |
| ĺ | - 636 | |
| should ents with | On 11/12/2019 The Reg (RN) Minimum Data Se Coordinator, Licensed F (LPN) Support nurses a Interdisciplinary team m | t (MDS) Practical Nurse any other nember that |
| | participates in the MDS process was in serviced MDS nurse consultant. The education focused | d /educated by the |
| been A rovement ion and dated | must conduct initially ar comprehensive, accura reproducible assessme resident's functional cal OBRA-required compre assessments include the both the MDS and the Care planning of | te, standardized nt of each pacity. shensive e completion of CAA process, as |
| 22/19 .RD of | assessments are comp admission, annually, an significant change in a has occurred or a signif | leted upon Id when a resident's status ricant correction to |
| al MDS esident The sible for se 019 been I. The an issue d her by b a | a prior comprehensive a required. They consist of Assessment, Annual Assignificant Change in Significant Comprehensive Assess Admission assessment comprehensive assessment comprehensive assessment are turning resident that completed by the end of the date of admission to as day 1 if: this is the region this facility, OR the regarding admitted to this facility and discharged return not a resident has been admitted. | of: Admission assessment, and tatus Assessment Correction to Prior ament (SCPA). The ais a ment for a new ane circumstances, at must be af day 14, counting at the nursing home assident's first time assident has been and was anticipated, OR the assessment (SCPA). The assessment (SCPA). The ais a ment for a new and exit for a new and and and and assessment (SCPA). The counting are assessment (SCPA). The counting ar |
| | ent #230 State of the sister o | PROVIDER'S PLAN (EACH CORRECTIVE RMATION) F 636 F 636 On 11/12/2019 The Reg (RN) Minimum Data Se Coordinator, Licensed F (LPN) Support nurses a Interdisciplinary team m participates in the MDS process was in serviced MDS nurse consultant. The education focused must conduct initially ar comprehensive, accura reproducible assessme resident's functional cap OBRA-required compre assessments include th both the MDS and the 0 well as care planning. O well as care planning. O assessments are comp admission, annually, an significant change in a i has occurred or a signif a prior comprehensive a required. They consist of Assessment, Annual As Significant Change in S Gesident The Significant Change in S Gesident Comprehensive Assess Admission assessment Comprehensive assessinent of the date of admission to as day 1 if: this is the re admitted to this facility, discharged return not a |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | ' ' | (X3) DATE SURVEY COMPLETED | |
|--------------------------|-------------------------------|--|--|-----|--|-------------------------------|----------------------------|
| | | 345503 | B. WING _ | | | 10/ | 24/2019 |
| NAME OF PI | ROVIDER OR SUPPLIER | | <u> </u> | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 10/ | 24/2013 |
| | | | | | 412 SOUTH MAIN STREET | | |
| LIBERTY | COMMONS NSG & REHA | AB CTR OF ROWAN COUNTY | | | ALISBURY, NC 28147 | | |
| ()(1) ID | CLIMMADV CT | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (VE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | X | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 636 | Continued From page | - 5 | F | 636 | | | |
| | · - | ssessments should be | ', | 550 | and did not roturn within 20 days of | | |
| | | mitted in a timely manner per | | | and did not return within 30 days of discharge. The Annual assessment is a | 3 | |
| | | Al manual. He stated the | | | comprehensive assessment for a resid | | |
| | | the interim Director of | | | that must be completed on an annual | CIIL | |
| | | eks in June and July 2019 | | | basis (at least every 366 days) unless | 2 | |
| | and had not been abl | | | | SCSA or a SCPA has been completed | u | |
| | | The Administrator also | | | since the most recent comprehensive | | |
| | stated he had receive | | | | assessment was completed. Its | | |
| | | ndicated the facility should | | | completion dates (MDS/CAA(s)/care pl | an) | |
| | - | mit MDS Assessments with | | | depend on the most recent | ٠, | |
| | and ARD of 10/1/19 of | | | | comprehensive and past assessments | , | |
| | differently. | | | | ARDs and completion dates. | | |
| | , | | | | Resident Assessment Instrument. A | | |
| | D. Resident #80 wa | is admitted to the facility on | | | facility must make a comprehensive | | |
| | 6/12/19 and discharg | ed on 8/15/19. His | | | assessment of a resident's needs, | | |
| | diagnoses included C | Chronic Kidney Disease, | | | strengths, goals, life history and | | |
| | Diabetes, and Demer | ntia. | | | preferences, using the resident | | |
| | | | | | assessment instrument (RAI) specified | by | |
| | | cal record for Resident #80, | | | CMS. The assessment must include at | | |
| | a discharged residen | t, on 10/24/19 revealed an | | | least the following:(i) Identification and | | |
| | | essment with an ARD of | | | demographic information(ii) Customary | ' | |
| | - | d on 7/26/19. A Submission | | | routine.(iii) Cognitive patterns.(iv) | | |
| | | S ASAP System showed | | | Communication.(v) Vision.(vi) Mood ar | ıd | |
| | | ssion MDS Assessment with | | | behavior patterns.(vii) Psychological | | |
| | an ARD of 7/1/19 was | | | | well-being.(viii) Physical functioning an | d | |
| | | /19. The Final Validation | | | structural problems.(ix) Continence.(x) | | |
| | | sessment was completed | | | Disease diagnosis and health condition | | |
| | more than 13 days af | | | | (xi) Dental and nutritional status.(xii) SI | kın | |
| | admission date and is | s late. | | | Conditions.(xiii) Activity pursuit.(xiv) | | |
| | A m imtomious sith the | MDC Nivrae on 10/04/40 of | | | Medications. Special treatments and | :: \ | |
| | | MDS Nurse on 10/24/19 at ne had taken over the | | | procedures.(xvi) Discharge planning.(x | , | |
| | | | | | Documentation of summary information regarding the additional assessment | 1 | |
| | | ctor of Nursing position and IDS Nurse in June and July | | | performed on the care areas triggered | hv | |
| | of 2019. She stated | | | | the completion of the Minimum Data S | • | |
| | | IDS Assessments during this | | | (MDS).(xviii) Documentation of | . . | |
| | | ehind and had completed or | | | participation in assessment. The | | |
| | | #80's Admission MDS | | | assessment process must include dire | nt | |
| | | ARD of 7/1/19 more than 13 | | | observation and communication with the | | |

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|--------------------------|---|---|--|--|---|----------------------------|
| | | 345503 | B. WING | | | 0/24/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| LIDEDTY | COMMONO NOO 8 DEI | IAB OTB OF BOWAN COUNTY | | 4412 SOUTH MAIN STREET | | |
| LIBERTY | COMMONS NSG & REP | IAB CTR OF ROWAN COUNTY | | SALISBURY, NC 28147 | | |
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| F 636 | Continued From pag days after his admis | | F 63 | resident, as well as communication licensed and non licensed direct of members on all shifts. | | |
| | 5:55 pm revealed his Minimum Data Set A completed and trans the direction of the F MDS Nurse had been Nursing for 6 to 8 wand had not been at Minimum Data Sets stated he had receiv corporate office that not complete or tran and ARD of 10/1/19 differently. | s expectation was the assessments should be smitted in a timely manner per RAI manual. He stated the en the interim Director of beeks in June and July 2019 ble to keep up with the a The Administrator also ared an email from the indicated the facility should smit MDS Assessments with | | This in service was completed by 11/14/2019. Any MDS nurse (full part time, and PRN) and member interdisciplinary team who did not in-service training will not be allow work until training is completed. To information has been integrated in standard orientation training and required in-service refresher cour all employees and will be reviewed Quality Assurance Process to ver the change has been sustained. Monitoring: To ensure compliance, The Direct Nursing and/or Minimum Data Set Nurse Consultant will review wee residents electronic records Minim Data Set (MDS) assessment this design and the set of the service was set of the set of the service was set of the set of the set of the service was set of the s | time, for the treceive wed to This into the in the reses for ed by the rify that tor of et (MDS) kly, 5 mum | |
| | weakness, chronic p dementia. A review of the med | gnoses that included muscle pain, anemia, depression and ical record of Resident # 5 | | either one of the following Compr assessments (Admission Assess Annual Assessment, and Significa Change in Status Assessment an Significant Correction to Prior | ehensive ment, ant d | |
| | comprehensive anni with an Assessment on 09/05/2019 was the MDS was accep Improvement Evalua Assessment Submis System on 10/24/20 | ation System (QIES) ssion and Processing (ASAP) | | Comprehensive Assessment) to a that the comprehensive assessm completed timely. This will be dor reviewing the validation reports a reviewing the warning message from comprehensive assessment. Thi done on weekly basis to include the weekend for 12 weeks then mont months. Reports will be presented weekly QA Committee by the Direction of the comprehensive assessment. | ents are ne be nd or each s will be he hly for 3 d to the | |
| | facility dated 10/24/2 | 2019 included a warning: the ted late more than 14 days | | Nursing and/or Mini Data Set (ME Coordinators to ensure corrective initiated as appropriate. Any immediate control of the cont | OS) action | |

Facility ID: 980260

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---------------------|--|---|-------------------------------|--|
| | | 345503 | B. WING | | 10 | /24/2019 | |
| | ROVIDER OR SUPPLIER | AB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP COI 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | • | | |
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| F 636 | MDS Nurse stated s responsibilities of MI Nursing in June and did not have any ass fallen behind in the M MDS nurse stated th with the MDS software problem. An interview with the at 5:55 PM revealed Minimum Data Set A completed and trans the direction of the F MDS Nurse had been Nursing for 6 to 8 we and had not been at Minimum Data Sets. stated he had receiv corporate office that not complete or trans and ARD of 10/01/20 differently. B. Resident # 129 w on 09/05/2019 with a Alzheimer's disease depression and anxi | on 10/23/2019 at 4:06 PM the he had taken over the DS Nurse and Director of July of 2019. She stated she sistance in either role and had MDS Assessments. The lere had also been an issue are program and the sultant had instructed her by the or transmit MDS are notified her due to a see Administrator on 10/24/2019 his expectation was the assessments should be mitted in a timely manner per that manual. He stated the in the interim Director of the sees in June and July 2019 to keep up with the The Administrator also an email from the indicated the facility should smit MDS Assessments with the one of the sees in June and July 2019 to later until notified the same areadmitted to the facility should smit MDS Assessments with the one of the same areadmitted to the facility diagnoses that included a dementia, diabetes mellitus | F 63 | concerns will be brought to the Nursing or Administrator for a action. Compliance will be mongoing auditing program revealing a committee meeting is attempted. Administrator, Director of Nu Coordinator, Unit Manager, Son Nurse, Therapy, HIM, Dietary Wound Nurse. | appropriate onitored and viewed at the ng. Weekly ended by rsing, MDS Support | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | SURVEY PLETED | |
|--|--|--|---|-----|--|------------------|----------------------------|
| | | 345503 | B. WING _ | | | 10/ | 24/2019 |
| | ROVIDER OR SUPPLIER | AB CTR OF ROWAN COUNTY | | 441 | REET ADDRESS, CITY, STATE, ZIP CODE 2 SOUTH MAIN STREET LISBURY, NC 28147 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 636 | Continued From page | e 8 | F 6 | 36 | | | |
| | Quality Improvement Assessment Submiss System on 10/16/201 A review of the Final | Validation Report for the | | | | | |
| | admission assessme | on the state of th | | | | | |
| | the MDS Nurse stated responsibilities of MD Nursing in June and a did not have any assifallen behind in the M MDS nurse stated the with the MDS softwar corporate MDS Consemail to not complete | ultant had instructed her by | | | | | |
| | at 5:55 PM revealed I Minimum Data Set As completed and transr the direction of the RA MDS Nurse had been Nursing for 6 to 8 wed and had not been abl Minimum Data Sets. stated he had receive corporate office that i not complete or trans | The Administrator also | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER COMMONS NSG & REH | AB CTR OF ROWAN COUNTY | 4 | STREET ADDRESS, CITY, STATE, ZIP CODE 1412 SOUTH MAIN STREET SALISBURY, NC 28147 | |
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| F 636 | Continued From pag | | F 636 | | |
| | on 12/10/2013 and h was dated 1/23/2017 | 179 was admitted to the facility per most recent readmission 7. Diagnoses for Resident ral vascular accident, and anxiety. | | | |
| The date | | rterly Minimum Data set ssed her to be moderately without behaviors. | | | |
| | I . | S was completed 5/15/2018. s due 7/5/2019 but was not | | | |
| | MDS Nurse stated si responsibilities of MI Nursing in June and did not have any ass fallen behind in the MDS Nurse stated the with the MDS software corporate MDS Consemail to not complete Assessments until si software problem. The | sulfant had instructed her by e or transmit MDS ne notified her due to a ne MDS nurse reported the #179 should have been | | | |
| | 5:55 pm revealed his Minimum Data Set A completed and trans the direction of the R MDS Nurse had bee Nursing for 6 to 8 we and had not been ab | Administrator on 10/24/19 at a sexpectation was the assessments should be mitted in a timely manner per that manual. He stated the nother interim Director of the seks in June and July 2019 alle to keep up with the The Administrator also | | | |

| 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 _ | | | 10/24/2019 |
| | ROVIDER OR SUPPLIER | AB CTR OF ROWAN COUNTY | • | STREET ADDRESS, CITY, STAT 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | E, ZIP CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | (EACH CORRECTI CROSS-REFERENC | LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY) | DATE |
| F 636 | • | ed an email from the indicated the facility should smit MDS Assessments with | F€ | 536 | | |
| | 7/5/2019 with diagno ulcers, hypertension recent admission Mir dated 7/12/2019 assemoderately cognitive behaviors. The admison 8/6/2019. The MDS nurse repo | as admitted to the facility ses to include pressure and diabetes. The most nimum Data Set assessment essed Resident #38 to be ly impaired without ssion MDS was completed arted the admission MDS mpleted by 7/26/2019. | | | | |
| | An interview was corwith the MDS Nurse the responsibilities of Nursing in June and did not have any ass fallen behind in the MMDS Nurse stated the with the MDS software corporate MDS Consemail to not complete Assessments until strong the software problem. The admission MDS for Fibeen completed 14 of 7/12/2019. | sultant had instructed her by | | | | |
| | An interview with the 5:55 pm revealed his | | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
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| | | 345503 | B. WING _ | | 10/24/2019 | |
| | ROVIDER OR SUPPLIER | AB CTR OF ROWAN COUNTY | STREET ADDRESS, CITY, STATE, ZIP COD 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE COMPLETION | |
| F 636 | completed and trans the direction of the RMDS Nurse had bee Nursing for 6 to 8 we and had not been at Minimum Data Sets. stated he had receiv corporate office that not complete or trans and ARD of 10/1/19 differently. c. Resident #36 wr 7/9/2019 with diagnor congestive heart fails admission Minimum 7/16/2019 assessed cognitively intact with The admission MDS 7/19/2019 and was comparked as complete The MDS nurse was pm and she stated s responsibilities of MI Nursing in June and did not have any ass fallen behind in the MMDS Nurse stated the with the MDS software problem. The Software problem. The MS software problem. The MS software problem. The MS was software problem. | essessments should be mitted in a timely manner per tal manual. He stated the in the interim Director of teks in June and July 2019 alle to keep up with the The Administrator also and an email from the indicated the facility should smit MDS Assessments with for later until notified as admitted to the facility on the sest to include hypertension, are and diabetes. The Data Set assessment dated Resident #36 to be the nout behaviors. assessment had an ARD of the by 7/30/2019 but was downward at the later over the DS Nurse and Director of July of 2019. She stated she istance in either role and had MDS Assessments. The there had also been an issue are program and the sultant had instructed her by the or transmit MDS are notified her due to a the MDS nurse reported the Resident #36 should have | F 6 | 36 | | |

| | | | (X3) DATE SURVEY COMPLETED | | |
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| | 345503 | B. WING _ | | 10/: | 24/2019 |
| | AB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | | |
| (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | | | (X5) COMPLETION DATE |
| An interview with the 5:55 pm revealed his Minimum Data Set As completed and transmithe direction of the RAMDS Nurse had been Nursing for 6 to 8 weard had not been abl Minimum Data Sets. stated he had receive corporate office that in not complete or trans and ARD of 10/1/19 of differently. Qrtly Assessment at LCFR(s): 483.20(c) §483.20(c) Quarterly A facility must assess quarterly review instruand approved by CMS once every 3 months. This REQUIREMENT by: Based on record revifacility failed to compl Minimum Data Set (Mays of the Assessment and every 92 days to Evaluation System (CSubmission and Proc (QIES ASAP) for 16 cm 47, #9, #12, #50, #79 #67, #16, #18, #56, # | Administrator on 10/24/19 at expectation was the expectation was the expessments should be nitted in a timely manner per Al manual. He stated the a the interim Director of eks in June and July 2019 to keep up with the The Administrator also do an email from the ndicated the facility should mit MDS Assessments with a resident using the ament specified by the State S not less frequently than are is not met as evidenced the ew and staff interviews the ete and submit a Quarterly IDS) Assessment within 14 the Reference Date (ARD) the Quality Improvement RES) Assessment essing (ASAP) System of 17 Residents, Residents, #11, #23, #2, #10, #16, | | The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be | l do II | 11/19/19 |
| | | | | | |
| | SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page An interview with the A 5:55 pm revealed his Minimum Data Set As completed and transn the direction of the RA MDS Nurse had been Nursing for 6 to 8 wed and had not been able Minimum Data Sets. stated he had receive corporate office that in not complete or transl and ARD of 10/1/19 of differently. Qrtly Assessment at L CFR(s): 483.20(c) §483.20(c) Quarterly A facility must assess quarterly review instruand approved by CMS once every 3 months. This REQUIREMENT by: Based on record revifacility failed to compl Minimum Data Set (M days of the Assessment and every 92 days to Evaluation System (C Submission and Proc (QIES ASAP) for 16 of #7, #9, #12, #50, #79 | An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the Minimum Data Set Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/1/19 or later until notified differently. Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete and submit a Quarterly Minimum Data Set (MDS) Assessment within 14 days of the Assessment Reference Date (ARD) and every 92 days to the Quality Improvement Evaluation System (QIES) Assessment Seriedents, Residents, Residents, 7, #9, #12, #50, #79, #11, #23, #2, #10, #16, #67, #16, #18, #56, #3, #19. | A BUILDIN 345503 B. WING_ COMMONS NSG & REHAB CTR OF ROWAN COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the Minimum Data Set Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. 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WIND STREET ADDRESS, CITY, STATE, ZIP CODE 4112 SOUTH MAIN STREET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST EPRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 An interview with the Administrator on 10/24/19 at 5:55 pm revealed his expectation was the Minimum Data Set Assessments should be completed and transmitted in a timely manner per the direction of the RAI manual. He stated the MDS Nurse had been the interim Director of Nursing for 6 to 8 weeks in June and July 2019 and had not been able to keep up with the Minimum Data Sets. The Administrator also stated he had received an email from the corporate office that indicated the facility should not complete or transmit MDS Assessments with and ARD of 10/1/19 or later until notified differently. Crty Assessment at Least Every 3 Months CFR(s): 483.20(c) \$483.20(c) 483.20(c) 5848.20(c) 584 |

| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | 0 | MB NO | <u>. 0938-0391 </u> | |
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| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X | X3) DATE COMP | SURVEY LETED |
| | | 345503 | B. WING _ | | | | 10/2 | 24/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| LIDEDTY | COMMONE NEC 9 DELL | AR CTR OF DOWAN COUNTY | | 44 | 412 SOUTH MAIN STREET | | | |
| LIBERTT | COMMONS NSG & REHA | AB CTR OF ROWAN COUNTY | | S | ALISBURY, NC 28147 | | | |
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| F 638 | 1. A. Resident #7 on 9/13/17 with diagr diabetes, parkinson's anxiety. On 10/23/19 a review record revealed she is Data Set (MDS) Asser Reference Date (ARD been submitted to the Evaluation System (OSubmission and Prod (QIES ASAP). The abeen completed by 9 ARD). Since the assectosed there was not During an interview of MDS Nurse stated sharmsmitted the Quart an ARD of 9/9/19. Stable to complete the she was responsible Director of Nursing roduly 2019 without any B. Resident #9 was a 1/9/15 with diagnoses hypertension, demental A review of the medic revealed Resident #9 Assessment with an AQuarterly MDS Asses | was admitted to the facility noses of hypertension, disease, depression and of Resident #7's medical nad a Quarterly Minimum resment with an Assessment of 9/9/19 that had not e Quality Improvement QIES) Assessment should have (ASAP) System resessing (ASAP) System resessing (ASAP) System resessing (ASAP) at 10:58 am the result of 10/24/19 at 10:58 am the result had not been a final validation report. In 10/24/19 at 10:58 am the result had not completed or rerly MDS Assessment with restated she had not been MDS Assessment because for the MDS Nurse and the roles during June 2019 and resistance. In admitted to the facility on the facility of the facility on the facility of the fa | F | 538 | LEAST EVERY 3 MONTHS Corrective Action: Resident #7 Quarterly Assessment Reference Date (ARD) 9/9/2019. Completed, Submitted and Accepted 10/25/2019 to the State Quality Improvement Evaluation System (Completed) System. Resident #9 Quarterly Assessment Reference Date (ARD) 9/12/2019. Completed, Submitted and Accepted 10/28/2019 to the State QIES system. Resident #12 Quarterly Assessment Reference Date (ARD) 9/19/2019. Completed, Submitted and Accepted 10/29/2019 to the State QIES ASAI system. Resident #50 Quarterly Assessment Reference Date (ARD) 8/11/2019. Completed, Submitted and Accepted 9/5/2019 to the State QIES ASAI system. Resident #79 Quarterly Assessment Reference Date (ARD) 7/18/2019. Completed, Submitted and Accepted 9/5/2019 to the State QIES ASAI system. Resident #79 Quarterly Assessment Reference Date (ARD) 7/18/2019. Completed, Submitted and Accepted 8/13/2019 to the State QIES ASAI system. Resident #11 Quarterly Assessment Reference Date (ARD) 9/19/2019. Completed, Submitted and Accepted 10/29/2019 to the State QIES ASAI system. Reference Date (ARD) 9/19/2019. Completed, Submitted and Accepted 10/29/2019 to the State QIES ASAI system. | ed on ty QIES) essing ed on ASAF nt ed on system nt ed on | | |
| | ASAP system and was completed within 14 of On 10/24/19 at 10:58 | transmitted to the QIES as late since it had not been days after the ARD. am an interview with the she had fallen behind in | | | Resident #23 Quarterly Assessmer Reference Date (ARD) 10/4/2019. Completed, Submitted and Accepte 10/30/2019 to the State QIES ASAI system. Resident #2 Quarterly Assessment | ed on P | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345503 | B. WING_ | | | 10/ | 24/2019 |
| | ROVIDER OR SUPPLIER | AB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | | | |
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| F 638 | with the MDS Assess responsible for the M of Nursing roles with C. Resident #12 was the facility o 9/19/19 failure and dementia. A review of the media revealed she had a C Assessment with an acompleted and had no QIES ASAP system a been completed with During an interview with 10/24/19 at 11:06 am completed or transm. Assessment with an Nurse stated she had of Nursing Position and during June and July on completing her MI stated she had also be Corporate Consultan any of the September because of a problem facility used. D. Resident #50 was 5/11/19 with diagnosiand pressure ulcer. On 10/23/19 a review revealed Resident #50 was revealed Resident #50 was review revealed Resident #50 was | sments because she was IDS Nurse and the Director out any assistance. as admitted to the facility to with diagnoses of heart cal record for Resident #12 Quarterly MDS ARD of 9/19/19 that was not not been transmitted to the and was late since it had not in 14 days after the ARD. with the MDS Nurse on a she stated she had not itted the Quarterly MDS ARD of 9/19/19. The MDS ARD of 9/19/19. The MDS d responsible for the Director and the MDS Nurse Position 2019 and had gotten behind DS Assessments. She been instructed by the the MDS Nurse to not complete | F | 638 | Reference Date (ARD) 9/4/2019. Completed, Submitted and Accepted of 10/24/2019 to the State QIES ASAP system. Resident #10 Quarterly Assessment Reference Date (ARD) 9/15/2019. Completed, Submitted and Accepted of 10/28/2019 to the State QIES ASAP system. Resident #16 Quarterly Assessment Reference Date (ARD) 9/16/2019. Completed, Submitted and Accepted of 10/29/2019 to the State QIES ASAP system. Resident #67 Quarterly Assessment Reference Date (ARD) 8/28/2019. Completed, Submitted and Accepted of 9/17/2019 to the State QIES ASAP system. Resident #16 Quarterly Assessment Reference Date (ARD) 9/16/2019. Completed, Submitted and Accepted of 10/29/2019 to the State QIES ASAP system. Resident #16 Quarterly Assessment Reference Date (ARD) 9/16/2019. Completed, Submitted and Accepted of 10/29/2019 to the State QIES ASAP system. Resident #18 Quarterly Assessment Reference Date (ARD) 9/20/2019. Completed, Submitted and Accepted of 10/29/2019 to the State QIES ASAP system. Resident discharged. Resident #56 Quarterly Assessment Reference Date (ARD) 8/16/2019. Completed, Submitted and Accepted of 10/2019 to the State QIES ASAP system. Resident discharged. Resident #56 Quarterly Assessment Reference Date (ARD) 8/16/2019. Completed, Submitted and Accepted of 10/2019 to the State QIES ASAP system. | n n | |
| | by the MDS Consulta | 9. Validation Report provided ant dated 10/24/19 for the assment with an ARD of | | | Resident #3 Quarterly Assessment Reference Date (ARD) 9/2/2019. Completed, Submitted and Accepted of 10/24/2019 to the State QIES ASAP system. | n | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345503 | B. WING _ | | 1 | 0/24/2019 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | • | 0/2-1/2010 | | |
| | | | | 4412 SOUTH MAIN STREET | | | | |
| LIBERTY | COMMONS NSG & RI | EHAB CTR OF ROWAN COUNTY | | SALISBURY, NC 28147 | | | | |
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| F 638 Continued Fro | | age 15 | F 6 | 38 | | | | |
| F 638 | 9/5/19 to the Quali System Assessment ASAP) more than late assessment. During an interview 10/24/19 at 10:58 behind in completi Assessments becar for the MDS Nurse roles without any a E. Resident #79 w 1/8/19 and decease Her diagnoses inchypertension, and A review of Reside revealed a Quarte ARD of 7/18/19 the days of the Assess A review of the Fir by the MDS Consi Quarterly MDS As 7/18/19 revealed to more than 14 days late assessment. During an interview 10/24/19 at 10:58 behind in completi | assessment was submitted on ity Improvement Evaluation ent Submission System (QIES 14 days after the ARD and is a w with the MDS Nurse on am she stated she had fallen ng and transmitting the MDS ause she had been responsible e and the Director of Nursing assistance. The state of the facility on sed in the facility on 8/17/19. Indeed heart failure, | F6 | Resident #19 Quarterly Assa Reference Date (ARD) 9/5/2 Completed, Submitted and A 10/24/2019 to the State QIE system. Identification of other residence be involved with this practice All current residents with Quarterly residents with Quarterly residents. On 11/1 through 11/15/2019 an audit completed by the MDS Nurse to ensure that the facility had Quarterly Review assessmen resident's. Out of the 84 curse on number of residents did not quarterly review assessmen within 92days since the ARD previous OBRA Quarterly Review assessment assessment or ARD of previous OBRA Quarterly Review assessment assessments were completed by 11/15/2019. Systemic Changes: On 11/12/2019 The Register (RN) Minimum Data Set (MDC Coordinator, Licensed Pract (LPN) Support nurses any of Interdisciplinary team membing participates in the MDS assess process was in serviced /edit MDS nurse consultant. | Accepted on S ASAP Ints who may estarterly seessments affected by 11/2019 at was see consultant d conducted ent of each rent residents, of have their ts completed D of the eview ious at This ed and and ared Nurse ther per that essment | | | |
| | for the MDS Nurse roles without any a An interview with t | e and the Director of Nursing | | The education focused on: I must conduct initially and pe Quarterly Review Assessme resident's functional capacity OBRA-required quarterly rev | eriodically a ent of each y. | | | |
| | | uld be completed and | | assessments are to be comp | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 345503 | B. WING _ | | | 10/24/2019 |) |
| NAME OF P | ROVIDER OR SUPPLIER | | • | STREET ADDRESS, CITY, STATE, Z | IP CODE | | |
| | | | | 4412 SOUTH MAIN STREET | | | |
| LIBERTY | COMMONS NSG & REH. | AB CTR OF ROWAN COUNTY | | SALISBURY, NC 28147 | | | |
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| F 638 | Continued From pag transmitted in a timel the RAI manual. He been the interim Dire weeks in June and Jable to keep up with The Administrator alsemail from the corpo facility should not con Assessments with ar until notified different 12/7/2018 with diagn hypertension, glauco The most recent qual assessment dated 6/#11 to be cognitively The quarterly MDS diprogress" and not con During an interview of MDS Nurse stated si | e 16 y manner per the direction of stated the MDS Nurse had betor of Nursing for 6 to 8 billy 2019 and had not been the Minimum Data Sets. So stated he had received an orate office that indicated the mplete or transmit MDS and ARD of 10/1/19 or later ly. 11 was admitted to the oses to include ma and collapsed vertebra. Interly Minimum Data Set 16/19 assessed Resident intact without behaviors. ated 9/19/2019 was "in mpleted. on 10/23/19 at 4:06 pm the ne had taken over the | F 6 | 92days since the ARD of OBRA Quarterly Review ARD of previous compressives assessment, or significated Prior Quarterly Assessment of the mentioned assessives calendar days). The MD (item Z0500B must be not 14days after the ARD (Adays). This in service was come 11/14/2019. Any MDS report time, and PRN) and interdisciplinary team which in the service training will not work until training is come information has been into standard orientation training required in-service refres all employees and will be Quality Assurance Processive the change has been sure Monitoring: To ensure compliance, To ensure consultant will reference to the change and/or Minimum Nurse Consultant will reference. | of the previous of Assessment of Phensive of ARD of an arments + 92 of Completion do later than ARD + 14 calend of ARD of the ARD of | r ny ate dar eve | |
| | Nursing in June and did not have any ass fallen behind in the MMDS Nurse stated the with the MDS softwa corporate MDS Consemail to not complete Assessments until strength. | sultant had instructed her by e or transmit MDS ne notified her due to a ne MDS nurse reported the t for Resident #11 should | | residents electronic record Data Set(MDS) Quarterl ensure that the assessment or ARD of procomprehensive assessment or ARD of procomprehensive assessment (ARD of any of the men assessments + 92 calencompleted timely: the Mate (item Z0500B must 14days after the ARD (ARD Data Set 14days after the ARD) | ly assessments nents are to be since the ARE arterly Review previous nent, or significaterly Assessmentioned and days) and MDS completions be no later that | o of ant nt | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| F 638 | 5:55 pm revealed his Assessments should transmitted in a timel the RAI manual. He been the interim Dire weeks in June and Ji able to keep up with The Administrator alsemail from the corpo facility should not facility should not facility should not facility should not facility assessments with a facility should not facility sho | Administrator on 10/24/19 at expectation was the MDS be completed and y manner per the direction of stated the MDS Nurse had actor of Nursing for 6 to 8 and 2019 and had not been the Minimum Data Sets. So stated he had received an arate office that indicated the mplete or transmit MDS and ARD of 10/1/19 or later lly. As admitted to the facility on oses to include diabetes, vascular accident. The most mum Data Set assessment assed Resident #23 to be nout behaviors. Ament dated 10/4/2019 was a completed. Adducted on 10/23/19 at 4:06 are stated she had taken ites of MDS Nurse and an June and July of 2019. She we any assistance in either exhind in the MDS MDS Nurse stated there had with the MDS software porate MDS Consultant had | F | 638 | days). This will be done on weekly bas to include the weekend for 12 weeks the monthly for 3 months. Reports will be presented to the weekly QA Committee the Director of Nursing and/or Mini Dats Set (MDS) Coordinators to ensure corrective action initiated as appropriat Any immediate concerns will be brough the Director of Nursing or Administrator for appropriate action. Compliance will monitored and ongoing auditing progra reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manage Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. | e by e e to to to be m | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
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| | | 345503 | B. WING _ | | 10/24/2019 |
| | ROVIDER OR SUPPLIER | HAB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, 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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE COMPLETION |
| F 638 | 5:55 pm revealed h Assessments shoul transmitted in a time the RAI manual. He been the interim Dir weeks in June and able to keep up with The Administrator a email from the corp facility should not co Assessments with a until notified differer c. Resident #2 wa 4/26/2019 with diag diabetes and deme Minimum Data Set assessed Resident impaired without be The quarterly asses progress" and not co The MDS Nurse wa pm and stated she responsibilities of M Nursing in June and did not have any as fallen behind in the MDS Nurse stated to with the MDS softw corporate MDS Core email to not comple Assessments until s software problem. T quarterly assessments | e Administrator on 10/24/19 at its expectation was the MDS do be completed and ely manner per the direction of e stated the MDS Nurse had rector of Nursing for 6 to 8 July 2019 and had not been in the Minimum Data Sets. Its o stated he had received an orate office that indicated the complete or transmit MDS and ARD of 10/1/19 or later office. The most recent quarterly assessment dated 6/4/2019 #2 to be severely cognitively haviors. Is interviewed 10/23/19 at 4:06 and taken over the IDS Nurse and Director of Id July of 2019. She stated she sistance in either role and had MDS Assessments. The there had also been an issue are program and the insultant had instructed her by | F 6 | 38 | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | LE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
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| | | 345503 | B. WING | | 10/24/2019 | | |
| | ROVIDER OR SUPPLIER | HAB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | O BE COMPLETION | | |
| F 638 | 5:55 pm revealed in Assessments should transmitted in a time the RAI manual. In been the interim Discovering the RAI manual. In been the interim Discovering the Administrator and able to keep up with the Administrator and the Administrator and the Administrator and the Assessments with until notified different d. Resident #10 to be behaviors. The Administrator and the Assessments with until notified different d. Resident #10 to be behaviors. The Administrator and the Assessments with until notified different d. Resident #10 to be behaviors. The Ambs Nurse was "in progress" and the Assessments until software and the Assessments until software problem. Quarterly assessments until software problem. Quarterly assessments Resident #2 should 9/18/2019. The MD | ne Administrator on 10/24/19 at his expectation was the MDS ald be completed and hely manner per the direction of the stated the MDS Nurse had be rector of Nursing for 6 to 8. July 2019 and had not been held the Minimum Data Sets. Halso stated he had received an expectate office that indicated the complete or transmit MDS and ARD of 10/1/19 or later intly. Was admitted to the facility on gnoses to include heart failure, the diabetes. The most recent expectation of the diabetes of the diab | F 63 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345503 | B. WING _ | | | 10/ | 24/2019 |
| | ROVIDER OR SUPPLIER COMMONS NSG & REHA | AB CTR OF ROWAN COUNTY | | 441 | REET ADDRESS, CITY, STATE, ZIP CODE 2 SOUTH MAIN STREET LISBURY, NC 28147 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 638 | 7/2/2016 with diagnos and dementia. The question of the following and dementia. The question of the following an interview of the quarterly MDS decompleted. During an interview of MDS Nurse stated showing in June and odd not have any assifulen behind in the MMDS Nurse stated the with the MDS software corporate MDS Consistent of the following in June and of the following in June and June | s admitted to the facility on ses to include hypertension parterly MDS dated her to be cognitively intact ated 9/19/2019 was not at 10/23/19 at 4:06 pm the e had taken over the S Nurse and Director of July of 2019. She stated she stance in either role and had DS Assessments. The ere had also been an issue e program and the facilitant had instructed her by or transmit MDS e notified her due to a e MDS nurse reported the sident #16 should have 130/2019. Administrator on 10/24/19 at expectation was the MDS be completed and or manner per the direction of stated the MDS Nurse had corroof Nursing for 6 to 8 and 19/2019 and had not been the Minimum Data Sets. To stated the had received an ate office that indicated the inplete or transmit MDS d ARD of 10/1/19 or later | F | 338 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 345503 | B. WING _ | | | 10/2 | 24/2019 |
| | ROVIDER OR SUPPLIER | AB CTR OF ROWAN COUNTY | • | STREET ADDRESS, CITY, STATE, ZIP 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE O THE APPROPRIAT | | (X5) COMPLETION DATE |
| F 638 | 4/22/2019 with diagn fibrillation, heart failure most recent quarterly assessed her to be completed on 9/16/20 During an interview of MDS Nurse stated shresponsibilities of ME Nursing in June and did not have any assifallen behind in the MMDS Nurse stated the with the MDS software corporate MDS Consemail to not completed Assessments until shresponsibilities of ME Nursing in June and did not have any assifallen behind in the MMDS Nurse stated the with the MDS software corporate MDS Consemail to not complete Assessments until shresponsible must be software problem. The quarterly MDS dated completed 9/11/2019 | as admitted to the facility on oses to include atrial re and hypertension. The MDS dated 8/28/2019 ognitively intact without ated 8/28/2019 was 019. In 10/23/19 at 4:06 pm the ne had taken over the DS Nurse and Director of July of 2019. She stated she istance in either role and had IDS Assessments. The ere had also been an issue re program and the ultant had instructed her by ero transmit MDS are notified her due to a ne MDS nurse reported the 8/28/2019 should have been | F | 638 | | | |
| | 5:55 pm revealed his Assessments should transmitted in a timel the RAI manual. He been the interim Dire weeks in June and Juable to keep up with The Administrator als email from the corpor facility should not cor Assessments with an until notified different | expectation was the MDS be completed and y manner per the direction of stated the MDS Nurse had ctor of Nursing for 6 to 8 uly 2019 and had not been the Minimum Data Sets. so stated he had received an rate office that indicated the mplete or transmit MDS id ARD of 10/1/19 or later | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , , | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 345503 | B. WING _ | | | 10/24/2019 | |
| | ROVIDER OR SUPPLIER | AB CTR OF ROWAN COUNTY | 1 | STREET ADDRESS, CITY, STATE, ZIP 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE THE APPROPRIAT | D.T. | |
| F 638 | F 638 Continued From page 22 on 01/16/2019 with diagnoses that included stage 4 chronic kidney disease, dementia, | | F 6 | 338 | | | |
| | hypothyroidism, deludencession. | sional disorder and | | | | | |
| | Resident # 16 reveal ARD of 09/16/2019. | ew of the medical record for ed a quarterly MDS with an The assessment (MDS) had within 14 days plus the ARD ne RAI (Resident | | | | | |
| | required to be comple | | | | | | |
| | at 4:06 PM revealed responsibility of Direct continued as the MD2 2019. She stated she assistance with the M time and had fallen be revealed she had not Resident # 16's quart 09/16/2019. The MD2 also been an issue we program and the corp instructed her by ematransmit MDS Assess due to a software process. | IDS assessments during this ehind. The MDS nurse completed or transmitted terly MDS with an ARD of S nurse stated there had eith the MDS software corate MDS Consultant had eil to not complete or ements until she notified her blem. | | | | | |
| | at 5:55 PM revealed MDS assessments si transmitted in a timel the RAI manual. He been the interim Dire weeks in June and Juable to keep up with The Administrator als | Administrator on 10/24/2019 his expectation was that hould be completed and y manner per the direction of stated the MDS Nurse had ctor of Nursing for 6 to 8 uly 2019 and had not been the Minimum Data Sets. o stated he had received an rate office that indicated the | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345503 | B. WING _ | | | 10/ | 24/2019 |
| | ROVIDER OR SUPPLIER | AB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 638 | F 638 Continued From page 23 | | F | 638 | | | |
| | | mplete or transmit MDS ad ARD of 10/01/2019 or later ly. | | | | | |
| | 04/14/2017 with diag | s admitted to the facility on noses that included a, anxiety, anorexia and | | | | | |
| | Data Set (MDS) with Date (ARD) set on 09 for Resident # 18. Th been completed with as of 10/22/2019 as i | that a quarterly Minimum an Assessment Reference 2/20/2019 had been initiated be quarterly MDS had not in 14 days plus the ARD date required by the RAI int Instruction) manual. The | | | | | |
| | at 4:06 PM revealed responsibility of Direct continued as the MD 2019. She stated she assistance with the Matime and had fallen be revealed she had not Resident # 18's quart 09/20/2019. The MD also been an issue we program and the corpinstructed her by ematic continued in the corpinstructed her by ematic continued in the corpinstructed her by ematic continued in the corpinstructed in the corporation of the corpinstructed in the corpinstructed in the corporation of the corporation | MDS assessments during this ehind. The MDS nurse completed or transmitted terly MDS with an ARD of S nurse stated there had with the MDS software corate MDS Consultant had ail to not complete or sments until she notified her | | | | | |
| | at 5:55 PM revealed | Administrator on 10/24/2019 his expectation was that hould be completed and | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 345503 B. WING | | | 10/24/2019 | | |
| | ROVIDER OR SUPPLIER | HAB CTR OF ROWAN COUNTY | • | STREET ADDRESS, CITY, STATE, ZIP COD 4412 SOUTH MAIN STREET SALISBURY, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 638 | the RAI manual. He been the interim Dir weeks in June and able to keep up with The Administrator a email from the corp facility should not concern the conce | ely manner per the direction of e stated the MDS Nurse had rector of Nursing for 6 to 8 July 2019 and had not been in the Minimum Data Sets. Iso stated he had received an orate office that indicated the omplete or transmit MDS and ARD of 10/01/2019 or later office. The sereadmitted to the facility on gnoses that included end (ESRD), venous thrombosis, white, dysphagia, muscle ession. The wiew of the medical record for alled that a quarterly Minimum in an Assessment Reference 108/16/2019 was completed on assessment was accepted to ment Evaluation System it Submission and Processing 109/10/2019. The Validation Report for the 2019 included a warning: the eted late. More than 14 days are MDS nurse on 10/23/19 at the had taken over the ector of Nursing position and DS Nurse in June and July of the did not have any MDS assessments during this behind. The MDS nurse | F 63 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345503 | B. WING _ | | | 10/24/2019 |
| | ROVIDER OR SUPPLIER | AB CTR OF ROWAN COUNTY | • | STREET ADDRESS, CITY, STATE, ZIP COE 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | | |
| (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 638 | an ARD of 08/16/201 transmitted the assess stated there had also software program an Consultant had instructomplete or transmit notified her due to a substantial An interview with the at 5:55 PM revealed MDS assessments of transmitted in a timel the RAI manual. He been the interim Directory weeks in June and Juliable to keep up with The Administrator also email from the corposicility should not contain Assessments with an until notified different D. Resident #3 was a 05/26/2016 with diag esophageal reflux dis (HTN), intervertebral radiculopathy, demend and sleep apnea. On 10/24/2019 a reversident #3 reveale Data Set (MDS) with Date (ARD) set on 09 10/23/2019 and the attendantial transmitted the quality Improvem (QIES) Assessments | # 56's quarterly MDS with 9 until 09/09/2019 and sement on 09/10/2019. She been an issue with the MDS d the corporate MDS ucted her by email to not MDS Assessments until she software problem. Administrator on 10/24/2019 his expectation was that hould be completed and y manner per the direction of stated the MDS Nurse had uctor of Nursing for 6 to 8 uly 2019 and had not been the Minimum Data Sets. So stated he had received an arate office that indicated the mplete or transmit MDS and ARD of 10/01/2019 or later ly. admitted to the facility on noses that included: gastro sease (GERD), hypertension | F 6 | 38 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | 345503 B. WING | | 1 | 0/24/2019 | | | |
| | ROVIDER OR SUPPLIER | HAB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | E, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EACH CORRECTIVE CROSS-REFERENCE | AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY) | (X5) COMPLETION DATE | |
| F 638 | facility dated 10/24/ assessment completed after the ARD date. An interview with the at 4:06 PM revealed responsibility of Direcontinued as the MI 2019. She stated seassistance with the time and had fallen had not completed quarterly MDS with 10/24/2019. She stissue with the MDS corporate MDS Coremail to not complete Assessments until sentence of the season of the sentence of the sentence of the season of the sentence of the season of the sentence of the se | al Validation Report for the 2019 included a warning: the sted late. More than 14 days e MDS nurse on 10/23/2019 deshe had taken over the sector of Nursing position and DS Nurse in June and July of the did not have any MDS assessments during this behind. The MDS nurse and for transmitted Resident # 3's an ARD of 09/02/2019 until stated there had also been an software program and the insultant had instructed her by | F | 638 | | | |
| | transmitted in a time the RAI manual. He been the interim Die weeks in June and able to keep up with The Administrator a email from the corp facility should not confacility should not confacility should not confacility should not confacility should not confide different expenses with a confidence of the confacility should not find the confacility should not confidence of the confidence of the confacility should not confidence of the confacility should not confidence of the co | should be completed and ely manner per the direction of e stated the MDS Nurse had rector of Nursing for 6 to 8 July 2019 and had not been in the Minimum Data Sets. Iso stated he had received an orate office that indicated the complete or transmit MDS and ARD of 10/01/2019 or later ontly. The state of the facility on gnoses that included cerebral hypertension (HTN). | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTII A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
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| | | 345503 | B. WING | | 10/24/2019 | |
| | ROVIDER OR SUPPLIER | HAB CTR OF ROWAN COUNTY | • | STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | , | |
| (X4) ID PREFIX TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE COMPLETION | |
| F 638 | Resident #19 reveal Data Set (MDS) with Date (ARD) set on 0 10/23/2019 and the the Quality Improve (QIES) Assessment (ASAP) System on A review of the Final facility dated 10/24/assessment complet after the ARD date. An interview with the at 4:06 PM revealed responsibility of Directontinued as the MI 2019. She stated sessistance with the time and had fallen revealed that she had transmitted Resider an ARD of 09/05/20 transmitted the assess stated there had alsoftware program a Consultant had instituted the cons | view of the medical record for led that a quarterly Minimum in an Assessment Reference 19/05/2019 was completed on assessment was accepted to ment Evaluation System is Submission and Processing 10/24/2019 (QIES ASAP). Il Validation Report for the 2019 included a warning: the sted late. More than 14 days in the letter of Nurse on 10/23/2019 if she had taken over the ector of Nursing position and DS Nurse in June and July of the did not have any MDS assessments during this behind. The MDS nurse and not completed or the sted in 10/23/2019 and the corporate MDS in the corporate MDS in the corporate MDS in the corporate MDS in the MDS assessments until she in MDS Assessments until she | F 63 | , | | |
| | at 5:55 PM revealed MDS assessments transmitted in a time the RAI manual. He been the interim Dir weeks in June and | e Administrator on 10/24/2019 If his expectation was that should be completed and sely manner per the direction of se stated the MDS Nurse had sector of Nursing for 6 to 8 July 2019 and had not been in the Minimum Data Sets. | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | (X2) MULT IDENTIFICATION NUMBER: 345503 (X2) MULT A. BUILDII | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED 10/24/2019 | |
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| | ROVIDER OR SUPPLIER | HAB CTR OF ROWAN COUNTY | 4 | STREET ADDRESS, CITY, STATE, ZIP CODE 1412 SOUTH MAIN STREET SALISBURY, NC 28147 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | |
| F 638 | email from the corporation facility should not co | orate office that indicated the omplete or transmit MDS and ARD of 10/01/2019 or later | F 638 | | | |
| F 689 SS=D | CFR(s): 483.25(d)(1) §483.25(d) Accident The facility must ens §483.25(d)(1) The re as free of accident h §483.25(d)(2)Each re supervision and ass accidents. This REQUIREMEN by: Based on observati facility failed to main storing two opened cans in an unlocked rooms observed (40) Findings included: The shower room or on 10/21/2019 at 11 door was unlocked a on the inside or outs on the right side of t mounted to the wall labeled Disinfectant the outer rim of the s labeled Disinfectant observed on the insiblack plastic storage | esident environment remains nazards as is possible; and resident receives adequate istance devices to prevent at is not met as evidenced ons and staff interviews, the nation a safe environment by chemical disinfectant spray location in 1 of 3 shower | F 689 | On 10/24/2019 the chemical disinfects spray was given to the Maintenance Director and secured on the housekeeping cart. The Director of Nursing removed extra supplies that heen stored in the shower rooms and Maintenance Director removed and discarded unlocked black cabinets fror all shower rooms on the evening of 10/24/19. On 10/24/2019 Director of Nursing and Maintenance completed 100% audit of other shower rooms and building sweet for any other unsecured chemicals with other issues noted. On 11/12/2019 Staff development nurs and Maintenance Director began in-services for all facility staff on safety | ad the m | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X | (X3) DATE SURVEY COMPLETED | |
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| | | 345503 | B. WING _ | B. WING | | 10/24/2019 | |
| | ROVIDER OR SUPPLIER | HAB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP CO 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | DDE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 689 | was visible lock for Deodorant cans we ingredients of ethyl chlorophenol and o on the cans include children." Other wa cause eye irritation be harmful if swallo vapors may cause on 10/22/2019 at 7 400-hall shower roor revealed the 2 spradeodorant remained they were observed. An observation of the conducted on 10/22 and black plastic state interior left wall cabinet pushed agawas easily moved a doors swung open of spray Disinfectar can located on the On 10/24/2019 at 7 400-hall shower roof unit pushed back and doors against the waway from the wall revealed the 2 spradeodorant remained cabinet. An interview conduration of the conducted on the wall revealed the 2 spradeodorant remained cabinet. | t were observed ajar and there the doors. The Disinfectant are labeled with listed alcohol, ortho-benzyl- para - rtho-phenyl phenol. A warning at "to keep out of reach of rnings listed included may, may cause skin irritation, may awed and the inhalation of respiratory irritation. 2:48 AM an observation of the om was conducted and y cans labeled Disinfectant d in the same locations that | F6 | practices and securing chemwill be completed on 11-15-20 On 11/20/2019 The Director will begin daily audits of all trooms for two weeks. The Nuty will complete daily aud showers rooms on the week weeks. These audits will reand off shifts. Weekly obserof 3 shower rooms will then using a quality assurance (Offer 4 weeks then monthly for Reports will be presented to QA committee by the Direct to ensure corrective action frongoing concerns is initiated appropriate. The weekly QA attended by the Administrate Nursing, Social Services Dir Coordinator, Unit Manager, nurse, Maintenance /Enviror Services director, Therapy Health information manager Manager. | of Nursing three shower Manager on lits of all three sends for two flect weekend rvation/ audits be completed QA) survey too 3 months. The weekly or of Nursing for trends or d as A Meeting is or, Director of rector, MDS Support nmental director, | I S I DI | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTIO A. BUILDING B. WING | | | | (X3) DATE SURVEY COMPLETED | |
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| | | | | | , | 10/24/2019 | |
| | ROVIDER OR SUPPLIER | IAB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP COD 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | • | 0.012-47.2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 689 | Continued From page | ge 30 | F 68 | 39 | | | |
| | was not able to explore the shower room. No | he shower room and the NA ain how the spray cans got in A # 2 revealed that she usekeeping staff used that | | | | | |
| | at 11:27 AM. The ho cleaned the shower she did use the spra times in the shower or staff were in the rethat she did not leave | as interviewed on 10/24/2019 usekeeper revealed that she room on the 400 hall and that y disinfectant deodorant at room but not if any residents boom. Housekeeper revealed e the cans in the shower boms and that she had one | | | | | |
| | _ | on and when not in use it was | | | | | |
| | conducted with the et (ESD) on 10/24/2019 revealed that the hor cleaning chemicals in all chemicals that we each locked housek that the shower room and were not equipped observed the gray at with the doors pushed shower room and the pull the plastic shelf doors opening and et Disinfectant Deodora The ESD removed that the shower room and housekeeper did not | r room on the 400 hall was environmental service director 9 at 11:35 AM. The ESD usekeepers did not leave any in the shower rooms and that ere used were maintained in eeper cart. The ESD stated in doors were never locked and the doors were never locked and black plastic storage unit ed against the left wall in the ee ESD observed the surveyor away from the wall and the 2 exposing 2 open cans of ant spray inside the cabinet. The cans from the storage unit ed that he was certain that the televant in the room | | | | | |
| | and that he had no is spray cans into the s | dea which staff brought the shower room and left them oved the 2 cans immediately. | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
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| | | 345503 | B. WING _ | | | 10/24/2019 |
| | ROVIDER OR SUPPLIER | IAB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 689 | Continued From pag | ge 31 | F 6 | 89 | | |
| | | hat he would research the a lock on the storage unit to ed and secured. | | | | |
| | the Director of Nurse 12:12PM, the DON know that 2 cans of had been observed and was not aware to locked cabinet in the items. The DON stanurse staff brought to and that she would puse and storage of cand would discuss to | 400 hall shower room with es (DON) on 10/24/2019 at revealed that she did not Disinfectant Deodorant spray in the 400 hall shower room that there was not a securely eshower room to store any ted that she believed the he cans into the shower room provide staff education about chemicals to the nurse staff the need for a secured or net in all the shower rooms inistrator and ESD. | | | | |
| F 693 SS=D | interviewed and reve staff and nurse staff any harmful chemica rooms or anywhere | /Restore Eating Skills | F 6 | 93 | | 11/19/19 |
| | both percutaneous e percutaneous endos enteral fluids). Base | ric and gastrostomy tubes, endoscopic gastrostomy and ecopic jejunostomy, and d on a resident's essment, the facility must | | | | |
| | eat enough alone or | dent who has been able to with assistance is not fed by ess the resident's clinical | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | IPLE CONSTRUCTION | (> | (X3) DATE SURVEY COMPLETED | |
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| | | 345503 | B. WING | | | 10/24/2019 | |
| NAME OF PI | ROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP CO | DDE | | |
| I IDEDTY | COMMONS NSC & DELLA | AB CTR OF ROWAN COUNTY | | 4412 SOUTH MAIN STREET | | | |
| LIDERIT | COMMONS NSG & REHA | AB CIR OF ROWAN COUNTY | | SALISBURY, 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 C ((EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | N |
| F 693 | Continued From page | e 32 | F 6 | 693 | | | |
| | | es that enteral feeding was d consented to by the | | | | | |
| | means receives the a services to restore, if and to prevent complincluding but not limit diarrhea, vomiting, de abnormalities, and na This REQUIREMENT by: Based on observation facility failed to discar formula with expired stored in 1 of 2 medic (100-200-300 hall medication room 300 halls was observed. The medication room 300 halls was observed. During this observed with the shelf with an expirate observation and stottles of tube feeding the observation and stottles of tube feeding discarded. The Director of Nursing on 10/24/2019 at 5:10 had checked the expirate of the service of the expirate of th | asal-pharyngeal ulcers. is not met as evidenced as and staff interviews, the d bottles of tube feeding expiration dates that were cation rooms observed edication room). as for the facility 's 100, 200, ed on 10/24/2019 at 5:06 rvation seven 8-ounce g formula were observed on ration date of 10/1/2019. as interviewed at the time of she reported the expired g formula should have been and (DON) was interviewed of PM and she reported she | | On 10/24/2019 the Director removed cartons of tube fee October 2019 dates from more room and were discarded. No residing in the facility receive feedings. On 10/24/2019 the Director checked 100% other medical and tube feeding cartons for dates. Those findings were were no other expired tube cartons On 11-12-2019 the Staff De Nurse and Director Of Nurse in-services for Tube Feeding management including tube storage for observation of discontainers for all facility lices staff This will be completed 11-15-2019. | eding with edication No residents e tube of Nursing ation rooms r expired that there feeding evelopment sing began g e feeding ates listed on nsed nursing | | |
| | expiration date on the DON reported the tra | g, but she misread the e tube feeding formula. The nsporter aide will put the tion room, but the nursing | | On 11-20-2019 The Directo will begin weekly observatio medication rooms using a q | n/ audits of 2 | 2 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345503 | B. WING _ | | | 10/ | 24/2019 | |
| | ROVIDER OR SUPPLIER | AB CTR OF ROWAN COUNTY | | 4412 | ET ADDRESS, CITY, STATE, ZIP CODE SOUTH MAIN STREET SBURY, 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 APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 693 F 695 SS=D | dates, and she or the check the expiration of schedule for performing reported it was her exputritional supplement were discarded by the | c and check expiration Unit Manager will double dates, but she did not have a ng this task. The DON spectation that expired tts or tube feeding formulas | | C c n w N tr a a N C n s ir T | ssurance (QA) survey tool. Observations /audits reports will be ompleted for 4 weeks then monthly for nonths. Reports will be presented to the yeekly QA committee by the Director of dursing to ensure corrective action for rends or ongoing concerns is initiated appropriate. The weekly QA Meeting is ttended by the Administrator, Director dursing, Social Services Director, MDS coordinator, Unit Manager, Support urse, Maintenance /Environmental ervices director, Therapy director, Heaformation manager, Dietary Manager the Director of Nursing is responsible to the Plan of Correction | ne as s of | 11/19/19 | |
| | § 483.25(i) Respirato tracheostomy care ar The facility must ensure needs respiratory car care and tracheal succare, consistent with practice, the comprehand 483.65 of this sure This REQUIREMENT by: Based on observation staff and nurse practifailed to obtain a physical therapy for 1 of 2 resisterapy (Resident #1 oxygen tubing and ox | nd tracheal suctioning. ure that a resident who e, including tracheostomy ctioning, is provided such professional standards of nensive person-centered nts' goals and preferences, | | c 1 c C | On 10/24/2019 the Unit manager hanged resident # 74 oxygen tubing. 0/24/2019 the Director of Nursing leaned resident #74 concentrator filter on 10/24/2019 resident #11 a had sign tanding orders for PRN oxygen use oncentrator was removed by Unit nanager and was not needed. | r. | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE SURVEY COMPLETED |
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| | | 345503 | B. WING | | 10/24/2019 |
| | ROVIDER OR SUPPLIER | IAB CTR OF ROWAN COUNTY | 4 | STREET ADDRESS, CITY, STATE, ZIP CODE 1412 SOUTH MAIN STREET SALISBURY, NC 28147 | , |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | OULD BE COMPLETION |
| F 695 | Continued From pag | ge 34 | F 695 | | |
| | with diagnoses to in and collapsed vertel The physician order order dated 5/13/20 minute (Ipm) titrate to levels greater than 9 hypoxia (Iow oxyger) The most recent qua (MDS) assessment Resident #11 to be obehaviors and that so Resident #11 's carron 12/7/2018 were rowere in place to add Current standing order reviewed. There was oxygen saturation le room air. Resident #11 was of 10:16 AM with O2 or Resident #11 reports her breathing. Resident #11 was interviewed. The o2 "all the time" Nurse #1 was interviewed. AM and she reported short of breath at tin help with her oxyger. | s were reviewed, and an 19 read "O2 at 2 liters per o keep (oxygen) saturation 23%, one time only for a level) for one day." arterly Minimum Data Set dated 6/16/19 assessed cognitively intact without the used oxygen. e plans which were initiated eviewed and no care plans ress the use of oxygen. ders for Resident #11 were an order to apply O2 if vels were less than 89% on open at 2 lpm by nasal cannula. The ported she were less than wore one of the ported she wore | | On 10/28/2019 100% audit was completed by float Registered nur resident utilizing oxygen for orders dates of oxygen tubing changes a cleanliness of the concentrator filtresidents who had oxygen orders audited and of those nine, all filter clean and tubing was found dated compliance. Those findings were resident utilizing oxygen had orde standing orders PRN, filters were and tubing was dated. On 11-12-2019 the Director of Nur and Staff Development nurse edu on oxygen utilization, tubing change concentrator filter maintenance. On 11-20/2019 The Director of Nur will begin weekly observation/ audresidents utilizing oxygen, tubing a concentrator maintenance using a assurance (QA) survey tool. The of Nursing will monitor this for eight weeks. Reports will be presented weekly QA committee by the Direct Nursing to ensure corrective action trends or ongoing concerns is initial appropriate. The weekly QA Mee attended by the Administrator, Dir Nursing, Social Services Director, Coordinator, Unit Manager, LPN sourse, Maintenance /Environment services director, Therapy director information manager, Dietary Mar | s, for and er. Nine were s were and in that all rs, and clean rsing cation ge, and a quality Director ht to the ctor of n for ated as ting is ector of MDS support ital r, Health |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | |
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| | | 345503 B. WING | | | | 10/24/2019 | |
| | ROVIDER OR SUPPLIER | AB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP COL 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 695 | certain. Resident #11 was in 9:40 AM and she repher oxygen level and the oxygen was take Resident #11 reported difficulty breathing. Nursing assistant #5 at 1:45 PM and she Resident #11 wearing. The Unit Manager wat 9:59 AM and she standing orders for owned and the practition of interviewed on 10/22 reported if a resident expect to see command the NP or physicuse. The NP explain used to start O2 for a (low oxygen level) brorders should be obtorders should be obtordered. | terviewed on 10/23/2019 at corted that the staff checked it said she was "okay", and en off on 10/22/2019. The said she was not having was interviewed 10/23/2019 reported she observed g the O2 "most of the time." as interviewed on 10/24/2019 reported the facility used oxygen use and the staff | F 6 | , | | | |
| | Resident #11 was us The Director of Nurs on 10/24/2019 at 3:5 facility standing orde initiate O2 therapy for nursing staff should Resident #11 's con physician or NP to re | sing oxygen. ing (DON) was interviewed is PM and she reported the ers would cover the nurse to or a resident, however, the have communicated | | | | | |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | ROVIDER OR SUPPLIER | HAB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
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| F 695 | expected nursing standing orders and communication with 2. Resident #74 v 2/17/2017 and her of dated 9/5/2019. Dia included chronic obemphysema and di Minimum Data Set 9/12/2019 assessed cognitively intact with assessed Resident a. A review of the #74 revealed an ord liters per minute by and to change the (Wednesday). The medication addressed Sept 2019 was revious tubing every we was noted on the M 9/11/19 (Nurse #5), 9/25/19 (Nurse #5) been completed. The MAR for Octob task "change O2 tu Wednesday" was noted on 10/2/19 (Nurse #5) in the mode on 10/2/19 (Nurse was noted on 10/2/19). | The DON reported she taff to receive clarification for d to see documentation of the in the physician. I was admitted to the facility most recent readmission was agnoses for Resident #74 structive pulmonary disease, abetes. The admission assessment (MDS) dated d Resident #74 to be thout behaviors. The MDS #74 to use Oxygen (O2) I physician orders for Resident der dated 9/5/2019 for O2 at 4 nasal cannula continuously | F 69 | | |
| | Resident #74 was of 12:35 PM and she | observed on 10/21/2019 at was wearing O2 at 4lpm with O2 tubing was dated | | | |

| STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAN STREET | | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY (X4) (1) | | | 345503 | B. WING | | 10/24/2019 | |
| FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 695 Continued From page 37 9/25/2019 An observation of Resident #74 was conducted on 10/22/2019 at 11:31 AM. The O2 tubing was dated 9/25/2019. The O2 tubing was observed on 10/23/2019 at 9:36 AM and the tubing was dated "10/22/2019". An interview was conducted with Resident #74 on 10/22/2019 at 11:31 AM and she reported she was not certain when the O2 tubing had been changed. Resident #74 was interviewed on 10/23/2019 at 9:36 AM and she reported her O2 tubing had been changed during the night on 10/22/2019. Nurse #1 was interviewed on 10/23/2019 at 9:36 AM and she reported the O2 tubing was to be changed on night shift, and she was not aware of the date on the O2 tubing for Resident #74. A phone interview was conducted with Nurse #4 on 10/23/2019 at 5:1 AM and she reported the frequently provided care for Resident #74 on night shift. Nurse #4 reported changing the O2 | | | HAB CTR OF ROWAN COUNTY | | 4412 SOUTH MAIN STREET | · | |
| 9/25/2019. An observation of Resident #74 was conducted on 10/22/2019 at 11:31 AM. The O2 tubing was dated 9/25/2019. The O2 tubing was observed on 10/23/2019 at 9:36 AM and the tubing was dated "10/22/2019". An interview was conducted with Resident #74 on 10/22/2019 at 11:31 AM and she reported she was not certain when the O2 tubing had been changed. Resident #74 was interviewed on 10/23/2019 at 9:36 AM and she reported her O2 tubing had been changed during the night on 10/22/2019. Nurse #1 was interviewed on 10/23/2019 at 9:40 AM and she reported the O2 tubing was to be changed on night shift, and she was not aware of the date on the O2 tubing for Resident #74. A phone interview was conducted with Nurse #4 on 10/23/2019 at 5:21 AM and she reported she frequently provided care for Resident #74 on night shift. Nurse #4 reported changing the O2 | PRÉFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI | OULD BE COMPLET | |
| tubing was a responsibility for night shift nurses and the task was completed on Wednesday nights. Nurse #4 explained that she changed the O2 tubing for Resident #74 several times over the past month but was not certain of the specific dates. Nurse #4 reported Resident #74 had extension tubing and wondered if the O2 cannula portion had been changed and not the entire tubing set. Nurse #4 reported she was not aware the tubing for Resident #74 was dated 9/25/2019. | F 695 | 9/25/2019. An observation of Fon 10/22/2019 at 11 dated 9/25/2019. The O2 tubing was 9:36 AM and the tu An interview was co 10/22/2019 at 11:3 was not certain who changed. Resident #74 was i 9:36 AM and she rebeen changed during Nurse #1 was interview was not certain who changed on night shift. Nurse #4 tubing was a respondent the task was conights. Nurse #4 extension tubing ar portion had been clubing set. Nurse # | Resident #74 was conducted 1:31 AM. The O2 tubing was observed on 10/23/2019 at bing was dated "10/22/2019". Inducted with Resident #74 on 1 AM and she reported she en the O2 tubing had been the O2 tubing had had the night on 10/23/2019 at exported her O2 tubing had had the O2 tubing was to be hift, and she was not aware of tubing for Resident #74. Investigation of the specific ported changing the O2 tubing the O2 tubing was to be hift, and she was not aware of tubing for Resident #74. Investigation of the specific ported changing the O2 the ported on Wednesday applained that she changed the lent #74 several times over the sent certain of the specific ported Resident #74 had and wondered if the O2 cannula thanged and not the entire 4 reported she was not aware | F 695 | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION | | OATE SURVEY OMPLETED |
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| | | 345503 | B. WING _ | | | 10/24/2019 |
| | ROVIDER OR SUPPLIER | HAB CTR OF ROWAN COUNTY | • | STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | · | |
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| F 695 | had provided care to over the past month reported Resident at the O2 tubing and a changed weekly, but had changed the tu #5 reported she was Resident #74 was of the Unit Manager at 9:59 AM and she cannula plus the exchanged weekly and tubing for Resident. The Director of Nur on 10/24/2019 at 3 the O2 tubing shound and as needed if so she would need to nurses to make cerwhen it was initialed. The Administrator was 15:36 PM and he nurses to change the ordered. b. A physician ordered. b. A physician ordered. b. A physician ordered. b. A physician ordered. cleaned weekly (Was The MAR for Septitask "clean O2 conshift: Wednesday" nurse initials on 9/1 | 241 AM and she reported she for Resident #74 frequently in on night shift. Nurse #5 #74 had extension tubing on all the tubing should have been ut she was not certain if she bing for Resident #74. Nurse is not aware the tubing on dated 9/25/219. Was interviewed on 10/24/2019 is reported that the nasal stension tubing should be dishe was not aware the O2 #74 was dated 9/25/2019. Sing (DON) was interviewed including the the extension tubing weekly billed, and she reported that start checking behind the tain a task was completed don the MAR. Was interviewed on 10/24/2019 reported he expected the ne O2 tubing as the physician der dated 9/8/2019 instructed concentrator was to be | F | 95 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 345503 | B. WING _ | | , | 10/24/2019 |
| | ROVIDER OR SUPPLIER | AB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP CO 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | • | |
| (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 ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 695 | Continued From pag | e 39 | F 6 | 95 | | |
| | task "change O2 con day shift: Wednesda initials were noted or and 10/23/19 which i completed. | r 2019 was reviewed and the ocentrator filter every week y" was noted and nurses of 10/2/19, 10/9/19, 10/19/19 ondicated the task had been | | | | |
| | 12:35 PM and the filt | eserved on 10/21/2019 at ers on the O2 concentrator a dry, fluffy white substance as and when touched, | | | | |
| | 12:35 PM and the O2 | oserved on 10/21/2019 at 2 concentrator filters had a tance imbedded in them and en touched. | | | | |
| | on 10/22/2019 at 11: | dry, fluffy white substance and when touched, the | | | | |
| | 9:36 AM and she sta | terviewed on 10/23/2019 at ted she was not certain er O2 concentrator had been | | | | |
| | 10/23/2019 at 9:40 A not certain when the supposed to be clear responsibility of night the O2 concentrator | nducted with Nurse #1 on M and she reported she was O2 concentrator filters were ned, but she thought it was a t shift. Nurse #1 observed filters for Resident #74 and oked very dusty and she cleaned. | | | | |

| STATEMENT OF DEFICIEI AND PLAN OF CORRECT | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | | E SURVEY PLETED |
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| NAME OF PROVIDER O | | AB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | | |
| | EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| A phone on 10/2: O2 cond Friday r Nurse # 10/24/2 concent on Frida The Unit at 9:59 dirty and and she filters w The Dirt on 10/2 the O2 the | 4/2019 at 5:2 centrator filte ight. 5 was intervi 019 at 5:41 A rator filters w y, night shift t Manager w AM and she d dusty O2 co was not cere ere not clean ector of Nurs 4/2019 at 3:5 ubing should annula and tr needed if soi uld need to si o make certa was initialed ninistrator was PM and he re o clean the C n ordered. ocurement, S 483.60(i)(1) (i) Food safe lity must - (i)(1) - Procu | as conducted with Nurse #4 11 AM and she reported the rs were cleaned weekly, on ewed by phone call on the AM and she reported the O2 tere supposed to be cleaned as interviewed on 10/24/2019 reported she had observed concentrator filters in the past tain why Resident #74 's ted. ing (DON) was interviewed tain and she reported that the changed, including the the extension tubing weekly ted, and she reported that the changed including the the extension tubing weekly ted, and she reported that the changed including the the extension tubing weekly ted, and she reported that the changed including the the extension tubing weekly ted, and she reported that the changed including the the extension tubing weekly ted, and she reported that the changed including the the extension tubing weekly ted, and she reported that the changed including the the extension tubing weekly ted, and she reported that the transition to the tra | F 81 | | | 11/19/19 |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | E SURVEY IPLETED |
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| | ROVIDER OR SUPPLIER | EHAB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP CO. 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | • | |
| (X4) ID PREFIX TAG | (EACH DEFIC | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 812 | from local product and local laws or (ii) This provision facilities from using gardens, subject safe growing and (iii) This provision from consuming from co | de food items obtained directly ers, subject to applicable State regulations. does not prohibit or prevent ag produce grown in facility to compliance with applicable food-handling practices. does not preclude residents boods not procured by the facility. Dre, prepare, distribute and ordance with professional diservice safety. ENT is not met as evidenced ations and staff interviews the asure foods were covered and red in 1 of 2 kitchen Dicolor am an initial observation of red there were three metal at that had been covered in clear but the edge of the clear wrap back on each container and left container dated 10/22/19 was second container was puree and 10/23/19; and the third red 10/23/19 and contained retal pan of liquid eggs was not ate. The Dietary Manager was a initial observation and stated beled and dated with future ated for the dates they were tould have been dated for the date | F 8 | The items that did not have date were removed and the member who failed to proper date items found during surv was verbally counseled by the manager on proper storage products and the end of the complete of the potential fected by the alleged deficition 10/21/19 the Dietary Mar completed a kitchen inspectial food items were properly dated. In-service education was profull time, part time, and as not 11/13/19 and the topics incluitems must be stored per NO Regulations and Food Safety Marking Policy reviewed. The has been integrated into the orientation training and in the in-service refresher courses | dietary staff rly store and rey inspection ne dietary protocol on tial to be ient practice. nager on to ensure stored and ovided to all eeded staff on ided all food c State y, Date nis information standard e required | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | | CONSTRUCTION | (X3) DATE COMP | SURVEY |
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| | | 345503 | B. WING | | | 10/ | 24/2019 |
| | ROVIDER OR SUPPLIER | AB CTR OF ROWAN COUNTY | · | 44 | TREET ADDRESS, CITY, STATE, ZIP CODE 112 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 APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 812 | usually cover food to with plastic wrap and covered and placed in Manager stated they plastic wrap around the were observed on 10 the large metal pan of date was placed in the must have forgotten to the thought it was accept left open while food with the thought it was accept left on the thought it | be stored in the walk-cooler date it with the day it is a the cooler. The Dietary must have failed to wrap the ne edges of the pans that (21/19. She further stated if liquid eggs with no label or ecooler by the cook who to label the pan. Dietician revealed she able for the film wrap to be as cooling to allow staff to e. She also stated the cook did date the pan of liquid eggs as interviewed on 10/24/19 at exast concerned with the cook properly to protect the cook properly to protect the cook program. It its QAPI plan to the State er than 1 year after the egulation; It is of information. It is of information is of information in the cook of such committee cook in committee with the | | 312 | and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The Dietary Manager will monitor food storage weekly x 2 weeks then monthly 3 months using the Dietary QA Audit To Monitoring will include auditing all area the kitchen in which food is stored. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective actionitiated as appropriate. Compliance wis be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrate Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager | ool. s of y on ill | 11/19/19 |

| | MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|---|---------------------|--|---|----------------------------|
| | | 345503 | B. WING _ | | | 10/24/2019 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| LIBERTY (| COMMONS NSG & REHA | AB CTR OF ROWAN COUNTY | | 4412 SOUTH MAIN STREET | | |
| | | | | SALISBURY, 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 865 | Continued From page | e 43 | F8 | 65 | | |
| | and correct quality de a basis for sanctions. This REQUIREMENT by: Based on record revifacility's Quality Assu Improvement commit implemented proceduinterventions the compecember 2018. This deficiencies which we 11/30/2018 (F636 and recertification/complacurrent recertification (F636 and 638). The facility during the two show a pattern of the an effective Quality A Improvement Program This tag is cross refer 1. F636 Based on rinterviews the facility comprehensive assessment within 36 comprehensive as | by the committee to identify efficiencies will not be used as a signification in its not met as evidenced itews and staff interviews, the rance and Performance tee (QAPI) failed to maintain ares and monitor these imittee put into place in a was for 2 re-cited ere originally cited on de F638) during the intropolar survey and on the survey on 10/24/2019 continued failure of the federal surveys of record facility's inability to sustain ssurance and Performance entered to: The findings included: The findings included: The findings included: The findings included: The failed to complete a sesment for 9 of 9 residents in its on of a comprehensive its on of a comprehensive its facility (Resident #8, #4, #179, #38, and #36). The findings included with the care and with the care and with the care and maintain and with the care and maintain and with the care and maintain and with the entered one per on of all the department | | This tag is cross reference to F Comprehensive Assessment Tir F638 Quarterly Assessment at every 3 months. F636 Comprehensive Assessment Timing: Resident #8. Annual Comprehe Assessment, Assessment Refer Date (ARD) 9/9/2019. Complete Submitted and Accepted on 10/ the State Quality Improvement If System QIES system Resident #4. Annual Comprehe Assessment, Assessment Refer Date (ARD) 9/4/2019. Complete Submitted and Accepted on 10/ the State QIES system Resident #230. Admission Comprehensive Assessment, A Reference Date (ARD) 10/7/201 Completed, Submitted and Acce 10/22/2019 to the State QIES sy Resident #80. Admission Comp Assessment, Assessment Refer Date (ARD) 7/1/2019. Complete Submitted and Accepted on 8/1 the State QIES system Resident #5. Annual Comprehe Assessment, Assessment Refer | ent | |
| | heads, including the I | MDS (Minimum Data Set) sician and the pharmacist. | | Date (ARD) 09/05/2019. Comple Submitted and Accepted on 10/ | eted, | |

| | | A. BUILDIN | G | СОМ | X3) DATE SURVEY COMPLETED | |
|---|---|---------------------|--|--|------------------------------|--|
| | 345503 | B. WING _ | | 10 | /24/2019 | |
| NAME OF PROVIDER OR SUPPLIER | | , | STREET ADDRESS, CITY, STATE, ZIP CODI | E | | |
| LIBERTY COMMONS NSG & REHAB CT | D OE DOWAN COUNTY | | 4412 SOUTH MAIN STREET | | | |
| LIBERTY COMMONS NSG & REHAD CT | R OF ROWAN COUNTY | | SALISBURY, NC 28147 | | | |
| (X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE | FBE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| The Administrator explained aware there were issues with and completing assessment should have let the QAPI coshe was behind on the asses Administrator reported the good as the information the they were not aware of the address the MDS issues. To reported he expected the acompleted appropriately. 2. F638 Based on record interviews the facility failed submit a Quarterly Minimure Assessment within 14 days Reference Date (ARD) and Quality Improvement Evalue Assessment Submission and System (QIES ASAP) for 10 #9, #12, #50, #79, #11, #23 #16, #18, #56, #3, #19. An interview was conducted Administrator on 10/24/201 reported the QAPI committed month with participation of heads, including the MDS rephysician and the pharmace explained he had not been issues with the MDS process assessments and the MDS the QAPI committee know to not he assessments. The Administration reported the CAPI was only as good committee had and if they visue, they could not addread the Administration reported. | ith the MDS process its and the MDS nurse committee know that essments. The QAPI was only as e committee had and if issue, they could not The Administration essessments were I review and staff to complete and in Data Set (MDS) is of the Assessment I every 92 days to the lation System (QIES) ind Processing (ASAP) ind Processing | F8 | the State QIES system Resident #129. Admission Comprehensive Assessment, Reference Date (ARD) 9/12/2 Completed, Submitted and Ac 10/16/2019 to the State QIES Resident #179 Significant Ch Comprehensive Assessment, Reference Date (ARD) 10/22/ Completed, Submitted and Ac 10/22/2019 to the State QIES Resident #38. Admission Com Assessment, Assessment Ref Date (ARD) 7/12/2019. Comp Submitted and Accepted on 8. the State QIES system Resident #36. Admission Com Assessment, Assessment Ref Date (ARD) 7/16/2019. Comp Submitted and Accepted on 8. the State QIES system F638 Quarterly Assessment a 3 months Resident #7 Quarterly Assess Reference Date (ARD) 9/9/20 Completed, Submitted and Ac 10/25/2019 to the State Qualit Improvement Evaluation Syste Assessment Submission and (ASAP) system. Resident #9 Quarterly Assess Reference Date (ARD) 9/12/2 Completed, Submitted and Ac 10/28/2019 to the State QIES system. Resident #12 Quarterly Assess Reference Date (ARD) 9/19/2 Completed, Submitted and Ac 10/28/2019 to the State QIES system. Resident #12 Quarterly Asses Reference Date (ARD) 9/19/2 Completed, Submitted and Ac | coepted on system cange Assessment 2019. Coepted on system capted on system capted on system capted on system capted on capted capted on capted capte | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | FIPLE CONSTRUCTION NG | | OATE SURVEY OMPLETED |
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| | | 345503 | B. WING | | | 10/24/2019 |
| | ROVIDER OR SUPPLIER | AB CTR OF ROWAN COUNTY | · | STREET ADDRESS, CITY, STATE, 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | ZIP CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EACH CORRECTIVE CROSS-REFERENCED | N OF CORRECTION E ACTION SHOULD BE) TO THE APPROPRIATE CIENCY) | (X5) COMPLETION DATE |
| F 865 | Continued From page | e 45 | F | system. Resident #50 Quarterly Reference Date (ARD) Completed, Submitted 9/5/2019 to the State Of Resident #79 Quarterly Reference Date (ARD) Completed, Submitted 8/13/2019 to the State system. Resident Disch Resident #11 Quarterly Reference Date (ARD) Completed, Submitted 10/29/2019 to the State system. Resident #23 Quarterly Reference Date (ARD) Completed, Submitted 10/30/2019 to the State system. Resident #2 Quarterly Reference Date (ARD) Completed, Submitted 10/30/2019 to the State system. Resident #2 Quarterly Reference Date (ARD) Completed, Submitted 10/24/2019 to the State system. Resident #10 Quarterly Reference Date (ARD) Completed, Submitted 10/28/2019 to the State system. Resident #16 Quarterly Reference Date (ARD) Completed, Submitted 10/29/2019 to the State system. Resident #67 Quarterly Reference Date (ARD) Completed, Submitted 10/29/2019 to the State system. Resident #67 Quarterly Reference Date (ARD) Completed, Submitted 10/29/2019 to the State system. Resident #67 Quarterly Reference Date (ARD) Completed, Submitted 10/29/2019 to the State | and Accepted on QIES ASAP system. Assessment 7/18/2019. and Accepted on QIES ASAP harged. Assessment 9/19/2019. and Accepted on QIES ASAP harged. Assessment 9/19/2019. and Accepted on QIES ASAP Assessment 10/4/2019. and Accepted on QIES ASAP Assessment 9/4/2019. and Accepted on QIES ASAP Assessment 9/4/2019. and Accepted on QIES ASAP Assessment 9/15/2019. and Accepted on QIES ASAP Assessment 9/16/2019. and Accepted on QIES ASAP Assessment Assessment 9/16/2019. and Accepted on QIES ASAP Assessment | |

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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 ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | ON SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 865 | Continued From page | e 46 | F8 | system. Resident #16 Quarterly Asse Reference Date (ARD) 9/16/2 Completed, Submitted and A 10/29/2019 to the State QIES system. Resident #18 Quarterly Asse Reference Date (ARD) 9/20/2 Completed, Submitted and A 10/29/2019 to the State QIES system. Resident discharged Resident #56 Quarterly Asse Reference Date (ARD) 8/16/2 Completed, Submitted and A 9/10/2019 to the State QIES system. Resident #3 Quarterly Asses Reference Date (ARD) 9/2/2 Completed, Submitted and A 10/24/2019 to the State QIES system. Resident #19 Quarterly Asses Reference Date (ARD) 9/5/2 Completed, Submitted and A 10/24/2019 to the State QIES system. Resident #19 Quarterly Asses Reference Date (ARD) 9/5/2 Completed, Submitted and A 10/24/2019 to the State QIES system. This tag is cross reference to Comprehensive Assessment F638 Quarterly Assessment F638 Quarterly Assessment every 3 months. All current residents with Cor Minimum Data Set (MDS) as due have the potential to be the alleged practice. On 11/1 through 11/14/2019 an audit completed by the MDS Nurse to ensure that the facility had comprehensive, accurate, sta | 2019. Accepted on S ASAP essment 2019. Accepted on S ASAP d. essment 2019. Accepted on ASAP d. essment 2019. Accepted on ASAP d. essment 2019. Accepted on S ASAP d. essment | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | LTIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED | |
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| | | 345503 | B. WING _ | | | 10/24/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | • | 10/24/2010 | |
| LIBERTY | COMMONS NSG & R | EHAB CTR OF ROWAN COUNTY | | 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 865 | Continued From p | age 47 | F8 | reproducible assessment of resident s functional capace 84 current residents, 8 number residents did not have their comprehensive assessment within 14 calendar days after excluding readmission in whis gnificant change in the resident did not he Annual comprehensive assessments were completed by timeframes. The assessments were completed by timeframes. The assessments were completed 11/15/2019. All current residents with Question Minimum Data Set (MDS) and the have the potential to be the alleged practice. On 11/1 through 11/15/2019 an audit completed by the MDS Nurse to ensure that the facility has Quarterly Review assessment residents. Out of the 84 curesidents, 0 number of residents have their quarterly review a completed within 92 days singulated within 92 days singulated the previous OBRA Quarterly Assessment or ARD of previous OBRA Quarterly Assessment or ARD of previous Comprehensive assessment assessments were completed submitted by 11/15/2019. On 11/12/2019, The Quality Nurse in serviced the Admining reference to the Quality Assessment and asses | ity. Out of the ber of as completed or admission, which there is no sident so and 4 wave their essments whis ed by uarterly essessments affected by 11/2019 at was see consultant do conducted ent of each surrent lents did not essessments affected by 11/2019 at was see consultant downward ent of each surrent lents did not essessments are the ARD of the lents did not essessments are the ARD of the lents did not essessments are the ARD of the lents did not essessments are the ARD of the lents did not essessments are the ARD of the lents did not essessments are the and entity in the lents did not essessments and entity in the lents did not essessments and entity in the lents did not essessment and entity in the lents did not essessment and entity in the lents did not essessment entity in the lents did not essessments entity in the lents | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345503 | | B. WING | | 10/24/2019 | |
| | ROVIDER OR SUPPLIER | EHAB CTR OF ROWAN COUNTY | | STREET ADDRESS, CITY, STATE, ZIP COD 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | | 1072-772010 | |
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| F 865 | Continued From p | page 48 | F 86 | Medical Director or his/her de At least three other members facility s staff, at least one of be the administrator, owner, a member or other individual in role; and The quality assess assurance committee must :(least quarterly and as needed coordinate and evaluate actividentifying issues with respect quality assessment and assuractivities are necessary; and(and implement appropriate plate to correct identified quality de Disclosure of information. A Secretary may not require distince requirements of this section. Good faith attempts by the condentify and correct quality de not be used as a basis for sa Effective 11/12/2019, this trainincorporated into the new emorientation program. This infoleen integrated into the standorientation training and in the in-service refresher courses femployees and will be review Quality Assurance Process to the change has been sustain. To ensure compliance, Admir Director of Nursing will monitor comfor F638 and F636. This will to the sull to the standorientation training and in the change has been sustain. | s of the f who must a board a leadership ment and ii) Meet at d to vities such as et to which rance (ii) Develop lans of action eficiencies;(h) State or the sclosure of the except in the leated to the the with the (i) Sanctions. The lated to the the with the the wi | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 345503 | B. WING | | | 10/24/2019 | |
| NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY | | | | STREET ADDRESS, CITY, STATE, ZIP COL 4412 SOUTH MAIN STREET SALISBURY, NC 28147 | DE | | |
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| F 865 | Continued From page | e 49 | F | weekly basis to include the weeks then monthly for 3 mo will be presented to the week Committee by the Director of and/or Mini Data Set (MDS) to ensure corrective action in appropriate. Any immediate to be brought to the Director of Administrator for appropriate Compliance will be monitored ongoing auditing program rev Weekly Quality of Life Meeting QA Committee meeting is att Administrator, Director of Nun Coordinator, Unit Manager, S Nurse, Therapy, HIM, Dietary Wound Nurse. | onths. Reportally QA Nursing Coordinatoralitiated as concerns win Nursing or action. d and viewed at the ag. Weekly ended by rsing, MDS Support | s II | |