PRINTED: 03/10/2020 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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		345532	B. WING _			02/	06/2020
NAME OF P	ROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
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E 039	EP Testing Requireme	ents	E	039			3/3/20
SS=C	l						
	*[For RNCHI at §403.	.748, ASCs at §416.54,					
	HHAs at §484.102, C	ORFs at §485.68, OPO,					
	"Organizations" unde	r §485.727, CMHC at					
	§485.920, RHC/FQH	C at §491.12, ESRD					
	Facilities at §494.62]:						
	(O) T+: TI 15:						
	, , ,	ity] must conduct exercises					
		/ plan annually. The [facility]					
	must do all of the follo	-					
	community-based eve	a full-scale exercise that is					
		community-based exercise is					
	` ′	uct a facility-based functional					
	exercise every 2	years; or					
	_	cility] experiences an actual					
		emergency that requires					
	activation of the emer						
		ging in its next required					
		individual, facility-based					
	-	kercise following the onset of					
	the actual event.	· ·					
	(ii) Conduct an a	dditional exercise at least					
	every 2 years, opposi	ite the year the full-scale or					
	functional exercise ur	nder paragraph (d)(2)(i) of					
		ted, that may include, but is					
	not limited to the follo	•					
		d full-scale exercise that is					
		individual, facility-based					
	functional exercise; o						
		disaster drill; or					
	` ,	pp exercise or workshop that					
	is led by a facilitator a	O 1					
	discussion using a na						
		t emergency scenario, and a					
		nents, directed messages, or					
	prepared questions	designed to challenge an					
	emergency plan.						
AROBATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITI F		(X6) DATE

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

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.

02/24/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			C 02/06/2020	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP COD 310 COMMERCE DRIVE SANFORD, NC 27332		12/00/2020	
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E 039	maintain documentate exercises, and emergrevise the [facility's] of the servise the [facility's] of the servises to test the annually. The hospid (i) Participate in community based even (A) When a not accessible, conduct based functional exent (B) If the hoor man-made emerged of the emergency platexempt from engaging scale community-based functional exercise of the emergency platexempt from engaging scale community-based functional exercise under the section is conducted in the section in the section is conducted in the section in the section in the section is conducted in the section in th	the [facility's] response to and ion of all drills, tabletop gency events, and emergency plan, as needed. 3.113(d):] Des that provide care in the hospice must conduct emergency plan at least the emust do the following: a full-scale exercise that is early 2 years; or community based exercise is suct an individual facility recise every 2 years; or spice experiences a natural ency that requires activation in, the hospital is gin its next required full end exercise or individual functional exercise following regency event. additional exercise every 2 earl the full-scale or inder paragraph (d) (2)(i) of otted, that may include, but is owing: and full-scale exercise that is a facility based functional disaster drill; or op exercise or workshop that and includes a group	EC				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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E 039	Continued From pag		E	039				
	care directly. The hot exercises to test the year. The hospice m (i) Participate in that is community-ba (A) When a not accessible, condificility-based function (B) If the hot or man-made emergency platexempt from engagin full-scale community functional of the emergency even (ii) Conduct an attention of the emergency even (iii) Conduct an attention of the emergency even (iv) Conduct an attention of the emergency even (iv) Conduct an attention of the emergency even (iv) Conduct an attention of the emergency even (b) A second community-based or exercise; or (B) A mock (C) A table by a facilitator that in using a narrated, emergency scenarion statements, directed questions definition of the emergency plan. (iii) Analyze the maintain documentate exercises, and emergency	emergency plan twice per nust do the following: an annual full-scale exercise sed; or community-based exercise is uct an annual individual nal exercise; or spice experiences a natural ency that requires activation in, the hospice is no gin its next required based or facility-based exercise following the onset ent. additional annual exercise is not limited to the not full-scale exercise that is a facility based functional disaster drill; or top exercise or workshop led cludes a group discussion clinically-relevant and a set of problem messages, or prepared signed to challenge an hospice's response to and cion of all drills, tabletop gency events and revise ency plan, as needed.						

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E 039	(2) Testing. The [PRT conduct exercises to twice per year. The [do the following:	F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must an annual full-scale exercise sed; or community-based exercise is act an annual individual, all exercise; or RTF, Hospital, CAH] I natural or man-made res activation of the [facility] is exempt from equired full-scale community individual, facility-based llowing the onset of the additional] annual exercise or but is not limited to the disaster drill; or op exercise or workshop that and includes a group arrated, at emergency scenario, and a ments, directed messages, or designed to challenge an afacility's] response to and on of all drills, tabletop tency events and revise incy plan, as needed.	E	039			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	test the emergency procedure including unannounce emergency procedure ICF/IID] must do the (i) Participate in that is community-base (A) When a not accessible, condustriality-based function (B) If the [LT] an actual natural or material requires activation of the LTC facility is exercived a full-scale of individual, facility following the onset of (ii) Conduct an athat may include, but following: (A) A second community-based or functional exercise; of (B) A mock (C) A tablet is led by a facilitator if using a narrated, emergency scenario, statements, directed questions desemble emergency plan. (iii) Analyze the response to and maindrills, tabletop exercise events, and revise the emergency plan, as in *[For ICF/IIDs at §48.]	lan at least twice per year, ed staff drills using the es. The [LTC facility, following: an annual full-scale exercise sed; or community-based exercise is act an annual individual, hal exercise. To facility] facility experiences han-made emergency that the emergency plan, mpt from engaging its next community-based or rebased functional exercise is not limited to the diffull-scale exercise that is an individual, facility based or ope exercise or workshop that includes a group discussion, clinically-relevant and a set of problem messages, or prepared signed to challenge an [LTC facility] facility's hatain documentation of all ses, and emergency elected.					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	ı	02/06/2020
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E 039	to test the emergency. The ICF/IID must do (i) Participate in that is community-ba (A) When a not accessible, conduction (B) If the ICI natural or man-made activation of the eme is exempt from engage full-scale community-based functional of the emergency even (ii) Conduct an amay include, but is not (A) A second community-based or functional exercise; (B) A mock (C) A tableto is led by a facilitator and is led by a f	the following: an annual full-scale exercise sed; or community-based exercise is act an annual individual, hal exercise; or. F/IID experiences an actual emergency that requires rgency plan, the ICF/IID ging in its next required based or individual, facility- exercise following the onset ent. dditional annual exercise that bot limited to the following: d full-scale exercise that is an individual, facility-based or disaster drill; or op exercise or workshop that and includes a group arrated, t emergency scenario, and a hents, directed messages, or designed to challenge an CF/IID's response to and ion of all drills, tabletop gency events, and revise hcy plan, as needed.	E	039		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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E 039	emergency scenario, statements, dire questions designed to plan. If the OPO experor man-made emerge of the emergency platengaging in its next following the onset of (ii) Analyze the Omaintain documentat and emergency even and OPO's] emergent This REQUIREMENT by: Based on record revifacility failed to particiand a full-scale community facility had no evidentabletop exercise or dexercise that was convear. An interview occurred 2/6/2020 at 9:00am, completed some different but could find no evident or full-scale community gast year. The administigned up to take par March 2020 and will will appear of the plant of the participant of the participant of the properties of the participant of the	and includes a group arrated, clinically relevant and a set of problem ected messages, or prepared or challenge an emergency eriences an actual natural ency that requires activation in, the OPO is exempt from required testing exercise if the emergency event. OPO's response to and ion of all tabletop exercises, its, and revise the [RNHCI's cy plan, as needed. The is not met as evidenced iew and staff interviews, the ipate in a tabletop exercise as cy Preparedness (EP)	EC	The statements made on this correction are not an admission not constitute an agreement valleged deficiencies. To remain in compliance with and state regulations the facilior will take the actions set for plan of correction. The plan of constitutes the facility's allegated compliance such that all allegate deficiencies cited have been corrected by the dates indicated by the alleged deficiencies were identified. 2. Corrective action for resinaffected by the alleged deficiencies were identified. 2. Corrective action for resinaffected by the affected by deficient practice. All current residents have the be affected by this alleged deficient practice.	on to and of with the all federal lity has tak the in this of correction of ged or will be ted. dent(s) ent practice dents with the alleged entered the potential terms with the potential terms w	een n e:	

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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E 039	Continued From page	e 7	E	039			
	community-based exercise to test their EP plan. On 2/6/2020 at 9:15am an interview was conducted with the Maintenance Director. He explained they had completed some disaster drills in the facility, such as fire drills, bomb				practice.		
					On 02/20/2020, the Administrator along with the Director of Nursing, Activities Director, Social Worker, Business Offic		
					Health Information Manager, Therapy		
	_ ·	nt drills, but was unaware of ecommunity-based exercise			Director, Maintenance Director, and Minimum Data Set Nurse and complete	ed he	
	in 2019.	o community bacca exercise			a table top exercise for Elopement as a part of their required emergency preparedness plan.		
					The Administrator is working with the lo Sherriff to schedule and completed a fu		
					scale community based exercise for active shooter as a part of their		
					emergency preparedness plan. This exercise will be completed by 03/03/20	20.	
					Measures /Systemic changes to prevent reoccurrence of alleged deficie	nt	
					practice:		
					On 02/24/2020 the Nurse Consultant educated the Administrator. Areas		
					covered were:		
					Emergency preparedness testing requirements for Long Term Care		
					This information has been integrated in	ito	
					the standard orientation training and in	the	
					required in-service refresher courses for	r	
					all staff identified above and will be reviewed by the Quality Assurance		
					process to verify that the change has		
					been sustained.		
					Monitoring Procedure to ensure the second control of the seco	at	
					the plan of correction is effective and the		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page	÷ 8	E 03	specific deficiency cited remains correand/or in compliance with regulatory requirements. The Nurse Consultant or designee wimonitor compliance utilizing the E309 Quality Assurance Tool weekly for more for 3 months. The tool will review emergency preparedness testing for required drills and exercises. Reports be presented to the weekly Quality Assurance committee by the Director Nurses to ensure corrective action is initiated as appropriate. Compliance we monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administration Director of Nursing, MDS Coordinator Therapy Manager, and the Dietary Manager.	II Denthly Swill Of Will Of Will Of Sitty Stor, Or,
F 000	survey was conducte 02/06/20 and 2 of 2 a	complaint investigation d from 02/02/20 through	F 00	0	
F 550 SS=D	Resident Rights/Exer CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a rig self-determination, ar access to persons an outside the facility, in this section.	(2)(b)(1)(2) Rights. ght to a dignified existence, nd communication with and	F 55	0	3/3/20

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		02/06/2020
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY	3	STREET ADDRESS, CITY, STATE, ZIP CODE B10 COMMERCE DRIVE SANFORD, NC 27332	1 02/03/2020
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F 550	resident in a manner promotes maintenand her quality of life, resindividuality. The far promote the rights of \$483.10(a)(2) The faccess to quality caseverity of condition must establish and practices regarding provision of service residents regardles \$483.10(b) Exercise The resident has the rights as a resident or resident of the U \$483.10(b)(1) The face of interference, coerciform the facility. \$483.10(b)(2) The face of interference reprisal from the facility. \$483.10(b)(2) The face of interference reprisal from the facility. \$483.10(b)(2) The face of interference reprisal from the facility. \$483.10(b)(2) The face of interference reprisal from the facility. \$483.10(b)(2) The face of interference reprisal from the facility. \$483.10(b)(2) The face of interference reprisal from the facility.	grity and care for each er and in an environment that ince or enhancement of his or ecognizing each resident's cility must protect and of the resident. Gacility must provide equal are regardless of diagnosis, in, or payment source. A facility maintain identical policies and transfer, discharge, and the is under the State plan for all is of payment source. For of Rights. For right to exercise his or her of the facility and as a citizen inted States. Facility must ensure that the is his or her rights without in, discrimination, or reprisal interview, discrimination, and cility in exercising his or her rights as required under this interview, the facility failed to with dignity and respect	F 550	The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all feder and state regulations the facility has to	d do

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F 550	Continued From pag	e 10	F 5	550			
	promote dignity. This reviewed for dignity.	s was for 2 of 2 residents			or will take the actions set forth in this plan of correction. The plan of correction	on	
	The findings included	i:			constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be		
		admitted to the facility on es that included Parkinson '			corrected by the dates indicated. F550		
	s disease.				Corrective action for resident(s) affected by the alleged deficient practic	e:	
of resident abuse was made on 11/1/19 at 7:00 interviewed on 0		For resident #28: Resident was interviewed on 02/17/2020 by the Social Worker regarding any care concerns or					
	and Nursing Assistar	nt (NA) #13. A facility visitor nistrator that he overheard			concerns of feeling like an inconvenien Resident denied any concerns.	nvenience.	
		#28 that "she was an			,		
	inconvenience". The identified for the resident	ere was no injury or harm dent.			For resident # 66: On 02/24/2020 the resident was audited by the Nurse Consultant and noted with a Foley		
		gation Guide indicated NA immediately upon report of			catheter Fig Leaf privacy bag in place.		
		nt #28 was assessed for any			Corrective action for residents with the potential to be affected by the alleg	ed	
	identified. The physi	njury and no concerns were cian and Responsible Party B were notified. Written			deficient practice. All residents have the potential to be affected by the deficient		
	statements were obta	ained from NA #13, the view was conducted with			practice. On 02/17/2020 the Social Worker interviewed all alert and oriented reside	ents	
	Resident #28 by the	Administrator. These s contained the following			for concerns related to dignity and feeli as thought they were an inconvenience	•	
	information:				This was completed on 02/17/2020. 4 of 24 residents reported concerns. Two		
		esident #28 on 11/1/19			the residents had their concerns addressed via the grievance process b	•	
	staff treated her inap	t stated that she felt as if propriately "sometimes".			the Administrator. One resident clarified her concerns with the Nurse Consultan	ıt	
	inconvenience". Res	A #13 made her "feel like an sident #28 was asked if NA an "inconvenience" and she			and Administrator and a task was enter into Point Click Care for Head of Bed to be elevated 30 minutes after meals. The)	
	stated "yes".	an inconvenience and she			was completed by the Nurse Consultar		

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F 550	Continued From page - A witness statement visitor on 11/1/19 indited Resident #28 's room get up. The witness Resident #28 that she she was talking down. - An undated written #13 indicated she we and was going to get stated that she had not reported that she told inconvenience for he passing of dinner tray. The facility 's Investignation in the social residents who were resided on the 100 has	t completed by a facility cated NA #13 came into an and the resident asked to reported that NA #13 told was an inconvenience and to the resident. Statement completed by NA ant into Resident #28's room her up when the resident of wanted to get up. NA #13 Resident #28 it would be an an to get her during the ys. Gation Guide additionally cial Worker (SW) interviewed e cognitively intact that all and no concerns were		550		on e 02/ ent ged 20. PR ne	
	residents to ensure n signs of unusual behaconcerns were identification reviewed all grievance the past 30 days for a no issues were identifor all full time, part timelated to verbal abuse and resident rights by Nurse Consultant. O conducted of the grie Council concerns by SW and information on the monthly Quality This Investigation Gu of the incident was the	seessments of all 100 hall to tearfulness, fearfulness, or avior were present and no fied. The Nurse Consultant tes and incident reports for any similar allegations and fied. Education was initiated the, and as needed staff the, customer service, dignity, to the Director of Nursing and the needing of the service of the			Beginning on 02/18/2020 the nurse manager audited all current residents f the presence of a Foley catheter and a privacy bag. This audited was completed by 02/21/2020. 2 out of 6 residents were noted without a privacy bag and this was corrected by the Support Nurse on 02/21/2020. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficies practice: Beginning on 02/19/2020, the Nurse Managers educated all full time, part time and as needed (PRN) nurses and Certified Nursing Assistants on resident dignity and privacy. Areas covered were Respecting resident rights	ed re as ent me,	

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE	(X5) COMPLETION
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	COMPLETION
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY SANFORD, NC 27332	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
F 550 Continued From page 12 F 550	
Resident #28 with dignity. • Providing timely care • Ensuring Foley Catheter bags are	
An Investigation Report completed on 11/6/19 covered with a privacy bag at all times indicated the allegation of resident abuse made	
on 11/1/19 related to NA #13 and Resident #28 This information has been integrated into	
was substantiated. NA #13 was terminated at the the standard orientation training and in the	
close of the investigation on 11/6/19. required in-service refresher courses for	
all staff identified above and will be	
The quarterly Minimum Data Set assessment reviewed by the Quality Assurance process to verify that the change has	
cognition was fully intact. She had no behaviors been sustained. The facility specific	
and no rejection of care.	
Nurses and CNA's who give residents	
An interview was conducted with Resident #28 on care in the facility. Any nursing staff who	
2/2/20 at 3:40 PM. Resident #28 was alert and does not receive scheduled in-service	
oriented to person, place, and time. She recalled training will not be allowed to work until	
the incident with NA #13 that occurred on 11/1/19 training has been completed by March 3,	
and confirmed the statements she made in her 2020.	
interview with the Administrator. She stated she	
had not seen NA #13 after the incident occurred. 4. Monitoring Procedure to ensure that	
the plan of correction is effective and that	
A phone interview was attempted with NA #13 on specific deficiency cited remains corrected and/or in compliance with regulatory	
2/3/20 at 2:12 PM. She was unable to be and/or in compliance with regulatory reached for interview.	
The Director of Nurses or designee will	
A review of the In-Service/Education sign in monitor compliance utilizing the F550	
sheets from 11/1/19 through 2/5/20 compared to Quality Assurance Tool weekly for 2	
the active staff roster revealed 100% of staff were weeks then monthly x 3 months or until	
not provided with education following the 11/1/19 resolved. The tool will interview residents	
incident with Resident #28 and NA #13. NA #1, for concerns related to dignity, staff	
NA #14 and NA #15 had not received education practices, and Foley catheter bags are	
on verbal abuse, customer service, dignity, and covered. Monitoring will be rotated to	
resident rights as indicated in the facility 's include all shifts and weekends. Reports	
Investigation Guide. A review of the staff time will be presented to the weekly Quality	
cards from the close of the investigation on Assurance committee by the Director of	
11/6/19 through 2/5/20 indicated NA #1 worked Nurses to ensure corrective action is	
12 times, NA #14 worked 15 times, and NA #15 initiated as appropriate. Compliance will be monitored and the ongoing auditing	
program reviewed at the weekly Quality	

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		345532	B. WING		C 02/06/2020		
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP COI 310 COMMERCE DRIVE SANFORD, NC 27332	•	210012020	
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F 550	2/6/20 at 10:10 AM s residents to be treate facility staff. She acceducation on verbal dignity, and resident the facility 's Investig completed for 100% #14, and NA #15 had The Administrator state process of updat so that when educat able to track comple: 2) Resident #66 was 1/14/2020 with diagrobstructive uropathy of urine is blocked) a sacral area. The review of Reside a problem area initial urinary catheter due the interventions included to the interventions included to the process of updat so that when educated a problem area initial urinary catheter due the interventions included to have a sistence Daily Living and use catheter. On 2/2/2020 at 1:25 made of Resident #6 noted to have an indicated to have an indicated to the urinary cathed and the drainage bag attabed.	with the Administrator on she stated she expected all ed with dignity and respect by knowledged that the abuse, customer service, rights that was indicated in gation Guide was not of the staff as NA #1, NA d not received the education. ated that the facility was in ing the active employee list ion was provided they were tion status for 100% of staff.	F 55	Assurance Meeting until dee longer necessary for complia dignity related to foley bags I covered. The weekly QA Meattended by the Administrato Nursing, MDS Coordinator, 1 Manager, Health Information and the Dietary Manager.	ance with being eting is or, Director of Fherapy		

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hallway. Resident #66 was ob 2/3/2020 at 9:50am, attached to the side cover and was visible. On 2/3/2020 at 11:00 observed in his room was hanging on the liprivacy cover and was hanging on the liprivacy cover an	oserved lying in his bed on the urinary drainage bag was of the bed, with no privacy of from the hallway. Oam Resident #66 was of the urinary drainage bag eft side of the bed without a cas visible from the hallway. Oather the hallway of the bed without a cas visible from the hallway. Oather the bed without a cas visible from the hallway. Oather the bed without a cas visible from the hallway. Oather the bed without a cas visible from the hallway. Oather the bed without a cas visible from the hallway. Oather the bed without a cas visible from the hallway. Oather the bed without a cas visible from the hallway. Oather the bed without a cas visible from the hallway. Oather the bed without a cas visible from the hallway. Oather the bed without a cas visible from the hallway.	F 55	0			
2/6/2020 at 10:10am expectation for nursi cover for urinary drai Safe/Clean/Comforta CFR(s): 483.10(i)(1)- §483.10(i) Safe Envi The resident has a ri	, she stated it was her ng staff to use a privacy nage bags. able/Homelike Environment -(7) ronment. ght to a safe, clean,	F 58	4		3/3/20	
	ROVIDER OR SUPPLIER COMMONS NSG AND R SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag hallway. Resident #66 was ob 2/3/2020 at 9:50am, attached to the side of cover and was visible On 2/3/2020 at 11:00 observed in his room was hanging on the I privacy cover and was Nurse Aide #3 was in 11:00am and stated urinary catheters had drainage bag for priv Resident #66 did not An interview occurre at 11:05am and state catheters normally had drainage bag especia working with therapy drainage bag should with a privacy cover a dmitted to the facilit this did not occur. An interview occurree 2/6/2020 at 10:10am expectation for nursi cover for urinary drai Safe/Clean/Comforta CFR(s): 483.10(i)(1)- §483.10(i) Safe Envi The resident has a ri	ROVIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 hallway. Resident #66 was observed lying in his bed on 2/3/2020 at 9:50am, the urinary drainage bag was attached to the side of the bed, with no privacy cover and was visible from the hallway. On 2/3/2020 at 11:00am Resident #66 was observed in his room. The urinary drainage bag was hanging on the left side of the bed without a privacy cover and was visible from the hallway. Nurse Aide #3 was interviewed on 2/3/2020 at 11:00am and stated normally residents with urinary catheters had a blue cover on the drainage bag for privacy but could not state why Resident #66 did not have one. An interview occurred with Nurse #1 on 2/3/2020 at 11:05am and stated residents with urinary catheters normally had a privacy cover on the drainage bag especially if they were up walking or working with therapy. She further added the drainage bag should have been changed to one with a privacy cover when Resident #66 was admitted to the facility but could not explain why	A BUILDING 345532 ROVIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 hallway. Resident #66 was observed lying in his bed on 2/3/2020 at 9:50am, the urinary drainage bag was attached to the side of the bed, with no privacy cover and was visible from the hallway. On 2/3/2020 at 11:00am Resident #66 was observed in his room. The urinary drainage bag was hanging on the left side of the bed without a privacy cover and was visible from the hallway. Nurse Aide #3 was interviewed on 2/3/2020 at 11:00am and stated normally residents with urinary catheters had a blue cover on the drainage bag for privacy but could not state why Resident #66 did not have one. 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The resident has a right to a safe, clean,	A BUILDING 345532 ROWIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SANFORD, NC 27332 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICE OF MILES EPIPLE PROBLEM OF ALL OF CORRECTION SHOULD CROSS-REFERENCE OF TO MAPPENDE DEFICIENCY MILES EPIPLE PROBLEM OF CORRECTIVE ACTION SHOULD CROSS-REFERENCE OF TO MAPPENDE DEFICIENCY OR LSO DENTIFY MIS INFORMATION) Continued From page 14 Resident #66 was observed lying in his bed on 2/3/2020 at 9:50am, the urinary drainage bag was attached to the side of the bed, with no privacy cover and was visible from the hallway. On 2/3/2020 at 11:00am Resident #66 was observed in his room. The urinary drainage bag was hanging on the left side of the bed without a privacy cover and was visible from the hallway. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SAMFORD, NC 27332 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY STATE, ZIP CODE 310 COMMERCE DRIVE SAMFORD, NC 27332 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY STATE, ZIP CODE 310 COMMERCE DRIVE SAMFORD, NC 27332 Continued From page 14 hallway. Continued From page 14 hallway. Resident #66 was observed lying in his bed on 2/3/2020 at 9:50am, the urinary drainage bag was attached to the side of the bed, with no privacy cover and was visible from the hallway. Nurse Aide #3 was interviewed on 2/3/2020 at 11:00am and stated normally residents with urinary catheters had a blue cover on the drainage bag for privacy but could not state why Resident #66 did not have one. 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F 584	homelike environment use his or her person possible. (i) This includes ensure receive care and serve physical layout of the independence and do (ii) The facility shall ethe protection of the roor theft. §483.10(i)(2) Housek services necessary to and comfortable interestand comfortable intere	eiving treatment and ng safely. ride- clean, comfortable, and and all belongings to the extent ring that the resident can rices safely and that the facility maximizes resident es not pose a safety risk. exercise reasonable care for resident's property from loss reeping and maintenance of maintain a sanitary, orderly, ior; ride- clean, comfortable, and the extent to all belongings to the extent to all belongin	F 584				
	by:	ns, resident, family, staff		The statements made on this plan of			

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F 584	Continued From pag	e 16	F 5	34			
	ensure laundered ite Resident #54. This v reviewed for persona included: Resident #54 was ac cumulative diagnose Failure, Chronic Kidn Resident #54's quart Set (MDS) dated 12 cognitively intact, ex make himself unders his vision was sever for extensive assista	d review, the facility failed to the swar returned to was for 1 of 1 resident all items. The findings dmitted on 9/1/17 with the sof Congestive Heart they Failure and Glaucoma. derly modified Minimum Data 19/19 indicated he was thibited no behaviors, able to stood, understood others and the stood, understood others and the stood of the sto		correction are not an admission to constitute an agreement walleged deficiencies. To remain in compliance with a and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility's allegat compliance such that all alleged deficiencies cited have been of corrected by the dates indicated F584 1. Corrective action for resident affected by the alleged deficient For resident #54: the Administrator purchased new paths and purchased new paths and purchased new paths affected by the resident.	all federal ty has taken in in this correction ion of ed r will be ed. ent(s) int practice: rator the resident the		
	Review of Resident #54's Activity Review dated 1/8/20 indicated choosing what clothes to wear was very important to him. In an interview on 2/2/20 at 1:46 PM, Resident #54 stated he was missing a lot of his clothes. He stated he was missing pajamas and underwear. He stated he reported the missing items to staff. In an interview on 2/3/20 at 2:50 PM, Nursing Assistants (NA) #5 and NA #6 stated they were aware that Resident #54 was missing his underwear but not aware of any missing pajamas. They stated a few months back, the laundry got backed up because two laundry staff quit and the new laundry staff were still learning. NA #5 stated the new laundry staff often put residents' clothes in the wrong rooms even when the items were marked with the resident's name.			2. Corrective action for residence the potential to be affected by deficient practice. Beginning on 02/17/2020 the Section worker interviewed all current oriented residents and resident their own responsible party for personal laundry. The audit was completed on 02/17/2020. 6 or residents were identified with reclothing. A grievance report was by the administrator and the multiple of the presence by 03/24/2020.	the alleged Social alert and ts who were missing as ut of 24 missing as initiated ussing items		
				process by 02/24/2020. Beginning on 02/17/2020 the S Worker interviewed the respon parties of all current residents not alert and oriented for missi	sible who were		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _				C 06/2020
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F 584	Continued From page	e 17	F 5	584			
	In a telephone interview on 2/3/20 at 3:15 PM, Resident #54's family member confirmed he was missing laundered items. In another interview and observation on 2/4/20 at 8:45 AM, Resident #54 was lying in bed. He stated he had just been given a bath. He stated the reason he had his sheet and blanket over him was because he was not wearing any underwear because the NA could not find any. In an interview on 2/4/20 at 8:47 AM, Nurse #6 stated she was aware that Resident #54 was				laundry. This audit will be completed by 03/03/2020.	/	
					Measures /Systemic changes to prevent reoccurrence of alleged deficie practice:	nt	
					On 02/19/2020, the Nurse Managers began educating all full time, part time, and PRN Nurses and CNA's on the following:		
					Reporting missing laundry items		
		ms. She stated she notified pervisor again of Resident rear.			On 02/20/2020, the Administrator bega educating all full time, part time, and PI Housekeepers, Laundry department employees, and Laundry Supervisor or	RN	
	Worker (SW) stated s Resident #54 was mis	d/20 at 9:00 AM, the Social the was not aware that ssing his laundered items.			the following: Personal Laundry Policy		
	She stated it was the facility practice to complete a grievance form if missing items could not be located and she confirmed there were no grievances completed for Resident #54's missing laundered items.				This information has been integrated in the standard orientation training and in required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance	the	
	her position October a other areas of the fact when she was named quit. She stated she hat the only one experient maternity leave and re	visor (HS) stated she started 2019 but had worked in ility for 4 years. She stated if HS, all the laundry staff had to hire all new staff and hice staff member was out of eturned to work yesterday.			process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff will does not receive scheduled in-service training will not be allowed to work until training has been completed by March 2020. Monitoring Procedure to ensure that the	ho I 3,	
	The HS stated she had been working to revamp the laundry room and identify who unlabeled items belonged too. She stated she had never seen but one pair of Resident #54's underwear in laundry and she was unsure if the aides were				plan of correction is effective and that specific deficiency cited remains correct and/or in compliance with regulatory requirements.	cted	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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		345532	B. WING _			02/	06/2020	
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F 584	asked the aides to chelp identify missing labeled items with falaundry staff were stabout A or B bed and initials. In another interview 9:40 AM, NA #5 state Resident #54 this mounderwear to but on put a pair of pajama observation with NA in any of Resident #54 thad not had a chandroom to see if she coalso confirmed his faall his clothing items. In another interview laundry room on 2/4, rack of unlabeled ite socks. She stated if missing laundered it come to the laundry items. Laundry Assisitems and confirmed for 90 days. In another interview Resident #54 stated underwear under his In another interview #54 stated the facility underwear yesterday.	ear away. The HS stated she ome to the laundry room to items that were unlabeled or ding. She stated the new ill having some confusion ditems only labeled with and observation on 2/4/20 at ed she bathed and dressed orning and did not have any him so she just went in and pants on him. In an #5, there was no underwear 54's drawers. She stated she ever yet to go to the laundry ould find his underwear. She amily had written his name in . and observation of the /20 at 2:20 PM, there was a ms and a box of unlabeled residents told her they had ems, she or the aides would room to look for the missing stant #1 was folding resident she has been in her position on 2/5/20 at 9:30 AM, he was not wearing any	F 5	584	The Administrator or designee will mon compliance utilizing the F584 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The tool will monit reports of missing laundry items and follow through utilizing the grievance process. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monito and the ongoing auditing program reviewed at the weekly Quality Assuran Meeting or until no longer deemed necessary for compliance with the miss laundry process. The weekly QA Meeti is attended by the Administrator, Direct of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	or ne y red nce sing ng or		

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F 584	stated the facility wer underwear yesterday other missing items a Resident #54 was fre but wearing underwe and his dignity.	and bought Resident #54 and will be replacing his as well. The SW stated quently incontinent of bowel ar was very important to him 6/20 at 10:11 AM, the t was her expectation that	F 58	4	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)- §483.10(j) Grievance §483.10(j)(1) The res grievances to the factor that hears grievances reprisal and without for the respect to care and to furnished as well as to furnished, the behavior residents, and other of facility stay. §483.10(j)(2) The respective grievances that the resolve grievance with this	ident has the right to voice dility or other agency or entity is without discrimination or ear of discrimination or ear of discrimination or ear of discrimination or eat include those with reatment which has been that which has not been or of staff and of other concerns regarding their LTC dident has the right to and the empt efforts by the facility to be resident may have, in paragraph.	F 58	5	3/3/20

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F 585	of all grievances re contained in this par provider must give to the resident. The include: (i) Notifying resider postings in promine facility of the right to (meaning spoken) or grievances anonym of the grievance and the grievance off can be filed, that is address (mailing ar number; a reasona completing the revito obtain a written or grievance; and the independent entitie be filed, that is, the Quality Improveme Agency and State I program or protecti (ii) Identifying a Gri responsible for ove receiving and track conclusions; leadin by the facility; main information associa example, the identifying rievances submitted written grievance do coordinating with stanecessary in light of (iii) As necessary, to prevent further potesting the identification of the province of the	ensure the prompt resolution garding the residents' rights aragraph. Upon request, the a copy of the grievance policy grievance policy must at individually or through the locations throughout the offile grievances orally or in writing; the right to file mously; the contact information ficial with whom a grievance, his or her name, business and email) and business phone ble expected time frame for the wof the grievance; the right decision regarding his or her contact information of s with whom grievances may pertinent State agency, and Organization, State Survey Long-Term Care Ombudsman on and advocacy system; evance Official who is reseing the grievance process, ing grievances through to their g any necessary investigations taining the confidentiality of all atted with grievances, for the resident for those and anonymously, issuing ecisions to the resident; and that and federal agencies as of specific allegations; aking immediate action to ential violations of any resident ped violation is being	F:	585		

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	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CO 310 COMMERCE DRIVE SANFORD, NC 27332		2/06/2020
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F 585	reporting all allege abuse, including ir and/or misapproprianyone furnishing provider, to the adas required by State (v) Ensuring that a include the date the summary statementhe steps taken to summary of the peregarding the residus to whether the confirmed, any contaken by the facility and the date the weare (vi) Taking appropriate and the date the weare (vi) Taking appropriate or if an outside enthe State Survey Aronganization, or loconfirms a violation rights within its are (vii) Maintaining eversult of all grievantally years from the is decision. This REQUIREMED by: Based on residente record review, the grievance form for returned to Resideresident reviewed included:	n §483.12(c)(1), immediately ad violations involving neglect, njuries of unknown source, iation of resident property, by services on behalf of the ministrator of the provider; and	F 5	The statements made on the correction are not an admission to constitute an agreement alleged deficiencies. To remain in compliance with an astate regulations the factor will take the actions set for plan of correction. The plan	sion to and do t with the th all federal cility has taken orth in this	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		C 02/06/2020		
NAME OF PR	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		2/00/2020	
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LIBERTY (COMMONS NSG AND RE	HAB CTR OF LEE COUNTY		SANFORD, NC 27332			
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F 585	Continued From page	÷ 22	F 5	85			
	cumulative diagnoses Failure, Chronic Kidno	of Congestive Heart ey Failure and Glaucoma.		constitutes the facility's allegation compliance such that all alleged deficiencies cited have been or wi			
	Resident #54's quarterly modified Minimum Data Set (MDS) dated 12/9/19 indicated he was			corrected by the dates indicated. F585			
	make himself underst	ibited no behaviors, able to ood, understood others and		Corrective action for resident(affected by the alleged deficient process.)	actice:		
	his vision was severely impaired. He was coded for extensive assistance with toileting, hygiene, a urinary catheter and frequently incontinent of bowel. In an interview on 2/2/20 at 1:46 PM, Resident #54 stated he was blind. He stated he was missing a lot of his clothes and had reported the missing items to staff. In an interview on 2/3/20 at 2:50 PM, Nursing Assistants (NA) #5 and NA #6 stated they were aware that Resident #54 was missing laundered items. In a telephone interview on 2/3/20 at 3:15 PM, Resident #54's family member confirmed he was missing laundered items. Review of the Missing Clothing Policy dated last revised 9/2014 read if missing items not located in the resident's room or in the laundry room, a grievance form should be completed.			For resident #54: the Administrato purchased new underwear for the	resident		
				on 02/05/2020. On 02/24/2020 the Administrator purchased new paja the resident.			
				Corrective action for residents the potential to be affected by the deficient practice.	alleged		
				Beginning on 02/17/2020 the Soci Worker interviewed all current aler oriented residents and residents witheir own responsible party for mis personal laundry. The audit was completed on 02/17/2020. 6 out of	t and ho were sing		
				residents were identified with miss clothing. A grievance report was ir by the administrator and the missi will be resolved through the grieva	ing itiated ng items		
				process by 02/24/2020. Beginning on 02/17/2020 the Soci Worker interviewed the responsibl parties of all current residents who	al e		
	Worker (SW) stated s Resident #54 was mis	/20 at 9:00 AM, the Social he was not aware that ssing his laundered items. facility practice to complete		not alert and oriented for missing plaundry. This audit will be complet 03/03/2020.	ersonal		
	a grievance form if mi located and she confi	ssing items could not be		For residents identified with missir personal laundry a grievance form completed and follow up by 03/03/	was		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C 02/06/2020	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (•	02/00/2020	
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(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 585	Housekeeping Sup the aides to come to identify missing iten items with faded la complete a grievant of resident missing. In another interview and NA #6 stated to grievance form for laundered items but room when they has items or just let the	2/4/20 at 9:13 AM, the servisor (HS) stated she asked to the laundry room to and help ms that were unlabeled or label beling. She stated she did not use form when she was notified laundered items. If you can be did not complete a Resident #54's missing at rather they go to the laundry and extra time to look for the HS know.	F 5	3. Measures /Systemic of prevent reoccurrence of all practice: On 02/19/2020, the Nurse began educating all full time and PRN Nurses and CNA following: Reporting missing lau Completing a grievand laundry items are missing Location of grievance grievance process This information has been the standard orientation training prevention of the standard orientation training preventions.	Managers ne, part time, A's on the undry items oe form when forms and integrated into aining and in the		
	In an interview on 2/4/20 at 11:40 AM, NA #7 stated she did not complete a grievance form for reports of missing items but rather let the HS know or went to the laundry room herself when she could get off the floor to look. In an interview on 2/6/20 at 10:28 AM, the SW stated the facility went and bought Resident #54 underwear yesterday and will be replacing his other missing items as well. The SW stated Resident #54 was frequently incontinent of bowl but wearing underwear was very important to him and his dignity. In an interview on 2/6/20 at 10:11 AM, the Administrator stated it was her expectation that a grievance form be completed for missing laundered items but the policy of completing a grievance form for missing items was not working and the process needed to be addressed.			required in-service refresh all staff identified above ar reviewed by the Quality As process to verify that the obeen sustained. The facili in-service will be provided Nurses and CNA's who give care in the facility. Any nurses not receive schedule training will not be allowed training has been complete 2020. 4. Monitoring Procedure the plan of correction is eff specific deficiency cited re and/or in compliance with requirements. The Administrator or design compliance utilizing the FS Assurance Tool weekly x 2 monthly x 3 months or untitool will monitor reports of	and will be assurance shange has thy specific to all agency we residents ursing staff who do in-service to work until ed by March 3, to ensure that fective and that mains corrected regulatory the will monitor in the stage of the service of the se		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	HAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	02/00/2020	
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F 585	CFR(s): 483.20(b)(2)(i) With determines, or should there has been a sign resident's physical or purpose of this sectio means a major declin resident's status that itself without further in implementing standar interventions, that has one area of the reside requires interdisciplin care plan, or both.) This REQUIREMENT by: Based on record revifacility failed to complestatus Minimum Data within 14 days after the	ssment After Signifcant Chg (ii) nin 14 days after the facility I have determined, that		items and follow through utilizing the grievance process. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance we be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance with a grievance process. The weekly QA Meeting is attended by the Administrate Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. For resident #67, a corrective action we obtained on 11/08/19. On 11/08/19, a Significant Change in Status Minimum Data Set Assessment with an Assessment Reference Date of the process.	ill y he or, 2/21/20	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 637	Continued From page 25 reviewed for hospice (#67). The findings included:		F	637				
					11/08/19 was opened for Resident #67 was closed prior to being completed du			
					to resident expiring on 11/19/19, which was before completion due date. The	due		
	on 9/9/19 with multipl	ginally admitted to the facility e diagnoses including portal			date for this assessment to be complet on is 11/22/19.			
		ood clot obstructing the			Corrective action for residents with the			
	portal vein which brings blood to the liver from the intestines) and cirrhosis of the liver.				potential to be affected by the alleged deficient practice.			
					All residents have the potential to be			
	The admission MDS assessment dated 9/16/19 indicated Resident #67 was cognitively intact and				affected by the alleged deficient practic	ce.		
	received limited assis	9			On 02/21/20, the Minimum Data Set Consultant completed a 100% audit of	all		
		for all other Activities of		residents who have been admitted to				
	Daily Living.	ioi ali otilei Activities oi		discharged from hospice care during the				
	Daily Living.				past 90 days to ensure that Significant			
	Resident #67's medic	cal record revealed a			Change Minimum Data Set assessmen			
		note dated 10/15/19 that she			have been completed.			
					The audit results are:			
	A hospice note dated	10/27/19 indicated Resident						
	#67 started to receive	hospice services.			4 of 5 residents who were transferred			
					either to or from hospice during the par	st		
		67's care plan revealed a			90 days had timely completion of			
	problem area initiated care due to failure to	d on 10/28/19 for hospice thrive.			Significant Change MDS.			
					1 of 5 residents who were transferred			
		MDS assessment dated			either to or from hospice was noted to	not		
	11/19/19 was comple	ted.			have had a Significant Change MDS			
	0:- 0/4/0000 -+ 4:00:-	the MDO News			completed during required timeframe a			
		m the MDS Nurse was			this transition in care. This was identification prior to this audit and a Significant	ea		
		d she couldn't speak as to nge MDS was not completed			Change MDS was completed with			
	, ,	ent person completing MDS			Assessment Reference Date of 1/31/2	n		
		ime. She could only say, a			Assessment Neterence Date of 1/3 1/2	<i>.</i>		
		status MDS assessment			Systemic Changes			
		mpleted 14 days after			- Systemic Changes			
	Resident #67 enrolled	· ·			On 02/18/20, the Minimum Data Set			
		1			Nurse Consultant in serviced the			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDI	IPLE CONST	(X3) DATE SURVEY COMPLETED			
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F 637	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	requencement reque	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '			(X3) DATE SURVEY COMPLETED	
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F 640	Continued From page			637	Nursing to ensure corrective action for trends or ongoing concerns is initiated appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing	he	2/23/20
F 640 SS=D	CFR(s): 483.20(f)(1)-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	d data processing ng data. Within 7 days after resident's assessment, a he following information for acility: ment. nt updates. e in status assessments. assessments. upon a resident's transfer, nd deathsheet) information, if there	F	640			2/23/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 640			F 64	0			
	§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete and transmit the quarterly Minimum Data Set (MDS) assessment within the required time frame for 1 of 22 sampled residents reviewed (Resident #11). The findings included: Resident #11 was initially admitted to the facility on 10/11/19 with multiple diagnoses that included			Resident #11: Specific deficiency for the resident was corrected on 02/06/20. The facility failed to complete the scheduled Omnibus Budget Reconciliation Act Minimum Data Set assessment for Resident #11 within regulated timeframe. The scheduled quarterly Minimum Data Set for this resident had an Assessment Reference Date of 01/18/20 with a completion due date of 02/01/20. After identification that the scheduled quarterly Minimum Data Set with	e		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 640	The most recent com assessment dated 10 #11 to have severe or required extensive to Activities of Daily Livin Record review for Remost recent quarterly Assessment Reference Upon further review, swere incomplete, and been transmitted. During an interview w 2/4/2020 at 9:40am swas incomplete and results She was unable to stanot been completed a she had recently become the last 3 weeks.	pleted admission MDS /18/19 revealed Resident ognitive impairment and total assistance with all ng to include eating. sident #11 indicated the MDS was set with an ce Date (ARD) of 1/18/2020. sections G, J, M, N, O and Z the assessment had not with the MDS Nurse on he acknowledged the MDS needed to be transmitted. ate why the assessment had and transmitted only to say ome the MDS nurse within s interviewed on 2/6/2020 at t was her expectation for the be completed and	F 6	Assessment Reference Date of was late, it was finished and control the facility Minimum Data Set No 2/06/20. The Minimum Data stransmitted and accepted into a database in Batch #1385 on 02. The Submission ID # was 182. Corrective action for residents potential to be affected by the adeficient practice. A 100% audit of all residents we had an Minimum Data Set with Assessment Reference Date of past 30 days 01/22/20 – 02/22 completed in order to identify if other late assessments. This acompleted by the Regional Mir Set Consultant on 02/23/20. The results of this audit were: 51 of 73 total assessments cor were identified as having been within required timeframe. 22 of 73 total assessments cor were identified as not having be completed within required timeframe. As of 02/23/20 all Minimum Datassessments that are currently be worked on are within required timeframe for completion, with assessments identified. Systemic Changes On 02/18/20, the Regional Minimum Changes	ompleted Nurse on Set was the state 2/07/20. 156122. with the alleged /ho have alluring the /20 was f there was audit was himum D	e ere s ata	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 640	Continued From page	≥ 30	F6	Set Nurse Consultant provide to the Minimum Data Set Coor the importance of scheduling completing all Minimum Data assessments according to reguine frames per chapter 2 of the Assessment Instrument manneducation also included requinenceding Minimum Data Set 7 days after completing a resemblem Minimum Data Set assessment tracking record, the provider of the Minimum Data Set data (information into the facility Minimum Data Set software). The encoding requirements a follows: For a comprehensive asset (Admission, Annual, Significate Status, and Significant Correct Comprehensive), encoding minimum Data Set Completion Date (V0200C2 + For a Quarterly, Significate to Prior Quarterly, Discharge, Prospective Payment System assessment, encoding must of 7 days after the Minimum Data Completion Date (Z0500B + Tor a tracking record, enshould occur within 7 days of Date (A1600 + 7 days for Enthand A2000 + 7 days for Death records). The monitoring procedure to the plan of correction is effect specific deficiency cited remaind/or in compliance with the	ordinator or and a Set gulated the Resider ual. The irements for data: Within sident's ent or must encoding are as sessment ant Change ction to Priorust occur Plan + 7 days). ant Correcting occur within ta Set 7 days). Incoding fithe Event try records h in Facility ensure that the sains correct that is a source that it is a source that is a sourc	nt or n de he ta in or ion	

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F 641 SS=E	Accuracy of Assessm CFR(s): 483.20(g)	ccuracy of Assessments FR(s): 483.20(g) 483.20(g) Accuracy of Assessments. The assessment must accurately reflect the		requirements; The Director of Nursing, Administrate designated Nurse Manager will revier random residents who have had any the following Minimum Data Set type (Admission, Quarterly, Annual) computating the past 30 days in order to validate whether or not the assessme was completed within the required timeframes according to Chapter 2 or Resident Assessment Instrument matusing the Quality Assurance Tool title "MDS Timely Completion." This will be presented to the weekly Quality Assurance committee by the Director Nursing to ensure corrective action for trends or ongoing concerns is initiate appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Funformation Management, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nurse.	w 5 of s sleted ent f the nual d be then c of or d as e lealth	2/26/20		
	The assessment mus resident's status.							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 641	1 Continued From page 32 Based on observation, record review, and staff		F 6	641	F641 Accuracy of Assessments				
		failed to code the Minimum			For resident #17, a corrective action wa	as			
		ssment accurately in the			obtained on 02/03/20.	10			
		raints (Residents #17, #23,			" The specific deficiency was correct	:ted			
		ations (Residents #28, #46,			on 02/03/20 by modifying the MDS				
		noses (Residents #1, #6,			assessment with an Assessment				
		cers (Residents #6 and			Reference Date of 10/31/19 in order to				
	#28), and alarms (Re	sident #60) for 10 of 25			correct miscoding of Section P0100A				
	residents reviewed.				□Restraints (Bedrails). This correction	ı			
	The findings included:				was completed by the facility MDS				
					Coordinator. The corrected MDS was				
					re-submitted and accepted by the state				
					database on 02/05/20 in Submission IE)			
		admitted to the facility on			#18198218.				
		s that included Parkinson' s			F :1 1//00 /: /:				
	disease.				For resident #23, a corrective action was obtained on 02/03/20.				
		review assessment date			" The specific deficiency was correct	ted			
		sident #23 had bilateral grab			on 02/03/20 by the facility MDS				
	· ·	on of her bed. Resident #23			Coordinator. The MDS assessment wi				
		grab bars for transfers and			Assessment Reference Date of 11/11/1	9			
	bed mobility. She had	d no other devices in use.			was modified in order to correct the	_			
	The quarterly Minimu	m Data Set (MDS)			coding for Section P0100A □Restraints (Bedrails). The corrected MDS was	,			
		/11/19 indicated Resident			re-submitted and accepted by the state	ا د			
		intact. The assessment			database on 02/05/20 in Submission IE				
		d rails used daily that were			#18198218.	•			
	physical restraints (ar					ſ			
	physical or mechanic				For resident #35, a corrective action wa	as			
		or adjacent to the resident's			obtained on 02/03/20.				
	body that the individu	al cannot remove easily			" The specific deficiency was correct	ted			
		m of movement or normal			on 02/03/20 by the facility MDS	ſ			
). The physical restraints			Coordinator. The MDS assessment wi				
		vas signed by the MDS			Assessment Reference Date of 12/07/	19			
	Nurse.				was modified in order to correct the				
					coding for Section P0100A □Restraints	;			
		ducted with the MDS Nurse			(Bedrails). The corrected MDS was	ĺ			
		. She stated that she was and was helping out with			re-submitted and accepted by the state database on 02/04/20 in Submission IE				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345532	B. WING_	B. WING			C 02/06/2020	
NAME OF P	ROVIDER OR SUPPLIER	2.0002			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	06/2020	
	10 115211 011 001 1 2.2.1				B10 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY	SANFORD, NC 27332					
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 641	Continued From page	∍ 33	F 6	641				
		out 3 weeks ago when she			#18190095.			
		urse full time. The 11/11/19						
	MDS for Resident #23	3 that indicated she had bed			For resident #51, a corrective action w	as		
	_	vere physical restraints was			obtained on 02/03/20.			
		S Nurse. She revealed that			" The specific deficiency was correct	ted		
		od what this question was npleted this MDS. She			on 02/03/20 by the facility MDS Coordinator. The MDS assessment w	ith		
	•	ought it was just asking if the			Assessment Reference Date of 12/10/			
	resident had bed rails and that she had not realized that she was only supposed to code this if the bed rail met the definition of a physical restraint. The MDS Nurse stated that Resident				was modified in order to correct the	.0		
					coding for Section P0100A □Restraint	S		
					(Bedrails). The corrected MDS was			
					re-submitted and accepted by the state			
		e not physical restraints and			database on 02/04/20 in Submission II)		
	that this MDS was co	ded incorrectly.			#18190095.			
		vith the Administrator on			For resident #43, a corrective action w	as		
		he stated that she expected accurately. She reported			obtained on 02/06/20.	stad		
	the former MDS Nurs	•			" The specific deficiency was correct on 02/06/20 by the facility MDS	ilea		
		ent MDS Nurse was new to			Coordinator. The MDS assessment w	ith		
	MDS coding and was				Assessment Reference Date of 12/26/			
	, o	3			was modified in order to correct the			
					coding for Section I-15800 to include			
		admitted to the facility on			Depression. The corrected MDS was			
	_	ses that included end stage			re-submitted and accepted by the state			
	renal disease and ort	hopedic aftercare.			database on 02/07/20 in Submission II #18215622.)		
		for Resident #46 dated						
		ercocet (opioid medication)			For resident #60, a corrective action w	as		
) every 4 hours as needed			obtained on 02/04/20.	at a d		
	(PRN) for pain.				" The specific deficiency was correct on 02/04/20 by the facility MDS	ieu		
	2a A review of the M	edication Administration			Coordinator. The MDS assessment w	ith		
		n 12/28/19 through 1/3/20			Assessment Reference Date of 01/01/			
		16 received PRN Percocet			was modified in order to correct the	*		
	on 6 of 7 days (12/28	/19 through 1/2/20).			coding for Section N0410A to accurate	ly		
		d no opioid medication on			reflect the correct number of days they	,		
	1/3/20.				received Antipsychotic medication duri	ng		
					7 day ARD lookback window. Section			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345532	B. WING			C 02/06/2020		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, , ,	<u> </u>	
I IDEDTY	COMMONS NSC VND BI	EHAB CTR OF LEE COUNTY		3′	10 COMMERCE DRIVE			
LIBERTT	COMMONS NSG AND RI	ENAB CIR OF LEE COUNTY		S	ANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 641	641 Continued From page 34		F	641				
	's cognition was intacopioid medications or	3/20 indicated Resident #46 ct. She was coded with			P0200E was also modified in order to reflect correct coding of Wanderguard Alarm that was used daily during lookb timeframe. The corrected MDS was re-submitted and accepted by the state database on 02/05/20 in Submission IE #18198218.)		
	An interview was conducted with the MDS Nurse on 2/5/20 at 1:10 PM. She stated that she was new to MDS coding and was helping out with assessments until about 3 weeks ago when she began as the MDS Nurse full time. The 1/3/20 MDS for Resident #46 that indicated she received opioid medication on 7 of 7 days during the MDS look back period was reviewed with the MDS Nurse. The MARs that indicated Resident #46 received opioid medication on 6 of 7 days during the MDS look back period (12/28/19 through 1/3/20) was reviewed with the MDS Nurse. The MDS Nurse revealed this coding for opioid medication was an error and should have been coded to indicated opioid medication was administered on 6 of 7 days. During an interview with the Administrator on				For resident #28 (1), a corrective action was obtained on 02/05/20 for inaccurate coding of Anticoagulant. "The specific deficiency was correct on 02/05/20 by the facility MDS Coordinator. The MDS assessment with Assessment Reference Date of 11/18/2 was modified in order to correct the coding for Section N0410E to accurate reflect the correct number of days they received Anticoagulant medication during 7 day ARD lookback window. The corrected MDS was re-submitted and accepted by the state database on 02/05/20 in Submission ID #18198218.	te ted th 19 ly ng		
	the MDS to be coded the former MDS Nurs October and the curro MDS coding and was 2b. A review of the M 1/3/20 indicated Resi Percocet for pain on a through 1/2/20). The admission MDS indicated Resident #4	ent MDS Nurse was new to still learning. ARs from 12/30/19 through dent #46 received PRN	d so gh		For resident #28 (2), a corrective action was obtained on 02/24/20 for inaccurat coding of Unstageable Pressure Ulcer due to Unremoveable Dressing. "The specific deficiency was correct on 02/24/20 by the MDS Consultant. TMDS assessment with Assessment Reference Date of 11/18/19 was modif in order to correct the coding for Section M0300E1 to accurately reflect that the resident did not have an Unstageable Pressure Ulcer due to Non-Removable Dressing/Device. The corrected MDS	o for inaccurate ressure Ulcer essing. rey was corrected Consultant. The essessment 19 was modified ding for Section eflect that the Unstageable on-Removable		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345532	B. WING				С		
		343532	D. WING_				02/06/2020		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE				
LIBERTY	COMMONS NSG AND	REHAB CTR OF LEE COUNTY			MMERCE DRIVE				
				SANFO	ORD, NC 27332				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION S			(X5) COMPLETION DATE		
F 641	Continued From p	age 35	F 6	641					
		tions were received during the pain section of this MDS was S Nurse.		stat	s re-submitted and accepted by te database on 02/24/20 in Bato 400.				
	on 2/5/20 at 1:10 new to MDS codir assessments until began as the MDS MDS that indicate asked if PRN pain during the last 5 d Nurse. The MAR received PRN Per from 12/30/20 through the MDS Nurse. The coding was incoded to indicate were administered During an interviee 2/6/20 at 10:10 AN the MDS to be conthe former MDS N	conducted with the MDS Nurse PM. She stated that she was ag and was helping out with about 3 weeks ago when she S Nurse full time. The 1/3/20 d no answer to the question that medications were received ays was reviewed with the MDS at that indicated Resident #46 recet for pain on 4 of 5 days ough 1/3/20 was reviewed with The MDS Nurse revealed this accurate and should have been that PRN pain medications d during the last 5 days. We with the Administrator on M she stated that she expected ded accurately. She reported lurse left that position in urrent MDS Nurse was new to was still learning.		obta " on 0 Coo Ass was cod refle rece ARI mod for (prr lool was stat ID # For obta " on 0	r resident #46, a corrective actional resident #46, a corrective actional resident #46, a corrective actional resident #46, a corrective action 22/05/20 by the facility MDS ordinator. The MDS assessment Reference Date of 1/3 is modified in order to correct the ding for Section N0410H to accurate the correct number of days to revived Opioid medication during in Dookback window. J0100B was diffied in order to reflect correct or resident having received as need in pain medication during the AF kback timeframe. The corrected is re-submitted and accepted by the database on 02/06/20 in Submitted and accepted by the database on 02/06/20 in Submitted and accepted by the database on 02/06/20 in Submitted and accepted by the database on 02/06/20 in Submitted and occepted by the database on 02/06/20 in Submitted and accepted by the database on 02/06/20 in Submitted and accepted by the database on 02/06/20 in Submitted and occepted by the database on 02/06/20 in S	orrected ont with 8/20 e urately they 7 day as also coding eded RD I MDS the mission a was orrected ont. The			
	3/29/19 with diagr s disease. A review of the wo from 11/1/19 throu #28 had one press	a. Resident #28 was admitted to the facility on /29/19 with diagnoses that included Parkinson ' disease. A review of the wound and skin assessments from 11/1/19 through 11/18/19 indicated Resident (28 had one pressure ulcer that was		in o I155 diaş MD data	order to correct the coding for Se 800 to accurately reflect the acti gnosis of Depression. The corre So was re-submitted to the state tabase on 02/24/20 in Batch #14	ection ive ected 100.			
	unstageable. The quarterly Min	mum Data Set (MDS)			ained on 02/24/20. The specific deficiency was co 02/24/20 by the MDS Consultar				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C 02/06/2020		
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		0 COMMERCE DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 641	#28 's cognition was 1 unstageable pressurenon-removable dress unstageable pressure wound bed by slough pressure ulcer section the Support Nurse.	/18/19 indicated Resident intact. She was coded with ure ulcer due to sing/device and 1 e ulcer due to coverage of and/or eschar. The n of this MDS was coded by	F€	641	MDS assessment with Assessment Reference Date of 01/17/20 was modifi in order to correct the coding for Sectio I5700 to accurately reflect the absence diagnoses of Anxiety. The corrected M was re-submitted to the state database 02/24/20 in Batch #1400.	n of DS		
	An interview was conducted with the Support Nurse on 2/4/20 at 4:11 PM. The wound and skin assessments from 11/1/19 through 11/18/19 that indicated Resident #28 had one unstageable pressure ulcer was reviewed with the Support Nurse. The 11/18/19 MDS that indicated Resident #28 had 1 unstageable pressure ulcer due to non-removable dressing/device and 1 unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar was reviewed with the Support Nurse. The Support Nurse revealed this MDS was coded inaccurately. She stated that Resident #28 had no pressure ulcers due to non-removable dressing/device. During an interview with the Administrator on 2/6/20 at 10:10 AM she stated that she expected the MDS to be coded accurately. 3b. Resident #28 was admitted to the facility on 3/29/19 with diagnoses that included Parkinson 's disease.				Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practic A 100% audit of all current residents most recent OBRA MDS assessment whose conducted by the MDS Consultant. This audit will include reviews for accuraceding of the following Sections of the MDS: "Section P Physical Restraints "Section P Alarms "Section M Pressure Ulcers "Section J PRN Pain Medications "Section N Antipsychotic,	rill ate		
	for November 2019 ir received no anticoag The quarterly MDS as	nistration Records (MARs) ndicated Resident #28 ulant medication. ssessment dated 11/18/19 28 's cognition was intact.			Anticoagulant and Opioid Use This audit will be completed no later tha 02/25/20. Any coding errors that are identified during the audit will be immediately modified and corrected and re-submitted to the state database.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING			C 02/06/2020		
NAME OF P	ROVIDER OR SUPPLIER	0.0002	1	S.	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	06/2020	
NAME OF T	TO VIDER OR GOL LEIER				10 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND F	REHAB CTR OF LEE COUNTY			ANFORD, NC 27332			
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 641	Continued From pag	ge 37	F	341				
	She was coded with	anticoagulant medication on			Systemic Changes			
	_	edications section of this MDS						
	was coded by the S	upport Nurse.			On 02/18/20, the Regional Minimum D			
					Set Consultant completed an in service			
		nducted with the Support			training for the facility Minimum Data S			
		H:11 PM. The MARs that			Coordinator that included the importan			
		\$28 received no anticoagulant			of thoroughly reviewing the medical rec prior to completion of all Sections of the			
		11/18/19 MDS that indicated ed anticoagulant medication			Minimum Data Set assessment. Speci			
		reviewed with the Support			emphasis was on correctly counting ar			
	_	Nurse revealed this MDS			coding medications such as Antipsycho			
		ately and that it should have			Opioids, Anticoagulants and prn pain	,		
	indicated no anticoagulant medications were				medications. Other areas that were			
	received.				emphasized were how to accurately co	de		
					Section P for Physical Restraints and			
	_	with the Administrator on			Section P for Alarms. Correct coding of			
		she stated that she expected			Active Diagnoses in Section I, including	-		
	the MDS to be code	d accurately.			Depression and Anxiety were reviewed			
					during the education. The importance thorough review of all skin problems,	OI		
	1a Resident #60 wa	as admitted to the facility on			focusing on Pressure Ulcers was			
		sis that included dementia.			discussed in order to be able to accura	itely		
	o, oo, ro mar diagno.	sie triat moiaded dementia.			code all portions of Section M.	.0.9		
	A physician 's order	dated 12/25/19 indicated			,	ĺ		
		otic medication) 25 milligrams			This information has been integrated ir	ıto		
	(mg) once daily at b	edtime for Resident #60.			the standard orientation training for ne			
					Minimum Data Set Coordinators and n	ew		
		ication Administration			Dietary Managers.			
	,	m 12/26/19 through 1/1/20			The manifestion of the second	_4		
		60 received Seroquel on 6 of			The monitoring procedure to ensure the			
	7 days (12/27/19 thr	ougn 1/1/20).			the plan of correction is effective and the specific deficiency cited remains corrections.			
	The quarterly Minim	um Data Set (MDS)			and/or in compliance with the regulator			
		/1/20 indicated Resident #60			requirements.	y		
		derately impaired. She was			The Director of Nursing or designee wi	II		
		sychotic medication. The			begin auditing the coding of Section J			
		of this MDS was signed by			PRN pain medications; Section M			
	the MDS Nurse.	Ç ,			Pressure Ulcers; Section I □ Psychiatr	ic		
					Diagnoses; Section N □ Antipsychotic,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING			C 02/06/2020		
NAME OF D	ROVIDER OR SUPPLIER	343332	5: 11::10		REET ADDRESS, CITY, STATE, ZIP CODE	02	2/06/2020	
NAME OF PI	ROVIDER OR SUPPLIER							
LIBERTY	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY			0 COMMERCE DRIVE			
				SA	ANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 641	Continued From page	÷ 38	F 6	541				
F 641	An interview was con on 2/4/20 at 4:12 PM new to MDS coding a assessments until ab began as the MDS Ni MDS for Resident #6i no antipsychotic med indicated she receive during the MDS look with the MDS Nurse. this was an error and coded to indicate anti 6 of 7 days. During an interview w 2/6/20 at 10:10 AM sl the MDS to be coded the former MDS Nurse October and the curre MDS coding and was 4b. Resident #60 was 8/30/19 with diagnosi A physician 's order wander/elopement also A review of the Treatr (TARs) from 12/1/19 Resident #60 had a w utilized daily. The quarterly Minimu assessment dated 1/1 s cognition was model.	ducted with the MDS Nurse She stated that she was and was helping out with out 3 weeks ago when she urse full time. The 1/1/20 that indicated she received ication and the MARs that d Seroquel on 6 of 7 days back period were reviewed The MDS Nurse revealed the MDS should have been psychotics were received on with the Administrator on the stated that she expected accurately. She reported the Indicated she received on with the Administrator on the stated that she expected accurately. She reported that position in the MDS Nurse was new to still learning. shadmitted to the facility on the stated that she expected accurately indicated wander/elopement alarm m Data Set (MDS) 1/20 indicated Resident #60 lerately impaired. She was	F	541	Anticoagulant and Opioid use; Section Physical Restraints and Section Palarms of the Minimum Data Set Assessment using the quality assurant survey tool entitled Accurate MDS Coc Audit Tool to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, He Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	ce ling in d be of as		
	coded with no wande	lerately impaired. She was r/elopement alarm in use.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			02/) 06/2020		
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	,	STREET ADDRESS, CITY, STATE, ZIP COD 310 COMMERCE DRIVE SANFORD, NC 27332	ΙΕ	, <u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE		
F 641	new to MDS coding a assessments until ab began as the MDS N MDS for Resident #6 wander/elopement al TARs that indicated a was in use daily were Nurse. The MDS Nu error and the MDS shindicate a wander/elopement al TARs that indicated a was in use daily were Nurse. The MDS Nu error and the MDS shindicate a wander/elopement was a to be coded the former MDS to be coded the former MDS nurse. October and the curre MDS coding and was 5) Resident #51 was facility on 6/24/15 with chronic pain syndrom dementia. A Device and Bed Ramoter and the second to use the grab mobility, and they did movement or normal were no other device. The quarterly Minimum 12/10/19 revealed Ramoderately impaired extensive assistance mobility and transfers she had bed rails use	She stated that she was and was helping out with out 3 weeks ago when she urse full time. The 1/1/20 that indicated no arm was in use and the wander/elopement alarm ereviewed with the MDS rese revealed this was an hould have been coded to openent alarm was in use. With the Administrator on the stated that she expected accurately. She reported the left that position in the end wander was new to still learning. Toriginally admitted to the hidiagnoses that included the, spinal stenosis and the was and the was a bars for transfers and bed anot restrict her freedom of access to the body. There is in use. The massessment indicated the daily that were physical all method, physical or	F	341					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345532	B. WING		C 02/06/2020			
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		32/06/2020		
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 641	individual cannot refreedom of moveme body). The physical was signed by the Month of the Month o	to the body that the move easily which restricts into rormal access to one's restraint section of the MDS MDS Nurse. In the MDS Nurse was sed she was new to MDS one out with assessments ago when she became the time. She reviewed the esident #51 which indicated daily and were physical. Nurse explained she had not equestion was asking when MDS and thought it was just thad bed rails. She further ealized she was only his if the bed rail met the cal restraint. The MDS nurse is grab bars were not physical DS was coded incorrectly. The move and thought it was just that bed rails as interviewed on 2/6/2020 at it was her expectation for the courately. She explained the	F 64	,				
	and the current MDS coding and was still 6) Resident #17 was facility on 2/22/12 w dementia. A Device and Bed R 7/19/19 indicated Rebars at the top secti	eft the position in October S Nurse was new to MDS learning. s originally admitted to the ith diagnoses that included tail Review assessment dated esident #17 had bilateral grab on of her bed. She was noted for bed mobility, and they did						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345532	B. WING_		02/06/2020			
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	•	72/00/2020		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 641	access to the body. in use. The quarterly Minim 10/31/19 revealed F cognitive impairment assistance of 2 staff and transfers. The abed rails used daily (any manual method device, material or adjacent to the body remove easily which movement or normal physical restraint sets by the MDS Nurse. On 2/3/2020 at 3:35 interviewed and staff coding and was help until about 3 weeks new MDS Nurse full 10/31/19 MDS for Red rails were used restraints. The MDS understood what the she completed the Masking if the resider stated she had not resupposed to code the definition of a physic stated Resident #17	ge 41 Itom of movement or normal There were no other devices um Data Set (MDS) dated Resident #17 to have severe It. She required extensive It members for bed mobility Itssessment indicated she had Ithat were physical restraints It, physical or mechanical Itequipment attached or It that the individual cannot In restricts freedom of It access to one's body). The Itection of the MDS was signed Item MDS Nurse was Ited she was new to MDS Item MDS one was Ited she was new to MDS Item MDS one was Ited she was new to MDS Item MDS one was Ited she was new to MDS Item MDS one was in the was only Item MDS one was only	F 6	41				
	10:10am and stated MDS to be coded a	as interviewed on 2/6/2020 at it was her expectation for the curately. She explained the eft the position in October						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			1	C 06/2020
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		310	REET ADDRESS, CITY, STATE, ZIP CODE COMMERCE DRIVE NFORD, NC 27332	1 02	00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 641	coding and was still 7. Resident #35 was cumulative diagnose Accident, dysphagia Review of Resident and Physician orders real side rails for position 10/23/19. Review of Resident and 10/23/19 read he received to maintain independent of the possible with an increinjuries. Review of Resident and 10/24/19 read upper side rails for possible with an increinjuries. Review of Resident and 10/24/19 read upper side rails for possible with an increinjuries.	S Nurse was new to MDS learning. admitted 4/9/18 with s of Cerebral Vascular , and epilepsy.	F	541			
	#35 was in bed leani between his head ar	2/2/20 at 5:00 PM, Residenting to the right with pillow in ad ¼ side rails. The bed was ith bilateral fall mats on the					
	Resident #35 was ly	on on 2/3/20 at 10:00 AM, ing in the same position as the was observed flaying his					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			1	06/2020	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		310	COMMERCE DRIVE NFORD, NC 27332	1 02/	00/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 641	Continued From page	e 43	F	641				
	right-side extremities	and yelling.						
	Assistant (NA) #5 sta	8/20 at 10:20 AM, Nursing sted the bilateral ¼ side rails ent #35 from movement or						
	stated Resident #35 and the ¼ bilateral si while in the bed. She	8/20 at 11:34 AM, Nurse #5 was able to get out of bed de rails did not restrain him stated the side rails were nce he tended to lean to the						
	Nurse stated the bilated prevent Resident #35 but rather used becaute to the right. She stated	8/20 at 2:20 PM, the MDS teral ¼ side rails did not 5 from getting out of the bed use of his tendency to lean ed Resident #35 has to the fall mat without injuries.						
	MDS Nurse stated it MDS Nurse so it was helping out with some couple of months, bu and acknowledged sl MDS Nurse stated sh MDS question regard restraints and was correstraints. She stated her that she was cod	on 2/3/20 at 3:35 PM, the was her 3rd full week as an new to her. She confirmed to of the assessments for a to she was brand new to MDS the was still learning. The ne did not understand the ling side rails as physical ording all side rails as I that a consultant group told ing the side rails incorrectly ck and modify the MDS.						
		6/20 at 10:11 AM, the the MDS Nurse still was uld have gone and modified						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345532	B. WING _				06/ 2020	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		<u>, , , , , , , , , , , , , , , , , , , </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 641	require the use of sid She further stated it it Resident #35's MDS 8. Resident #1 was a 8/30/18 with the diag insomnia, chronic pa autoimmune disease. The resident 's quart documented she had understood/understa cognition. The resident antidepressant and a The care plan was up covered all the resident antidepressant medication administr goals and interventio antidepressant medic There was a physicia milligrams (antidepreday which was docur administration record during the MDS look) On 2/6/2020 at 9:40 conducted with the M the depression diagnores.	erly MDS to reflect he did not le rails as physical restraint. was her expectation that was coded correctly. admitted to the facility on noses of heart disease, in, Lupus (inflammatory), and rheumatoid arthritis. terly MDS dated 1/3/2020 I clear speech and nds and had an intact ent's active diagnoses were expected to consider the distribution of the distribution of the distribution. In order for Bupropion XL 75 issant) two tablets twice a mented on the medication I as administered as ordered back period of 1/3/2020.	F	541				
		am an interview was dministrator who stated she						

		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345532	B. WING _				C / 06/2020	
	EHAB CTR OF LEE COUNTY		310 COMM	IERCE DRIVE	1 02/	00,2020	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT ATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		(EACH CORRECTIVE ACTION SHOULD I	BE.	(X5) COMPLETION DATE	
expected the MDS to 9. Resident #6 was 6/12/17 with the diag hemiparesis, dyspha The resident 's quar documented the resi and was understood cognition was intact. non-Alzheimer's den depression, and psyr received 7 days of ar antipsychotic. The resident's updat included psychotropi to include antianxiety antipsychotic admini side effects. Pharma for possible changes A review of the resid medication administr not receive an antiar treatment for anxiety period of 1/17/2020. On 2/6/2020 at 9:40 conducted with the M the anxiety diagnose coded on the 1/17/20 be corrected. On 2/6/2020 at 10:18 conducted with the M conducted with the M	admitted to the facility on moses of hemiplegia and gia, and diabetes. Iterly MDS dated 1/17/2020 dent had adequate hearing funderstands and her The active diagnoses were mentia, hemiplegia, anxiety, chotic disorder. The resident intidepressant and ed care plan of 1/9/2020 comedication administration and assessment for cry to review and recommend for reduction. The treative diagnoses were mentia, hemiplegia, anxiety, chotic disorder. The resident intidepressant and stration and assessment for cry to review and recommend for reduction. The active diagnoses were mentia, hemiplegia, anxiety, chotic disorder. The resident intidepressant and stration and assessment for cry to review and recommend for reduction. The active diagnoses were mentia, hemiplegia, anxiety, chotic disorder. The resident intidepressant and stration and assessment for cry to review and recommend for reduction. The active diagnoses were mentia, hemiplegia, anxiety, chotic disorder. The resident intidepressant and stration and assessment for cry to review and recommend for reduction. The active diagnoses were mentia, hemiplegia, anxiety, chotic disorder. The resident intidepressant and stration and assessment for cry to review and recommend for reduction. The active diagnoses were mentia, hemiplegia, anxiety, chotic disorder. The resident intidepressant and stration and assessment for cry to review and recommend for reduction. The active diagnoses were mentia, and her active d	F	341				
10. Resident #43 wa	as admitted to the facility on						
	ROVIDER OR SUPPLIER COMMONS NSG AND R SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page expected the MDS to 9. Resident #6 was 6/12/17 with the diagon hemiparesis, dysphated the resident supplied to include antipsychotic. The resident's update included psychotropic to include antianxiety antipsychotic administing effects. Pharmater for possible changes of 1/17/2020. A review of the residential medication administration administration administration and psychotropic to include antianxiety antipsychotic administration administration administration administration administration administration administration administration and psychotropic to include antianxiety antipsychotic administration	ROVIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 45 expected the MDS to be coded accurately. 9. Resident #6 was admitted to the facility on 6/12/17 with the diagnoses of hemiplegia and hemiparesis, dysphagia, and diabetes. The resident 's quarterly MDS dated 1/17/2020 documented the resident had adequate hearing and was understood/understands and her cognition was intact. The active diagnoses were non-Alzheimer's dementia, hemiplegia, anxiety, depression, and psychotic disorder. The resident received 7 days of antidepressant and antipsychotic. The resident's updated care plan of 1/9/2020 included psychotropic medication administration to include antianxiety, antidepressant and antipsychotic administration and assessment for side effects. Pharmacy to review and recommend for possible changes or reduction. A review of the resident 's January 2020 medication administration record revealed she did not receive an antianxiety medication or treatment for anxiety during the MDS lookback period of 1/17/2020. On 2/6/2020 at 9:40 am an interview was conducted with the MDS Coordinator who stated the anxiety diagnoses should not have been coded on the 1/17/2020 quarterly MDS and would	ROVIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 45 expected the MDS to be coded accurately. 9. Resident #6 was admitted to the facility on 6/12/17 with the diagnoses of hemiplegia and hemiparesis, dysphagia, and diabetes. The resident 's quarterly MDS dated 1/17/2020 documented the resident had adequate hearing and was understood/understands and her cognition was intact. The active diagnoses were non-Alzheimer's dementia, hemiplegia, anxiety, depression, and psychotic disorder. The resident received 7 days of antidepressant and antipsychotic. 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ROVIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 45 expected the MDS to be coded accurately. 9. Resident #6 was admitted to the facility on 6/12/17 with the diagnoses of hemiplegia and hemiparesis, dysphagia, and diabetes. The resident's quarterly MDS dated 1/17/2020 documented the resident had adequate hearing and was understood/understands and her cognition was intact. The active diagnoses were non-Alzheimer's dementia, hemiplegia, anxiety, depression, and psychotic disorder. The resident received 7 days of antidepressant and antipsychotic. The resident's updated care plan of 1/9/2020 included psychotropic medication administration to include antianxiety, antidepressant and antipsychotic administration and assessment for side effects. Pharmacy to review and recommend for possible changes or reduction. A review of the resident's January 2020 medication administration record revealed she did not receive an antianxiety medication or treatment for anxiety during the MDS lookback period of 1/17/2020. On 2/6/2020 at 9:40 am an interview was conducted with the MDS Coordinator who stated the anxiety diagnoses should not have been coded on the 1/17/2020 quarterly MDS and would be corrected. On 2/6/2020 at 10:15 am an interview was conducted with the Administrator who stated she expected the MDS to be coded accurately.	A BUILDING 346532 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SAMFORD, NC 27332 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY) Continued From page 45 expected the MDS to be coded accurately. 9. Resident #6 was admitted to the facility on 6/12/17 with the diagnoses of hemiplegia and hemiparesis, dysphagia, and diabetes. The resident's quarterly MDS dated 1/17/2020 documented the resident had adequate hearing and was understood/understands and her cognition was intact. The active diagnoses were non-Alzheimer's dementia, hemiplegia, anxiety, depression, and psychotic disorder. The resident received 7 days of antidepressant and antipsychotic administration and assessment for side effects. Pharmacy to review and recommend for possible changes or reduction. A review of the resident's January 2020 medication administration received an antianxiety, medication or treatment for anxiety during the MDS lookback period of 1/17/2020 quarterly MDS and would be corrected. On 2/6/2020 at 9-40 am an interview was conducted with the Administrator who stated she expected the MDS to be coded accurately.	A BUILDING 345532 B. WING TOOMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WITH	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			C 02/06/2020		
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 641	9/4/17 with the diagnoses of post-concussional		F 6	41				
	and functional quad							
	documented that the hearing, clear speed understands. The reintact cognition for rappropriate decision diagnoses were seiz quadriplegia, post-cunspecified injury at pain syndrome. His treatment was providays of antianxiety a medication.	esident was scored having an memory but does not have in making. The active zure, anxiety, functional oncussional syndrome, it cervical 5 spine, and chronic is pain was assessed, and ded. The resident received 7 and antidepressant						
	potentials and beha	's diagnoses including viors. The resident had goals revaluation of side effects of anxiety medication.						
	medication administ documentation the r Escitalopram Oxala (antidepressant) ear period of 12/26/19.	te Tablet 20 mg ch day for the MDS look-back The resident was also ng assessed in the same and symptoms of						
	conducted with the the depression diag	am an interview was MDS Coordinator who stated noses should have been /19 quarterly MDS and would						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			C 02/06/2020		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	02/00/2020		
				310 COMMERCE DRIVE				
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332				
(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 CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 641	Continued From page	e 47	F 6	641				
	On 2/6/2020 at 10:15 conducted with the Adexpected the MDS to	dministrator who stated she						
F 657 SS=E	Care Plan Timing and CFR(s): 483.21(b)(2)	d Revision	F 6	557		2/28/20		
	be- (i) Developed within 7 the comprehensive a (ii) Prepared by an inincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the rand their resident report practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by the (iii)Reviewed and reviteam after each asse comprehensive and cassessments. This REQUIREMENT by:	orehensive care plan must of days after completion of sesessment. terdisciplinary team, that nited to //sician. e with responsibility for the of and nutrition services staff. eticable, the participation of resident's representative(s). The included in a resident's participation of the resident resentative is determined and evelopment of the staff or professionals in ined by the resident's needs are resident. Itsed by the interdisciplinary sesment, including both the quarterly review of is not met as evidenced		F657 Care Plan Timing and Po	evision			
		iew, observation, resident terview, the facility failed to		F657 Care Plan Timing and Re Resident #4, a corrective action				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING				06/2020	
NAME OF P	ROVIDER OR SUPPLIER		,	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				3	310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY	SANFORD, NC 27332		SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
		· 			DEFICIENCY)			
F 657	657 Continued From page 48		F	657				
		e plans in the areas of			obtained on 02/05/20.			
	,	#4 and #9) and medications			On 02/05/20 the Activities care plan for	-		
	, ,	of 22 residents reviewed for			resident #4 was revised in order to			
		The facility also failed to			accurately reflect that resident is not			
		sistant (NA) was involved in			currently receiving antibiotic medication	٦.		
		cess for 4 of 4 residents			This was completed by the Activities Director.			
	participation in the ca	#36, and #60) reviewed for			Director.			
	participation in the ca	ne planning process.			Resident #9, a corrective action was			
	The findings included	:			obtained on 02/23/20.			
	1. Resident #4 was a	admitted to the facility on			On 02/23/20 the Activities care plan for	-		
		es that included heart failure.			resident #9 was revised in order to			
					accurately reflect that he is no longer to	00		
	The quarterly Minimu	m Data Set (MDS)			weak to participate in his usual activitie	s.		
	assessment dated 1/	7/20 indicated Resident #4 '			This was completed by the MDS			
	s cognition was intact	t.			Consultant.			
	A review of Resident	#4 ' s physician ' s orders			Resident #60, a corrective action was			
	from 10/1/19 through	2/5/20 indicated she had			obtained on 02/04/20.			
	not been on an antibi	otic since October of 2019.			0.00/04/00 # A 1: 1:			
	Desident #41 esstive				On 02/04/20 the Activities care plan for	-		
		care plan was reviewed on n included the focus areas			resident #60 was revised in order to accurately reflect that she is not curren	.th.		
		cipating in most activities at			receiving antibiotic medication. This w			
		was for Resident #4 to			completed by the Activities Director.	as		
	, ,	e in activities. The goal			dompleted by the Notivities Birector.			
		t Resident #4 was on an			Resident(s) #11, #28, #36 and #60, a			
		was last revised on 4/12/19.			corrective action was obtained on			
					02/24/20.			
		ducted with the MDS Nurse						
	on 2/5/20 at 8:15 AM				On 02/24/20 the care plans for the abo			
		on an antibiotic and that this			residents (#11, #28, #36, and #60) wer	е		
		s was not accurate. She			reviewed with their routine nursing			
	reported that the Activ				assistants in order to potentially identif	-		
		ng care plans related to			any areas that may need to be revised			
	activities.				update, as well as to potentially identify			
	Λ = imta = is	A			new concerns that need to be added to			
	An interview was con	ducted with the Activities			the care plan. This was completed by	ше		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _				C /06/2020	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2020	
	10 113211 011 001 1 2.2.1				310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY			SANFORD, NC 27332			
				_	SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From page	e 49	F	657				
		8:30 AM. The Activities he was responsible for			MDS Coordinator.			
	developing and revisi	ng care plans related to			Corrective action for residents with the	;		
		lan related to activities for			potential to be affected by the alleged			
	Resident #4 that indic	cated she was on an			deficient practice.			
	antibiotic was reviewe	ed with the Activities			A 100% audit was completed for all			
		es Director revealed that			current residents who have had antibio			
		onger on an antibiotic and			medication completed/discontinued du	•		
	•	ould have been revised.			the past 30 days in order to validate th			
		she had not known how to			the care plan for affected residents ha	ve		
		ce it was created. She was			been updated in order to show that	- a d		
		/ she had not asked another revise the care plans.			antibiotic is no longer being administer Audit results: 1 of 9 residents identifie			
	Stall Hiellibel How to	revise the care plans.			as having a care plan in place for	u		
	During an interview w	vith the Administrator on			antibiotic use even though resident is	20		
	_	he stated that she expected			longer receiving antibiotic. This	.0		
		ewed and revised to reflect			resident⊡s care plan was updated on			
	the current status of t				02/23/20 in order to resolve the antibio	otic		
	additionally stated that	at she expected staff			use, so that it may reflect resident□s			
	responsible for care p	olan revisions to know how			current status. This was completed by	the		
	to revise the care pla	ns.			MDS Consultant.			
					8 of 9 residents reviewed care plans			
					accurately reflected that they currently	do		
		nost recently admitted to the			not receive antibiotic medication.			
	<u>-</u>	diagnoses that included			A 100% audit was completed for all			
	heart failure.				current residents activities care plans order to validate whether or not this ca			
	The quarterly Minimu	m Data Sat (MDS)			plan reflects resident □s current ability			
		19/19 indicated Resident #9			participate in activities.	lo		
	's cognition was intac				Audit results: 9 of 65 residents review	ed		
	o oogimion was max				were identified as having an activities			
	The 1/17/20 Activities	Assessment indicated			plan that did not reflect their current			
		l bingo and select food			activity status. These 9 residents□ ca	re		
	events. He was note	•			plans were revised on 02/23/20 by the			
	wheelchair through th				MDS Consultant in order to accurately			
					reflect their current activity status.			
	On 2/4/20 at 10:50 Al	M Resident #9 was			56 of 65 residents reviewed were note	d to		
	observed in attendan	ce at a resident council			have care plans that accurately reflect			
	meeting.				their current activity ability and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _				06/ 2020	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2020	
					310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From page 50 F 657 participation status.							
	During an interview w	ith Resident #9 on 2/4/20 at			A 100% audit of all current residents			
	_	d he enjoyed attending			most recent care plan conferences wa	S		
	bingo.	, ,			completed in order to validate whether			
					not resident⊡s nursing assistant(s) we	re		
		care plan was reviewed on			involved in the care planning process.			
		n included a focus area of			Audit results: 27 of 65 residents review			
		cipate in his usual daily			identified to have had nursing assistan	t		
	,	goal indicated that Resident			participation in care plan meeting and			
		issue that made him too			process.			
	revised on 5/14/19.	ies. This goal was last			38 of 65 residents reviewed identified to not have had nursing assistant	0		
	16 VISEU 011 3/14/19.			participation in their care planning meeting				
	An interview was con	ducted with the Activities		and process.				
		8:30 AM. The Activities			These 38 residents will have their care			
		he was responsible for			plans reviewed with their routine nursing	ng		
		ng care plans related to			assistant in order to possibly identify			
	activities. The care p	lan related to activities for			changes and revisions that need to be			
	Resident #9 that indic	cated he was too weak to			made to care plan. This will be comple	eted		
	attend activities was ı	reviewed with the Activities			by members of the Interdisciplinary Tea			
		es Director revealed that			including the MDS Coordinator and fac	ility		
		onger too weak to attend			Social Services Director and MDS			
		care plan should have been			Consultant. These reviews will be			
		revealed she had not known			completed no later than 02/28/20.			
		plan once it was created.			Systemic Changes	ĺ		
		cplain why she had not nember how to revise the			On 02/21/20, the MDS Nurse Consulta	ınt		
	care plans.	ICHIDOL HOW TO LCVISE THE			in-serviced the MDS Nurse and	116		
	ouro piurio.				Interdisciplinary Team on the important	ce		
	During an interview w	vith the Administrator on			of maintaining up to date care plans th			
	_	he stated that she expected			are reflective of the resident □s current			
		ewed and revised to reflect			functioning level and special needs, ar			
	the current status of t				that the care plan should be	ĺ		
	additionally stated that	at she expected staff			updated/revised as the resident□s nee	:ds		
		olan revisions to know how			change.	ĺ		
	to revise the care pla	ns.				ſ		
					The monitoring procedure to ensure the			
					the plan of correction is effective and the			
	3a. Resident #60 was	s admitted to the facility on			specific deficiency cited remains corre	cted		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	. ,	TE SURVEY
		345532	B. WING _			(C 02/06/2020
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIDEDTV	COMMONS NEC AND B	EHAB CTR OF LEE COUNTY		3	10 COMMERCE DRIVE		
LIDEKTT	COMMONS NSG AND R	EHAB CIR OF LEE COUNTY		S	ANFORD, NC 27332		
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F 657	Continued From pag	ne 51	F 6	357			
	8/30/19 with diagnos	sis that included dementia.			and/or in compliance with the regulator requirements;	У	
		/1/20 indicated Resident #60 derately impaired, and she			The Director of Nursing, Administrator designated Nurse Manager will review random (current) residents in order to validate whether or not the care plan	5	
		ration Records (MARs) from 0 indicated Resident #60	on Records (MARs) from dicated Resident #60 edication. The residents will also be reviewed to identify whether or not their nursing assistant was involved in the care				
	on 2/4/20. This care of antibiotic therapy	ve care plan was reviewed plan included the focus area related to a Urinary Tract focus area was initiated on ed on 10/28/19.	planning meeting and/or process. The bedone on weekly basis for 4 weeks was area monthly for 2 months. Reports will be tact presented to the weekly QA committed on the Director of Nursing to ensure corrective action for trends or ongoin		be done on weekly basis for 4 weeks the monthly for 2 months. Reports will be presented to the weekly QA committee	nen by	
	on 2/4/20 at 4:12 PM antibiotic therapy for with the MDS Nurse Resident #60 was no care plan should hav	nducted with the MDS Nurse 1. The care plan related to Resident #60 was reviewed 1. The MDS Nurse stated that 1. The MDS nurse sta			weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy HIM, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursir	,,	
	2/6/20 at 10:10 AM s	with the Administrator on she stated that she expected ewed and revised to reflect the resident.				.9.	
		s admitted to the facility on sis that included dementia.					
		um Data Set (MDS) 0/1/19 indicated Resident s moderately impaired.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		OATE SURVEY OMPLETED
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F 657	Continued From pag	e 52	F 6	657		
	A review of the care dated 10/11/19 and 2	plan conference summaries 2/4/20 indicated a Nursing ned to care for Resident #60				
	Worker (SW) on 2/4/ stated that care plan develop and review t residents. She repor attendees were herse floor nurse, Activities and rehabilitation state in therapy. The SW normal facility praction resident to attend the additionally revealed practice for an NA as included in the care p She stated that with a floor nurse in attendate was sufficient for the The SW revealed sharegulations required	ted that the normal staff elf, the MDS Nurse and/or Director, Dietary Manager, ff if the resident was involved revealed that it was not se for an NA assigned to the e care plan meetings. She it was not normal facility signed to the resident to be blan review/revision process. the MDS Nurse and/or the ance at the meeting that this floor staffs ' involvement. e was unaware that the a direct care NA to be				
	at 7:50 AM. She was the care plans for the to. NA #4 revealed t care guide/kardex, b During an interview v 2/6/20 at 10:10 AM s	aducted with NA #4 on 2/6/20 asked if she ever reviewed e residents she was assigned that the NAs reviewed the aut not the care plans. with the Administrator on the stated that she expected and to the care planning				
		admitted to the facility on es that included Parkinson '				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	C	X3) DATE SURVEY COMPLETED
		345532	B. WING _			C 02/06/2020
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY	,	STREET ADDRESS, CITY, STATE, ZIP 310 COMMERCE DRIVE SANFORD, NC 27332	, CODE	02/00/2020
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F 657	assessment dated 4 's cognition was mode 4 's cognition was mode 4 a review of the care dated 7/11/19, 7/16, indicated a Nursing care for Resident #2 meetings. An interview was complete was end of the care plant develop and review residents. She report attendees were herefloor nurse, Activities and rehabilitation stin therapy. The SW normal facility pract resident to attend the additionally revealed practice for an NA a included in the care She stated that with floor nurse in attending was sufficient for the The SW revealed she regulations required included in the care An interview was contact at 7:50 AM. She was the care plans for the NA #4 revealed	mum Data Set (MDS) A/5/19 indicated Resident #28 oderately impaired. In plan conference summaries A/19, 10/2/19, and 2/4/20 Assistant (NA) assigned to Assistant in the Anducted with the Social A/20 at 2:15 PM. The SW In meetings were utilized to A the care plans for all A the the normal staff A self, the MDS Nurse and/or A so Director, Dietary Manager, Aff if the resident was involved A revealed that it was not A tice for an NA assigned to the A tice care plan meetings. She A tid was not normal facility A signed to the resident to be A plan review/revision process. A the MDS Nurse and/or the A lance at the meeting that this A effoor staffs ' involvement. A the was unaware that the A direct care NA to be	F	957		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
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F 657	Continued From pag	e 54	F 6	657		
	2/6/20 at 10:10 AM s	with the Administrator on the stated that she expected ed to the care planning ed.				
	facility on 10/11/19 w	originally admitted to the vith a readmission date of ses included cerebrovascular				
	The admission Minimum Data Set (MDS) assessment dated 10/18/19 indicated Resident #11's cognition was severely impaired.					
	dated 12/13/19 indic	Plan Conference Summary ated a Nursing Assistant e for Resident #11 was not ng.				
	(SW) on 2/4/2020 at plan meetings were the care plans for all normal staff attended MDS Nurse and/or fl Director, Dietary Maif the resident was in revealed it was not in NA assigned to the replan meetings. She normal facility practic resident to be included review/revision process. Nurse and/or floor not meeting that was confloor staff's involvem.	d with the Social Worker 2:15pm, who stated the care utilized to develop and review residents. She reported the es were herself, if able, the oor nurse, the Activities nager and rehabilitation staff volved in therapy. The SW ormal facility practice for the esident to attend the care additionally stated it was not be for the NA assigned to the ed in the care plan ess. She stated with the MDS urse in attendance at the ensidered sufficient for the ent. The SW revealed she gulations required a direct				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 657		e 55 ed in the care planning	F	657				
	#4 on 2/6/2020 at 7:5 nurse aides reviewed not the care plans for assigned to. On 2/6/2020 at 10:10 with the Administrato	Dam an interview occurred r. She stated it was her egulations related to the care						
	facility on 11/25/13 w end stage renal disea The annual Minimum	Data Set (MDS) 12/19 indicated Resident						
	dated 10/3/19 indicat	Plan Conference Summary ted a Nursing Assistant (NA) Resident #36 was not						
	(SW) on 2/4/2020 at plan meetings were used the care plans for all normal staff attended MDS Nurse and/or flucture plans of the resident was intrevealed it was not not be plant with the resident was not not plant was not plant was not plant was not not plant was not not plant was not	d with the Social Worker 2:15pm, who stated the care utilized to develop and review residents. She reported the es were herself, if able, the cor nurse, the Activities nager and rehabilitation staff volved in therapy. The SW ormal facility practice for the esident to attend the care						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658 SS=D	normal facility practic resident to be include review/revision proces. Nurse and/or floor numeeting that was confloor staff's involvement was unaware the region care NA to be include process. An interview was confloor and the care plans for assigned to. On 2/6/2020 at 10:10 with the Administrato expectation for the replanning process be Services Provided M CFR(s): 483.21(b)(3) Services provided as outlined by the compustion of the compustion of the compustion of the plans of the services provided as outlined by the compustion of the plans of the plans of the services provided as outlined by the compustion of the plans o	additionally stated it was not be for the NA assigned to the ed in the care plan and in the care plan ass. She stated with the MDS are in attendance at the asidered sufficient for the ent. The SW revealed she all the care planning and ucted with Nurse Aide (NA) and the care planning are ducted with Nurse Aide (NA) and and the latter care guide/Kardex, but are residents they were are an interview occurred and interview occurred and interview occurred are stated it was her gulations related to the care followed. The stated it was her gulations related to the care followed. The entire Care Plans are dor arranged by the facility, and arranged by the facility, and arranged by the facility, and are and staff interviews, the cribe the correct medication for 1 of 1 resident reviewed the (Resident #11).	F 658		on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 658	Continued From page	÷ 57	F 658			
		ginally admitted to the facility noses including aphasia		by the MDS Consultant.		
		age), gastrostomy and		Corrective action for residents with the potential to be affected by the alleged deficient practice.		
	(MDS) dated 10/18/19 cognitive impairment. assistance with all Ac	tivities of Daily Living and		A 100% audit was completed for all current residents who have feeding tub in order to validate that their care plan accurately reflects the route in which the should receive medications.		
		and fluids via a feeding tube. care plan revealed Resident		Audit results: 7 of 7 residents reviewed were identifie		
		ding for all nutrition and		as not having route of medication administration reflected on care plan. 7 of 7 residents had care plan revisions		
	dated 11/5/19 for Glu (mg) 1 tablet by mout diabetes and an orde	r dated 1/30/2020 for Claritin ith one time a day for 10		completed on 2/23/20 in order to accurately reflect their current medicati administration route. This was comple by the MDS Consultant. Systemic Changes		
	through the gastric fe	eding tube.		On 02/21/20, the MDS Nurse Consulta in-serviced the MDS Nurse and		
	Nurse #1 who was we for Resident #11's ha medications earlier. Sidid not receive any mad not provided the Glucophage or Clariti	m an interview occurred with orking the medication cart II and had administered her the confirmed Resident #11 edications by mouth and morning doses of In by mouth. Nurse #1		Interdisciplinary Team on the important of maintaining up to date care plans the are reflective of the resident surrent functioning level and special needs, and that the care plan should be updated/revised as the resident sneed change including oral status/NPO status.	at d ds	
	to be provided by mo An interview was con 3:50pm with Nurse #2 medication cart for Re	uth and was inaccurate. ducted on 2/4/2020 at 2 who was working on the esident #11's hall. She ar with the resident and had		The monitoring procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements; The Director of Nursing, Administrator	nat oted y	
	administered her med	lications many times. Nurse sident #11 did not receive		designated Nurse Manager will review random (current) residents in order to		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	C	X3) DATE S COMPL	
		345532	B. WING _			02/0	; 06/2020
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F 658	Continued From page	∍ 58	F 6	58			
F 677	any medications by medications by medications and the medication via the medications and did medications and medi	nouth and had transcribed 10mg on 1/30/2020. The ication route by mouth was have reflected to administer to gastric feeding tube. In a phone interview 1/4 who had revised the order on 1/5/2020. She hally changed the time of icide with the other mot catch the medication as by mouth. She further received all her medications in the state of the interview was to a who had transcribed the interview was to a who had transcribed the interview was the interview was to a who had transcribed the interview was the interview was to a who had transcribed the interview was the	F 6	validate whether or not the care accurately reflects the resident medication administration route Quality Assurance tool titled Comprehensive Care Plan QA will be done on weekly basis for then monthly for 2 months. Reppresented to the weekly QA concerns to the Director of Nursing to ensure concerns is initiated as approprised Weekly QA Meeting is attended Director of Nursing, MDS Coortunit Manager, Support Nurse, HIM, Dietary Manager and the Administrator The title of the person respons implementing the acceptable procorrection; Administrator and for Director of Manager and for Direc	Tool. This or 4 weeks ports will be mmittee be re ongoing riate. The dinator, Therapy, ible for lan of	e s s oe opy	3/3/20
	out activities of daily I services to maintain of personal and oral hyo This REQUIREMENT by: Based on observatio	living receives the necessary good nutrition, grooming, and		The statements made on this correction are not an admission	•	lo	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 677	Continued From page	e 59	F 6	677			
	facility failed to provide daily living dependent Resident #54 and fail scheduled for ADL de Resident #19. This was for ADLs. The findings 1. Resident #35 was cumulative diagnoses Accident and contract Review of a grievance completed by Resident RP voiced that Reside being taken care of Scut and very dirty. The facility and would routine nail care. Review of Resident #Data Set (MDS) dated cognitive impairment and verbal behaviors for extensive staff assinguiene. Review of Resident #3/29/19 read Res	le nail care for activities of t (ADL) Resident #35 and ed to provide showers as ependent Resident #5 and as 4 of 6 residents reviewed is included: admitted 4/9/18 with sof Cerebral Vascular ture of the left elbow. e form dated 11/19/19 Int #35's RP read as follows: ent #5's left hand was no she voiced his nails were not e concern was confirmed by work on a process for 35's quarterly Minimum do 12/7/19 indicated severe and he exhibited physical and Resident #35 was coded sistance with personal			not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has tall 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 corrected by the dates indicated. F677 1. Corrective action for resident(s) affected by the alleged deficient practic For resident #35, on 02/24/2020 nail cawas provided and documented by the hurse. For resident #54, on 02/24/2020 nail cawas provided and documented by the hurse. For resident #5, on 02/24/2020 the nurconsultant updated the residents show task to Tuesday and Friday 3-11. For resident #19, on 02/24/2020 the nurconsultant updated the residents show task to Tuesday and Friday 7-3. 2. Corrective action for residents with the potential to be affected by the alleg deficient practice. Beginning on 02/18/2020, the nurse manager began auditing all current residents for the need of nail care. This audit will be completed by 03/03/2020. Nail care was provided to those resider identified in need of nail care.	ken on ee: are hall are er er er ed	
	February 2020 read g	35's aide documentation for grooming(including nail by the aides for every shift.			Beginning on 02/18/2020 the Nurse Secretary and Nurse Manager interview all current alert and oriented residents		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
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F 677	Continued From pag	ge 60	F 6	77		
				their preference regarding sho	wer days	
	In an observation on	2/2/20 at 5:00 PM, Resident		This will be completed by 03/03		
	#35 was in bed. He had a left-hand contracture.				0,2020.	
		long, jagged and dirty.		The MDS nurse will then task t	the	
	3	3,1 33		requested shower schedule to		
	In an interview on 2/	2/20 at 5:45 PM, Nursing		to fire to the CNA's for docume		
		ssistant (NA) #9 stated nail care was done as This will be completed by 03/03/2020.		3/2020.		
				For current non-alert and orien	ited	
		on on 2/3/20 at 10:00 AM,		residents, the CNA's were edu	-	
	Resident #35 was lying in bed. He had a left-hand			the nurse managers on the new		
	_	er nails were long, jagged		shower schedule and it should		
	and dirty.			as posted. Showers will be doo		
				the personal care task of Point		
		on on 2/3/20 at 12:08 PM,		This will be completed by 03/03	3/2020.	
		ing in bed. He had a left-hand				
	_	er nails were long, jagged		3. Measures /Systemic chan	-	
	and dirty.			prevent reoccurrence of allege	a deficient	
	In an intensious on 2/	2/20 at 2:27 DM tha MDS		practice: On 02/19/2020 and 02/24/2020	O the Nurse	
		3/20 at 2:37 PM, the MDS empted to complete nail care		Managers began education to		
		lier on 2/3/20 but was only		part time, and PRN Nurses and		
		on his right hand and unable		the following:	3 011/13 011	
		is contracted left hand. She		New revised Shower sche	dule	
		updating his care plan for the		Nail care should be perfor		
		e MDS Nurse confirmed the		with baths/showers	,	
		ger nails to a contracted		Refusal documentation		
	hand to include skin	~		Diabetic nail care schedule	е	
	In an interview on 2/	3/20 at 2:50 PM, NA #5		This information has been inte	grated into	
		IDS Nurse attempted to		the standard orientation trainin	-	
	complete his nail care on 2/3/20 but were unable			required in-service refresher co		
		ls on his contracted hand.		all staff identified above and wi		
	_			reviewed by the Quality Assura	ance	
	In an interview on 2/	4/20 at 8:50 AM, Resident		process to verify that the chang	ge has	
		had voiced concerns about		been sustained. The facility sp		
		ene to include nail care. He		in-service will be provided to al		
		racture and his finger nails		Nurses and CNA's who give re		
	were long, jagged ar	nd dirty on observation. His		care in the facility. Any nursing	g staff who	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMF	SURVEY
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F 677	Continued From page	e 61	F 6	677			
	RP stated she had completed a grievance about his nail care months ago but has not seen any improvement.			does not receive scheduled in-service training will not be allowed to work unti training has been completed by March 2020.			
	#35's finger nails on I	tion on 2/5/20 at 9:20 AM, Resident ails on his contracted left hand had . Resident #35 stated his left hand			 Monitoring Procedure to ensure the plan of correction is effective and the specific deficiency cited remains correction and/or in compliance with regulatory 	nat	
	In an interview on 2/5/20 at 1:09 PM, the Medical Record Supervisor stated after reviewing Resident #35's medical record, she did not locate any documented evidence of his refusals nail care.				requirements. The Director of Nurses or designee wil monitor compliance utilizing the F677 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or untiresolved. The Director of Nursing will		
	Administrator stated in Resident #35's finger and if he refused, statement until complete 2. Resident #54 was	n an interview on 2/6/20 at 10:11 AM, the administrator stated it was her expectation that Resident #35's finger nails be clean and trimmed and if he refused, staff should go back and attempt until completed. 2. Resident #54 was admitted on 9/1/17 with a remulative diagnoses of Congestive Heart			monitor shower and nail care complian Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at weekly Quality Assurance Meeting or un	/ the	
	Failure, Chronic Kidney Failure and Glaucoma. Review of Resident #54's quarterly modified Minimum Data Set (MDS) dated 12/9/19 indicated he was cognitively intact, exhibited no behaviors and his vision was severely impaired. He was coded as requiring extensive staff assistance with personal hygiene.				deemed not necessary for compliance with ADL Care. The weekly QA Meeting attended by the Administrator, Director Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	g is of	
	9/19/19 read he was staff assistance with	54's care plan last revised legally blind and required his activities of daily living planned for the refusal of					
	Review of the undate	d electronic care guide for					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		PLETED
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F 677	Continued From page	e 62	F	677			
	the aides to follow rean nails short.	ad as follows: keep finger					
	February 2020 read (54's aide documentation for grooming(including nail by the aides for every shift.					
	#54's finger nails wer and dirty. He stated h his finger nails need	2/2/20 at 1:46 PM, Resident e observed to be very long he was blind but apparently some attention. He stated it e anyone trimmed his nails.					
		2/20 at 5:45 PM, Nursing ted nail care was completed					
		./20 at 8:30 AM, NA #6 ware of any refusals of nail					
	8:45 AM, Resident #5 observed to be very I staff must have not g nails. In another interview a 9:30 AM, Resident #5 observed to be very I	ong and dirty. He stated the otten around to trimming his and observation on 2/5/20 at					
	stated Resident #54 seldom took showers	on 2/5/20 at 9:40 AM, NA #5 oreferred bed baths and . She stated she trimmed wers because the nails are im.					
	In another interview a	and observation on 2/5/20 at					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		(X3) DATE SURVEY COMPLETED	
	345532	B. WING		C 02/06/2020	
	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 32:00:2020	
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1:25 PM, Resident 54 observed to be very I the past 3rd shift trim stated the staff must Resident #54 stated appearing long and diblind, he was worried accident. In an interview on 2/5 Record Supervisor st Resident #54's medic any documented evic care. In an interview on 2/5 Nurse stated she assinalls and observed the stated she was not accare and she would of Resident #54 immediant in another interview of Support Nurse stated Resident #54's nail of was in the room trimming declined her assistant In an interview on 2/5 Administrator stated Resident #54's nails 3. Resident #54's nails 3. Resident #54's nails 4. Resident #54's nails 4. Resident #54's nails 5. Resident #54's nails 6. Resident #	d's finger nails were ong and dirty. He stated in med his finger nails. He have forgotten to do it. he disliked his finger nails lirty. He stated since he was about scratching himself by 5/20 at 1:09 PM, the Medical rated after reviewing cal record, she did not locate dence of his refusals nail solvent essed Resident #54's finger nem to be long and dirty. She ware of any refusals of nail complete nail care for rately. The stated since he was about scratching himself by 5/20 at 1:30 PM, the Support rement to be long and dirty. She ware of any refusals of nail complete nail care for rately. The stated since he was about scratching himself sand rate but his family member ming his finger nails and rate. The stated on 12/16/17 with the stated on 12/16/17 with sof Congestive Heart Failure rate.	F 67	7		
	COMMONS NSG AND RI SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page 1:25 PM, Resident 54 observed to be very I the past 3rd shift trim stated the staff must Resident #54 stated I appearing long and d blind, he was worried accident. In an interview on 2/5 Record Supervisor st Resident #54's medic any documented evic care. In an interview on 2/5 Nurse stated she ass nails and observed th stated she was not at care and she would of Resident #54 immedi In another interview of Support Nurse stated Resident #54's nail of was in the room triming declined her assistant In an interview on 2/6 Administrator stated Resident #54's nails 3. Resident #54's nails 3. Resident #54's nails 4. Resident #54's nails 3. Resident #54's nails 4. Resident #54's nails 5. Resident #54's nails 6. Resident #54's nails 7. Resident #54's nails 8. Resident #54's nails 9. Resident #54's nails 10. Resident #54's nails 11. Resident #54's nails 12. Resident #54's nails 13. Resident #54's nails 14. Resident #54's nails 15. Resident #54's nails 16. Resident #54's nails 17. Resident #54's nails 18. Resident #54's nails 19. Resident #54's nails 19. Resident #54's nails 10. Resident #54's nails 10. Resident #54's nails 10. Resident #54's nails 10. Resident #54's nails	COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 63 1:25 PM, Resident 54's finger nails were observed to be very long and dirty. He stated in the past 3rd shift trimmed his finger nails. He stated the staff must have forgotten to do it. Resident #54 stated he disliked his finger nails appearing long and dirty. He stated since he was blind, he was worried about scratching himself by accident. In an interview on 2/5/20 at 1:09 PM, the Medical Record Supervisor stated after reviewing Resident #54's medical record, she did not locate any documented evidence of his refusals nail	A BUILDING 345532 ROVIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 63 1:25 PM, Resident 54's finger nails were observed to be very long and dirty. He stated in the past 3rd shift trimmed his finger nails. He stated the staff must have forgotten to do it. Resident #54 stated he disliked his finger nails appearing long and dirty. He stated since he was blind, he was worried about scratching himself by accident. In an interview on 2/5/20 at 1:09 PM, the Medical Record Supervisor stated after reviewing Resident #54's medical record, she did not locate any documented evidence of his refusals nail care. In an interview on 2/5/20 at 1:30 PM, the Support Nurse stated she assessed Resident #54's finger nails and observed them to be long and dirty. She stated she was not aware of any refusals of nail care and she would complete nail care for Resident #54's mail care but his family member was in the room trimming his finger nails and declined her assistance. In an interview on 2/6/20 at 10:11 AM, the Administrator stated it was her expectation Resident #54's nails be trimmed and clean. 3. Resident #5 was admitted on 12/16/17 with cumulative diagnoses of Congestive Heart Failure and oxygen dependence. Review of Resident #5's quarterly Minimum Data Set dated 1/7/20 indicated severe cognitive	ROWIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTIONS SHOULD) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD) (EACH CORRECTIVE	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION NG		(X3) DATE S COMPL	
		345532	B. WING _			02/0	6/2020
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F 677	Continued From page	e 64	F 6	577			
	was coded for staff physical help with bathing.						
	7/12/19 read she requ	5's care plan last revised uired staff assistance with iving (ADLs). She was not sals of her showers.					
		d electronic care guide for ade no mention of showers					
		d Shower Schedule read eceive a shower on 2nd shift curdays.					
	completed with the in choice between show very important to her.	Assessment dated 1/7/20 put of Resident #5 indicated vers or bed baths was not There was no documented 5's Responsible Party (RP).					
	#5's RP stated she di	ne stated showers were very ident #5 appeared					
		e/20 at 250 PM, Nursing ted Resident #5 did not her ADLs.					
		5's Personal Care records 20 revealed no documented vers.					
	#5 was appeared dish	2/5/20 at 9:25 AM, Resident neveled and absent of rgic and complained of not					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	•	310	REET ADDRESS, CITY, STATE, ZIP CODE O COMMERCE DRIVE NFORD, NC 27332	, , , , ,	
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F 677	Continued From page	e 65	F	677			
	stated showers were	5/20 at 9:40 AM, NA #6 very important to Resident een feeling well for the last					
	Record Supervisor st Resident #5's medica	5/20 at 1:09 PM, the Medical ated after reviewing al record, she did not locate dence of his refusals of					
	In an interview on 2/5/20 at 3:40 PM, NA #8 stated Resident #5 refused her showers but she completed a bed bath when she refused. NA #8 stated she did not recall if she reported Resident #5's refusals.						
	Resident #5 received	t was her expectation that her showers as scheduled ss of starting a shower team					
		admitted on 10/30/19 with s of Hypertension and					
	Data Set (MDS) date cognitive impairment	19's admission Minimum d 11/6/19 indicated severe with physical behaviors. She hysical help with bathing.					
	revised 10/30/19 read assistance with his ad	19's care planned last d she required staff ctivities of daily living (ADLs). nned for refusals of her					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
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F 677	Continued From pa	ge 66	F 67	77		
		ted electronic care guide for nade no mention of showers				
		ed Shower Schedule read o receive a shower on 1st Thursdays.				
	completed with the	ity Assessment dated 11/4/19 input of Resident #19's family tween showers or bed baths to her.				
		#19's Personal Care records 4/20 revealed no documented owers.				
	#19 was observed s appeared clean and was unable to recal	n 2/2/20 at 3:50 PM, Resident sitting on her bed. She d well groomed. Resident #19 I the last time she had a she loved taking showers.				
	Resident #19 was s	ion on 2/3/20 at 9:50 AM, still in bed and not dressed for she did not need assistance				
	stated Resident #19	2/3/20 at 10:20 AM, NA #5 9 required staff assistance with 9 bathing and showers.				
	stated she on occas whirlpool but she ha record as a shower Resident #19 did no Monday 2/3/20, she	on 2/5/20 at 9:40 AM, NA #5 sion put Resident #19 in the ad to chart it in the electronic. When questioned why of receive a shower on estated sometimes she bath accidently and thought				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345532	B. WING _		C 02/06/2020
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 02/00/2020
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 679 SS=E	In an interview on 2/Administrator stated Resident #19 receive and was in the procest to ensure resident reactivities Meet IntereCFR(s): 483.24(c)(1) \$483.24(c)(1) The fathe comprehensive a and the preferences program to support ractivities, both facility individual activities a designed to meet the physical, mental, and each resident, encount and interaction in the This REQUIREMENT by: Based on record restaff interview, the facility and the preferences are activities as designed to meet the physical of	219 a shower on 2/3/20. 26/20 at 10:11 AM, the it was her expectation that ed her showers as scheduled ess of starting a shower team eceived their showers. 25t/Needs Each Resident 25cility must provide, based on assessment and care plan of each resident, an ongoing esidents in their choice of ey-sponsored group and and independent activities, in interests of and support the dipsychosocial well-being of uraging both independence	F 6	77	and do
	expressed that it was group activities (Res #52) for 5 of 5 reside The findings included A review of the Activ through January 202 - July 2019: There w			alleged deficiencies. To remain in compliance with all fee and state regulations the facility ha or will take the actions set forth in t plan of correction. The plan of correctionstitutes the facility sallegation compliance such that all alleged deficiencies cited have been or will corrected by the dates indicated. F679 1. Corrective action for resident(saffected by the alleged deficient professions).	s taken his ection of be

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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		345532	B. WING _			02/	/06/2020
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LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		S	ANFORD, NC 27332		
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F 679	Continued From page group activity was pla with the exception of planned. The weeke religious/spiritual actiration - August 2019: There activities planned dur weekend group activities planned. The weekend days with the group activities planned. The were all religious/spiractivities planned dur weekend group activities planned dur weekend group activities were all religious - October 2019: The activities were all religious - October 2019: The activities planned dur weekend group activities planned dur weekend group activities planned dur weekend days with the group activities planned activities were all religious activities were all religious planned dur weekend days with the group activities were all religious activities were all religious planned dur weekend days with the group activities were all religious planned dur weekend days with the group activities were all religious planned dur weekend days with the group activities were all religious planned dur weekend days with the group activities were all religious planned dur weekend days with the group activities were all religious were all religious planned dur weekend days with the group activities were all religious planned dur weekend days with the group activities were all religious planned dur weekend group activities planned dur weekend days with the group activities were all religious planned dur weekend days with the group activities planned dur weekend group activiti	anned on all weekend days 1 that had 2 group activities and group activities were all vities. were 2 evening group ing the entire month and 1 ty was planned on all ne exception of 1 that had 2 ed and 1 that had no group ne weekend group activities itual activities. nere were 3 evening group ing the entire month and 1 ty was planned on all ne exception of 1 that had 2 ed. The weekend group gious/spiritual activities. e were 2 evening group ing the entire month and 1		679	For resident s #2, #4, #9, #22, and #5 the resident was interviewed on 02/18/2020 by the Social Worker for th activities preference for evenings and weekends. On 02/18 and 02/21/2020 the Administrator and Activities Coordinato met to discuss how to incorporate the resident s preference for activities in the evenings and on weekends. A new act calendar will be generated by 03/01/20 incorporating the ideas of the resident interviews. 2. Corrective action for residents with the potential to be affected by the allegt deficient practice. On 02/18/2020 the Social Worker interviewed all alert and oriented reside for their preference of evening and weekend activities. The Administrator and Activity Director generate a new activity calendar by 03/01/2020 incorporating the ideas of the resident interviews. 3. Measures /Systemic changes to	eir he ivity 20 n jed ents	
	activities planned dur weekend group activi weekend days with the group activities plann	ing the entire month and 1 ty was planned on all ne exception of 1 that had 2 ed. The weekend group gious/spiritual activities.			prevent reoccurrence of alleged deficie practice: On 02/24/2020, the Administrator educated the Activity Coordinator on the		
	- December 2019: Th activities planned dur weekend group activi weekend days with th	ere were 3 evening group ing the entire month and 1 ty was planned on all ne exception of 1 that had 2 ed. The weekend group			following: " Offering activities to include the weekends and evenings. This information has been integrated in		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 679	Continued From page	e 69	F	679			
	- January 2020: Ther activities planned dur weekend group activities weekend days with the group activities planned activities were all religions. 1. Resident #22 was the facility on 8/29/18 included heart failure. The annual Minimum assessment dated 11 #22's cognition was	most recently admitted to with diagnoses that Data Set (MDS) /7/19 indicated Resident fully intact. This assessment very important to Resident			the standard orientation training and in required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any identified staff who does not receive scheduled in-service training will not be allowed to work untitationing has been completed by March 2020. 4. Monitoring Procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements. The Administrator will monitor compliant utilizing the F679 Quality Assurance Toweekly for 2 weeks then monthly x 3	no I 3, at nat cted	
	it was very important with groups of people almost every activity. Resident #22 's active focus area of particip offered in the facility. ensuring that she was each activity as need. During a Resident Coat 10:50 AM Resident hardly any activities of weekends. She added activities and attended held at the facility.	re care plan included the ating in most activities The interventions included as up and ready to attend ed. buncil meeting held on 2/4/20 at #22 indicated there were			months. The tool will monitor to ensure activities are offered at the scheduled times and meet the interest of the residents. Reports will be presented to weekly Quality Assurance committee b the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	the y the e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345532	B. WING _				06/ 2020
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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	((EACH CORRECTIVE ACT CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 679	Director confirmed the activities planned in only 1 group activity weekend day. She aweekend activities weekend activities weekend activities we community church grown was activities herself on the she had not schedule times. During an interview was a sufficient amount of held on the evenings needs/interests of the she was already wor activity calendar to in availability/frequency the residents in needs? 2. Resident #9 was refacility on 1/7/19 with heart failure. The quarterly Minimulassessment dated 7 is cognition was intained as a cognition was a cognition was a cognition was a	2:30 PM. The Activities here were normally no group the evenings and typically was planned on each additionally confirmed the ere all conducted by roups. She stated that she less hours on Monday he was unable to conduct he evenings or weekends, so ed activities during these with the Administrator on the stated that she expected of activities to be planned and and weekends to meet the eresidents. She reported king on a plan to revise the include a greater variety and of activities geared toward is and interests. Inost recently admitted to the indiagnoses that included with the Administrator on the stated that she expected in activities to be planned and and weekends to meet the eresidents. She reported king on a plan to revise the include a greater variety and of activities geared toward is and interests. Inost recently admitted to the indiagnoses that included included in Data Set (MDS) (19/19 indicated Resident #9 ict.) In Data Set (MDS) (19/19 indicated Resident #9 ict.) In Data Set (MDS) (19/19 indicated Resident #9 ict.)	F6	579			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345532	B. WING			C 02/06/2020
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F 679	Continued From pag	ge 71 e to participate in his usual	F 6	79		
	daily activity routine. Resident #9 had a n him too weak to atte last revised on 5/14/ included, in part, asl preferences and hel During a Resident C	The goal indicated that lew health issue that made and activities. This goal was 19. The interventions king about his activity ping him plan activities. Souncil meeting held on 2/4/20 ant #9 indicated there were				
	hardly any activities weekends. He state "rough", explaining t					
	Director on 2/4/20 at Director confirmed that activities planned in only 1 group activity weekend day. She weekend activities we community church g worked normal busin through Friday and sactivities herself on	nducted with the Activities t 2:30 PM. The Activities here were normally no group the evenings and typically was planned on each additionally confirmed the vere all conducted by iroups. She stated that she hess hours on Monday she was unable to conduct the evenings or weekends, so led activities during these				
	Activities Director or revealed that Reside an accurate represe She explained that h attend activities and have been revised.	was conducted with the 12/5/20 at 8:30 AM she ent #9's care plan was not ntation of his current status. The was no longer too weak to that this care plan should She stated that Resident #9 such as bingo and parties.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345532	B. WING				C 06/2020
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	•	STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		(X5) COMPLETION DATE
F 679	2/6/20 at 10:10 AM s a sufficient amount of held on the evenings needs/interests of this he was already wor activity calendar to in availability/frequency the residents ' needs. 3. Resident #4 was 3/16/18 with diagnos. The quarterly Minimulassessment dated 1/1s cognition was intact. The Activities Assessit was very important with groups of people bingo, church activitic resident council. Resident #4 's activition focus area of attendiactivities at the facilitiensuring that she was each activity as needs. During a Resident Cat 10:50 AM Resider hardly any activities weekends. She reported.	with the Administrator on the stated that she expected of activities to be planned and and weekends to meet the eresidents. She reported king on a plan to revise the include a greater variety and of activities geared toward is and interests. Admitted to the facility on est that included heart failure. Alm Data Set (MDS) Alticle (MD	F	679			
		nducted with the Activities 2:30 PM. The Activities					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345532	B. WING				06/2020	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
F 679	activities planned in only 1 group activity weekend day. She a weekend activities weekend activities we community church groworked normal busing through Friday and sactivities herself on the she had not schedule times. During an interview of 2/6/20 at 10:10 AM is a sufficient amount of held on the evenings needs/interests of the she was already wor activity calendar to in availability/frequency the residents 'needs'. 4. Resident #2 was 7/1/16 with diagnose The quarterly Minimulassessment dated 10 's cognition was more than the session of the activities assess it was somewhat imputnings with groups of attend parties, church and resident council. Resident #2 's activities activities activities activities activities and resident council.	the evenings and typically was planned on each additionally confirmed the ere all conducted by roups. She stated that she ess hours on Monday he was unable to conduct he evenings or weekends, so ed activities during these with the Administrator on the stated that she expected activities to be planned and and weekends to meet the eresidents. She reported king on a plan to revise the activities geared toward and interests. Admitted to the facility on the state of the triple of the planned and the properties of the planned and the p	F	579				
	focus area of particip	ating in most activities at the ions included ensuring that						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 679		e 74 to attend each activity as	F6	679			
	at 10:50 AM Residen hardly any activities of weekends. He report activities. An interview was condification Director on 2/4/20 at Director confirmed the activities planned in the only 1 group activity weekend day. She as weekend activities we community church groworked normal busing through Friday and stactivities herself on the	ducted with the Activities 2:30 PM. The Activities ere were normally no group he evenings and typically was planned on each dditionally confirmed the ere all conducted by oups. She stated that she ess hours on Monday he was unable to conduct ne evenings or weekends, so					
	times. During an interview w 2/6/20 at 10:10 AM s a sufficient amount o held on the evenings needs/interests of the she was already worl activity calendar to in availability/frequency the residents ' needs 5. Resident #52 was 8/30/18 with diagnose	admitted to the facility on es that included dementia.					
	The annual Minimum assessment dated 8/	Data Set (MDS) 9/19 indicated Resident #52					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			C 02/0	6/2020		
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	'	02/0	9,292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 679	indicated that it was w #52 to do things with The Activities Assess indicated it was very it do things with groups to attend bingo, partie bands, church and re Resident #52 's active focus area of attendir activities at the facility assisting her to and for During a Resident Co at 10:50 AM Resident hardly any activities of weekends. She reporactivities and attende facility. An interview was con Director on 2/4/20 at Director confirmed the activities planned in the only 1 group activity weekend day. She a weekend activities we community church grown worked normal busine through Friday and sh activities herself on the she had not schedule times. During an interview was	intact. This assessment very important to Resident groups of people. Iment dated 11/25/19 important to Resident #52 to of people. She was noted es, games, exercises, sident council. It is care plan included the eng and participating in most of the interventions included from activities as needed. In the evenings or ented she enjoyed group defined most activities at the evenings and typically was planned on each diditionally confirmed the ere all conducted by oups. She stated that she ess hours on Monday he was unable to conduct the evenings or weekends, so and activities during these with the Administrator on	F6	579					
		ne stated that she expected activities to be planned and							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345532	B. WING		C 02/06/2020		
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 02/00/2020		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION		
F 679	needs/interests of the	and weekends to meet the e residents. She reported king on a plan to revise the	F 67	9			
F 686 SS=D	availability/frequency the residents ' needs	revent/Heal Pressure Ulcer	F 68	6	3/3/20		
	resident, the facility in (i) A resident received professional standard pressure ulcers and dulcers unless the indidemonstrates that the (ii) A resident with professional starpromote healing, prenew ulcers from deverthis REQUIREMENT by: Based on record revand resident interview the physician order for dressing for 1 of 6 repressure ulcers (Resident #6 was adm 6/12/17 with the diaghemiparesis and diabate the resident had a professional starpromote healing, prenew ulcers from devertible and resident interview the physician order for dressing for 1 of 6 repressure ulcers (Resident #6 was adm 6/12/17 with the diaghemiparesis and diabate the resident had a professional starpromote healing, prenew ulcers from devertible the physician order for t	ehensive assessment of a must ensure that- s care, consistent with a fixed of practice, to prevent does not develop pressure invidual's clinical condition bey were unavoidable; and essure ulcers receives and services, consistent and ards of practice, to went infection and prevent eloping. I is not met as evidenced being observation and staff when the facility failed to follow for pressure ulcer prevention sidents reviewed for ident #6). Findings included:		The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all federand state regulations the facility has or will take the actions set forth in the plan of correction. The plan of correctionstitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	nd do eral taken is ction		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245520	D MING			1	С		
		345532	B. WING _			02/	/06/2020		
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE				
LIBERTY	COMMONS NSG AND	REHAB CTR OF LEE COUNTY		31	0 COMMERCE DRIVE				
2.52.				SA	ANFORD, NC 27332				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 686	Continued From pa	age 77	F 6	886					
	· ·	r comfort. The plan was to			Corrective action for resident(s)				
		ım for open skin area.			affected by the alleged deficient practic	· ·			
	Todoscoo the sacre	in for open skin area.			For resident# 6, on 02/17/2020 the nur				
	The resident 's au	arterly Minimum Data Set			consultant updated the resident's	-			
	· ·	ocumented the resident had			duoderm order to check placement of	the			
	adequate hearing	and was			duoderm each shift to ensure it was in				
	understood/unders	stands and her cognition was			place.				
	intact. The resider	nt required two-person							
	extensive assist fo			Corrective action for residents with					
		er activities of daily living			the potential to be affected by the alleg	jed			
		e active diagnoses were			deficient practice.				
		eimer's dementia, hemiplegia,			On 02/19/2020 the treatment nurse				
	resident had no pre	e knee amputation. The			audited all current residents with treatments ordered to ensure the				
	resident had no pre	sssure dicer.			treatments were performed and any				
	A review of the res	ident ' s updated care plan			dressings ordered were in place and				
		vealed the resident had the			intact. This was completed on 02/19/20	020.			
		ure ulcer and history of							
	pressure ulcer of the				The nurse consultant audited all currer residents with duoderm orders to upda				
	On 2/2/2020 at 4:0	0 pm the resident was			the order with check every shift for				
		he stated that her "bum is			placement of the dressing and replace	as			
	burning" and that "	the dressing on my butt had			needed. This was completed by				
	fallen off and no or	ne put it back on."			02/19/2020.				
		s done of the resident 's			3. Measures /Systemic changes to				
		on 02/02/2020 at 4:06 pm.			prevent reoccurrence of alleged deficie	nt:			
		was provided by Nursing s 9 and 10. The resident was			practice:				
	, ,	tissue to the buttocks and			On 02/19/2020, the nurse managers				
		pressure ulcers that had			began educating all full time, part time,				
		ed Duoderm dressing was not			and PRN Nurses and CNA's on the				
		crum. The resident was			following topics:				
		eam was placed, and the			Carrying out the prescribed treatm	ent			
	· ·	sed. The resident had a			order for pressure ulcers.				
	pressure reduction	cushion on her wheel chair			What to do when a dressing is four	nd			
	and an air mattress	s on her bed.			off a wound.				
					How to enter orders for duoderm				
	An interview was conducted with NA #9 on				dressing.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345532	B. WING			1	C 06/2020
NAME OF PE	ROVIDER OR SUPPLIER	0.0002	-1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	06/2020
TAPAWIE OF TH	TO VIDER OR OUT FIER				10 COMMERCE DRIVE		
LIBERTY (COMMONS NSG AND R	REHAB CTR OF LEE COUNTY			SANFORD, NC 27332		
							I
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 686	Continued From pag	ge 78	F 6	386			
	2/2/2020 at 4:25 pm	. NA #9 stated that Resident					
	#6 's skin was intac	t, she was provided barrier			This information has been integrated ir	nto	
	cream and there was	s no dressing. NA #9			the standard orientation training and in	the	
	commented that he	followed the care			required in-service refresher courses for		
	guide/kardex for care	e provided and wound			all staff identified above and will be		
	dressings are on the	nurses' care plan.			reviewed by the Quality Assurance		
					process to verify that the change has		
	An interview was co	nducted with NA #10 on			been sustained. Any staff who does no	ot	
	•	. NA #10 stated that she was			receive scheduled in-service training w		
familiar with the resident. NA					not be allowed to work until training ha	S	
		t ' s care guide/kardex for			been completed by March 3, 2020.		
	•	elieved this resident required					
	barrier cream becau	se her skin was intact.			4. Monitoring Procedure to ensure th		
					the plan of correction is effective and the		
		erviewed on 2/3/2020 at			specific deficiency cited remains correct	cted	
		g up in her wheel chair. The			and/or in compliance with regulatory		
		I that her dressing (to the			requirements.		
	sacrum) was still off.				The Director of Nurses or designee wil	l	
	The Treetment Nurs	e was observed on 2/4/2020			monitor compliance utilizing the F686	de	
					Quality Assurance Tool weekly x 2 week		
		e pressure ulcer prevention s sacrum. The resident did			then monthly x 3 months or until resolv The Director of Nursing will monitor	eu.	
		dressing in place. The			compliance with pressure ulcer		
		mmented during care that			treatments. Monitoring will be rotated	in	
		or Duoderm dressing to			order to include all shifts and weekend		
		er and provide comfort and			Reports will be presented to the weekly		
		eek and as needed. She			Quality Assurance committee by the	,	
	-	Duoderm falls off or becomes			Director of Nurses to ensure corrective		
		expected to inform her or to			action is initiated as appropriate.		
	replace it after care.	•			Compliance will be monitored and the		
	•				ongoing auditing program reviewed at	the	
	On 2/4/2020 at 2:40	pm the Treatment Nurse was			weekly Quality Assurance Meeting unti		
		ted that she was not informed			deemed no longer necessary for		
	yesterday or today tl	hat the Duoderm was not on			compliance with pressure ulcer		
	the resident's sacrur	m. Today was the ordered			treatments. The weekly QA Meeting is		
		n she noticed the dressing			attended by the Administrator, Director	of	
	was not in place.				Nursing, MDS Coordinator, Therapy		
					Manager, Health Information Manager		
	On 2/6/2020 at 7:50	am an interview was			and the Dietary Manager.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		C 02/06/2020
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 02/00/2020
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 686	the care guide/karde not the nursing care have access to the eview the nursing car On 2/6/2020 at 10:4 conducted with the A	the who stated the NAs review ex before providing care, but plans. She said they don't belectronic health record to	F 686	6	
F 688 SS=D	CFR(s): 483.25(c)(1) §483.25(c) Mobility. §483.25(c)(1) The faresident who enters range of motion doe range of motion unle condition demonstrated of motion is unavoid. §483.25(c)(2) A resimption receives appropriated assistance to maintathe maximum practices reduction in mobility. This REQUIREMENT by: Based on observation partices appropriated assistance to maintathe maximum practices appropriated assistance appropriated assist	ecrease in ROM/Mobility)-(3) acility must ensure that a the facility without limited s not experience reduction in ess the resident's clinical ttes that a reduction in range	F 688	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 feder	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
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		345532	B. WING _			02/	06/2020	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LIBERTY	COMMONE NEC AND DE	CHAR CTR OF LEE COUNTY		31	10 COMMERCE DRIVE			
LIBERTY	COMINIONS NOG AND RE	EHAB CTR OF LEE COUNTY		S	ANFORD, NC 27332			
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 688	Continued From page	2 80	F	886				
	Review of Resident # Physician orders read 5/24/18-Restorative N on and off resident's I splint-tolerates up to 2 Review of Resident # 3/29/19 read he was a upper extremity splint muscle/skeleton statu left elbow contracture wear his left upper ex with the intervention of	s of Cerebral Vascular ture of the left elbow. 35's February 2020 d an order dated lursing Order per OT: Don left upper extremity 2 hours. 35's care plan revised on restorative nursing for left			and state regulations the facility has tall 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 corrected by the dates indicated. F688 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: 1. Corrective action for resident(s) affected by the alleged deficient practic. For resident #35, on Occupational Therapy worked with the resident for splinting of the left elbow from 02/04 to 02/12/2020. On 02/24/2020 the resident task and orders were updated with	e e:		
	Review of the undate the aides to follow rea Nursing Order per OT extremity splint-tolera nurse if there were ar splint. Review of Resident # Data Set (MDS) dated cognitive impairment and verbal behaviors for functional limited rupper and lower extremits was in bed. He had the splint of the spl	d electronic care guide for ad as follows: Restorative T-don on and off left upper ted up to 2 hours. Report to my skin problems under the 35's quarterly Minimum d 12/7/19 indicated severe and he exhibited physical Resident #35 was coded range of motion of 1 side emities.			application of the splint and palm guard per therapy recommendations. 2. Corrective action for residents with the potential to be affected by the allegateficient practice. Beginning on 02/18/2020 the nurse manager audited all current residents worders for splint use to ensure the splin was in place. This was accomplished be auditing orders and care plan task for those devices. Once it was determined who needed a splint the nurse manage ensured the device was in place, had a MD order, CNA task, and care plan. The process will be completed by 03/03/2020.	ed vith t y d r n is		
	and a left-hand contra	acture.		_	3. Measures /Systemic changes to			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _				06/ 2020
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		00,2020
				31	10 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			ANFORD, NC 27332		
(X4) ID PREFIX TAG			ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 688	In an interview on 2/2/20 at 5:45 PM, Nursing Assistant (NA) #9 stated Resident #35 did not wear any left upper extremity splints but only a left lower leg extremity for transfers. NA #9 stated he performed PROM to his left upper extremity during his activities of daily living (ADLs). In another observation on 2/3/20 at 10:00 AM, Resident #35 was lying in bed. There was no observed splint to his left elbow.		F6	6888	prevent reoccurrence of alleged deficie practice: On 02/19/2020, the Nurse Managers began an in-service education to all full time, part time, and as needed nurses CNA's. Topics included: The importance for applying splints ordered by the MD. Inspecting skin at least daily or mo frequently as ordered for irritation, redness or skin breakdown. What to do when the device cannot be located.	l and s as ore	
	In an interview on 2/3/20 at 10:20 AM, NA #5 stated Resident #35 did not have a left elbow splint and staff only performed PROM to his left upper extremity. NA #5 stated the facility did not have restorative aides but rather the aides on the floor provided any restorative programs ordered. In an interview on 2/3/20 at 11:34 AM, Nurse #5 stated she thought his left elbow splint was discontinued but the aides provided PROM to his left upper extremity. In another observation on 2/3/20 at 12:08 PM, Resident #35 was lying in bed. There was no observed splint to his left elbow. In another observation on 2/3/20 at 2:34 PM, Resident #35 was lying in bed. There was no observed splint to his left elbow.				This information has been integrated in the standard orientation training and in required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff will does not receive scheduled in-service training will not be allowed to work until training has been completed by March 2020. 4. Monitoring Procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements. The Director of Nurses will monitor compliance utilizing the F688 Quality	the or ho 3, at nat	
	In another interview v	vith NA #5 on 2/3/20 at 2:50			Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345532	B. WING		02/06/2020
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY	;	STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	,
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 688	Continued From pag	ge 82	F 688		
	Resident #35's left e	as her understanding that elbow splint was discontinued. verbally and physically during ADL care.		Monitoring will be rotated in order to include all ordered shifts and weeked. The Director of Nursing will monitor application and compliance. Report be presented to the weekly Quality. Assurance committee by the Direct	ends. splint swill
	In another observation on 2/3/20 at 4:18 PM, Resident #35 was lying in bed. There was no observed splint to his left elbow.			Nurses to ensure corrective action initiated as appropriate. Compliance be monitored and the ongoing audit program reviewed at the weekly Qu Assurance Meeting until deemed no longer necessary for compliance wi	e will ting ıality o
	7/29/19 read the reafamily request. The multiple times over tupper extremity pas to ensure the prograre-train the staff. Th Resident #35 awake to his agitation. The attempt to review th education. The scre by the Rehabilitation unable to provide ar Occupational Thera	ew of A Physical Therapy (PT) Screen dated 19 read the reason for the screen was at 7 request. The screen read the PT attempted ole times over the past 3 weeks to perform 8 extremity passive range of motion (PROM) 10 sure the program was appropriate and to 10 in the staff. The PT was unable to get 11 lent #35 awake to participate or perform due 12 agitation. The PT was to continue to 13 per to review the programs and provide staff 13 ation. The screen was electronically signed 14 action. The RD was 15 e to provide any documented PT or 16 pational Therapy (OT) Screen but rather 16 Rehab Post Fall and Device Screens since 16 per 16 per 17 per 18 p		splint application. The weekly QA M is attended by the Administrator, Di of Nursing, MDS Coordinator, There Manager, Health Information Managand the Dietary Manager.	leeting rector apy
	stated he found Res a drawer in his room nursing notes regard. The RD stated that a putting the splint on be re-evaluated by t Resident #35's left of discontinued and it was	/3/20 at 4:33 PM, the RD sident #35's left elbow splint in and stated he found some ding the refusal of the splint. Since the aides had not been Resident #35 would need to he OT. The RD stated elbow splint was never was his expectation that the elbow splint as ordered. He			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDII		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			1	C (06/2020	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332			00,2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 688	Continued From pag	Continued From page 83						
	stated he was not aw applying Resident #3	vare the aides were not 35's left elbow splint.						
	#35's RP stated she the staff not applying recalled asking thera #35 months ago but the evaluation. Resid	4/20 at 8:50 AM, Resident had voiced concerns about his left elbow splint. She py to re-evaluate Resident did not know the outcome of lent #35 was up in a reclining station. He was not wearing						
	stated he received a the process of their s for him to complete a there was no docume OT Screen and only Screens at the time of MDS assessment da unless the staff let hi Resident #35's left up	on 2/4/20 at 2:00 PM, the RD list of residents who were in scheduled MDS assessment a therapy screen. He verified ented evidence of a PT or Rehab Post Fall and Device of Resident #35's quarterly ted 12/7/19. The RD stated m know of changes in pper extremity, he would not contacted the OT and was to 35 on 2/4/20.						
	stated the OT picked services. He stated F splint still fit properly ordered for his left ha	on 2/5/20 at 9:17 AM, the RD up Resident #35 for Resident #35's left elbow and a palm protector was and. He also stated OT would of his left upper extremity.						
	In an interview on 2/5 Record Supervisor s	5/20 at 1:09 PM, the Medical tated after reviewing						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345532	B. WING_			C
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	02	06/2020
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 688	Resident #35's medicany documented evid	e 84 cal record, she did not locate ence of his refusals of cian order to discontinue his	F 6	88		
	OT was to treat Residence exercise, therapeutic	n order dated 2/4/20 read lent #35 for therapeutic activity and orthotic contracture of his left hand				
	his left elbow extension with proper fit but state splint program. The g	n of Care dated 2/4/20 read on splint was appropriate if needed training on the oal was for Resident #35 to n protector and his left elbow				
	stated Resident #35 h decline in his ROM to	/20 at 3:40 PM, the OT nad not experienced a his left upper extremity but educate the staff on his program.				
F 689 SS=D	Resident #35 be regu contracture managen applied as ordered.	t was her expectation that llarly assessed for nent and for his splints be ards/Supervision/Devices	F 6	89		3/3/20
	, , , ,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345532	B. WING _			1	C 06/2020		
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2020		
				31	10 COMMERCE DRIVE				
LIBERTY	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY		S	ANFORD, NC 27332				
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI)			Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	85	F	689					
	supervision and assis accidents.	sident receives adequate tance devices to prevent is not met as evidenced							
	interview, the facility f an intervention of a P that was developed th	n, record review, and staff ailed to promptly implement hysical Therapy evaluation brough a root cause analysis ents reviewed for falls			The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has tall or will take the actions set forth in this	al			
	The findings included Resident #60 was add	: mitted to the facility on			plan of correction. The plan of correction constitutes the facility ☐s allegation of compliance such that all alleged	n			
		es that included dementia.			deficiencies cited have been or will be corrected by the dates indicated.				
	The quarterly Minimu	m Data Set (MDS)			F689				
		/1/19 indicated Resident			 Corrective action for resident(s) 				
		moderately impaired. She			affected by the alleged deficient practic				
		sistance of 2 or more for			For resident #60, the Physical Therapis	st			
		sfers and the extensive			worked with the resident from 12/11 to				
	assistance of 1 for loc				12/27/2020. An additional post fall scre	en			
		I hygiene. Resident #60 's			was completed on the resident	:41ـ			
	stabilize with staff ass	dy, and she was only able to			02/24/2020 by the Physical Therapist w no recommendations at this time.	viu i			
		with range of motion, she			no recommendations at this time.				
		and she was frequently			2. Corrective action for residents with	1			
		and bowel. Resident #60			the potential to be affected by the alleg				
	was actively receiving began on 9/18/19.	Physical Therapy (PT) that			deficient practice. Beginning on 02/20/2020 the Director of Nursing audited all current residents wi				
		n indicated Resident #60 3/19 through 10/24/19.			falls in the past 90 days to ensure interventions documented on the incide report was entered in to the care plan a	ent			
		ed 11/2/19 indicated unobserved fall with minor sident #60 was reported to			carried out. This will be completed by 03/03/2020.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		0.	C 2/06/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	2/00/2020	
				310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND F	REHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 689			F 68		4-		
	attempt to ambulate from her bed to her roommates' bed and she fell to the floor. She was assessed with a red mark to her right upper side and mid back. The Interdisciplinary Team (IDT) review, dated 11/2/19 and written by the Director of Nursing (DON), indicated 15-minute checks for Resident #60. An incident report dated 11/7/19 indicated Resident #60 had an unobserved fall with minor injury at 1:57 PM. Resident #60 was found on the floor in her room, she stated she was attempting to walk to the bathroom, lost her balance and fell on the bed to the floor. She reported she hit her back on the bed when she fell, and a red area was noted to left side of her upper back. The IDT review, dated 11/7/19 and written by the DON, indicated the fall was discussed and the intervention was a PT evaluation and/or treatment. The resident's medical record revealed the intervention of a PT evaluation was not implemented for Resident #60 after the 11/7/19 fall. An incident report dated 11/24/19 indicated Resident #60 had an unobserved fall with minor injury at 3:20 AM. Resident #60 was found laying in the doorway of her room on the right side with a laceration to her upper lip with swelling and swollen nose. The IDT review, dated 11/25/19 and written by the DON, indicated the root cause was confusion and the intervention was a medication review. Resident #60's care plan included the focus area actual falls with the risk for further falls related to poor communication/comprehension,			3. Measures /Systemic change prevent reoccurrence of alleged practice: On 02/20/2020, the administrate ducated the interdisciplinary to (Director of Nursing, MDS Nursing Manager, Business office mana Medical Records director, Thermanager, Social Worker, and A Director) on the following topics: "Root cause analysis and to interventions. "On 02/24/2020 a new thermal required in-service refresher con all staff identified above and will reviewed by the Quality Assurated process to verify that the change been sustained. Any staff who receive scheduled in-service trans to be allowed to work until trait been completed by March 3, 20	d deficient for eam se, Dietary ager, apy activity s: mely fall apy screen grated into g and in the burses for II be ince ge has does not aining will ining has		
				4. Monitoring Procedure to er the plan of correction is effectiv specific deficiency cited remain and/or in compliance with regul requirements. The Director of Nursing or design monitor compliance utilizing the Quality Assurance Tool weekly then monthly x 3 months. The I Nursing will monitor to ensure finterventions are carried out tim Reports will be presented to the Quality Assurance committee by	nsure that we and that as corrected latory gnee will e F689 x 2 weeks Director of fall nely. e weekly		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C 02/06/2020		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2020	
				31	0 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY			ANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	F 689 Continued From page 87		F6	889				
	area was last revised interventions included evaluation (initiated 1 consultation for stren 11/25/19). An incident report data Resident #60 had an injuries at 2:29 PM. It the floor of the hallware resident stated that swheelchair and she may review, dated 11/26/1 indicated the root cau intervention was for a	d, in part, medication 1/25/19) and a PT gth and mobility (initiated ted 11/26/19 indicated unobserved fall with no Resident #60 was found on ny lying on her left side. The			Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at weekly Quality Assurance Meeting. Th weekly QA Meeting is attended by the Administrator, Director of Nursing, MDC Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	the e		
	lethargy. She was not trying to get up and wassistance and she was balance. Resident #6 the morning of 11/24/bruising and sorenes mouth. The physicial review and indicated be completed. An incident report dance Resident #60 had an injury at 11:45 PM. The seated on the floor by she was trying to rear off the bed. The IDT written by the DON, in	ed 11/26/19 indicated ing seen related to falls and oted with frequent falls due to valk without her walker or vas very unsteady with poor 60 was noted with a fall on 1/19 and split her lip with s/pain around the nose and n completed a medication that a PT evaluation was to ted 11/29/19 indicated unobserved fall with no the resident was found y her bed and she reported ch something, and she slid review, dated 12/2/19 and indicated the intervention of a personal items were within						

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		NSTRUCTION		SURVEY LETED
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her reach. A PT Screen dated 1. Rehab Director indicated referred for the scree screen indicated Res in spite of measures prevention. PT had a unsuccessfully, howe frequent falls, PT will decrease fall risk throbalance and safety attraining. A physician 's order PT evaluation and trefrequent falls in facility. A physician 's clarific indicated PT 5 times continued falls. A physician 's order discontinuation of PT potential. An observation was continued falls. An observation was continued falls. During an interview was 2/5/20 at 8:30 AM shown reviewed falls was Support Nurse, and F	2/11/19 completed by the ated Resident #60 was in by nursing staff. The ident #60 had repetitive falls in place to assist with addressed falls in the past in place to assist with addressed falls in the past in place and attempt to ough improvement of its well as family and staff. Idated 12/11/19 indicated a reatment after continued by a repeated for 8 weeks due to its dated 12/27/19 indicated a reatment after a due to maximum functional in the same and th	F	589			
questions related to f	alls could be directed to the					
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page her reach. A PT Screen dated 12 Rehab Director indicareferred for the scree screen indicated Res in spite of measures i prevention. PT had a unsuccessfully, howe frequent falls, PT will decrease fall risk throbalance and safety as training. A physician 's order of PT evaluation and trefrequent falls in facility. A physician 's clarific indicated PT 5 times continued falls. A physician 's order of discontinuation of PT potential. An observation was of her room on 2/2/20 at but was unable to and to her previous falls of and confusion. During an interview was 2/5/20 at 8:30 AM shown reviewed falls was Support Nurse, and Fthe DON was unavail questions related to fall the screen and the poon and t	ROVIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 88 her reach. A PT Screen dated 12/11/19 completed by the Rehab Director indicated Resident #60 was referred for the screen by nursing staff. The screen indicated Resident #60 had repetitive falls in spite of measures in place to assist with prevention. PT had addressed falls in the past unsuccessfully, however, given continued frequent falls, PT will evaluate and attempt to decrease fall risk through improvement of balance and safety as well as family and staff training. A physician 's order dated 12/11/19 indicated a PT evaluation and treatment after continued frequent falls in facility. A physician 's clarification order dated 12/11/19 indicated PT 5 times per week for 8 weeks due to continued falls. A physician 's order dated 12/27/19 indicated a discontinuation of PT due to maximum functional potential. An observation was conducted of Resident #60 in her room on 2/2/20 at 1:35 PM. She was alert but was unable to answer any questions related to her previous falls due to cognitive impairment	ROVIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 88 her reach. A PT Screen dated 12/11/19 completed by the Rehab Director indicated Resident #60 was referred for the screen by nursing staff. The screen indicated Resident #60 had repetitive falls in spite of measures in place to assist with prevention. PT had addressed falls in the past unsuccessfully, however, given continued frequent falls, PT will evaluate and attempt to decrease fall risk through improvement of balance and safety as well as family and staff training. A physician 's order dated 12/11/19 indicated a PT evaluation and treatment after continued frequent falls in facility. A physician 's order dated 12/27/19 indicated a discontinuation of PT due to maximum functional potential. An observation was conducted of Resident #60 in her room on 2/2/20 at 1:35 PM. She was alert but was unable to answer any questions related to her previous falls due to cognitive impairment and confusion. During an interview with the Administrator on 2/5/20 at 8:30 AM she reported the IDT members who reviewed falls were the DON, MDS Nurse, Support Nurse, and Rehab Director. She stated the DON was unavailable for interview and that questions related to falls could be directed to the	ROVIDER OR SUPPLIER COMMONS NSG AND REHAB CTR OF LEE COUNTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 88 February 174 February 185 February	A BUILDING 345532 A BUILDING 346532 B WING STREETADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SAMFORD, NC 27332 SUMMARY STATEMENT OF DEPICIENCIES (EACH OEFCIENCY WIST ES PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 88 A PT Screen dated 12/11/19 completed by the Rehab Director indicated Resident #60 was referred for the screen by nursing staff. The screen indicated Resident #60 had repetitive falls in spite of measures in place to assist with prevention. 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She stated the DON was unavailable for interview and that questions related to falls could be directed to the	A BUILDING 345532 B. WING STREETADORESS, CITY, STATE, 2IP CODE 310 COMMERCE DRIVE SAMPORD, NC 27332 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) SAMPORD, NC 27332 Continued From page 88 her reach. A PT Screen dated 12/11/19 completed by the Rehab Director indicated Resident #60 was referred for the screen by nursing staff. The screen indicated Resident #60 had repetitive falls in spite of measures in place to assist with prevention. PT had addressed falls in the past unsuccessfully, however, given continued frequent falls, PT will evaluate and attempt to decrease fall risk through improvement of balance and safety as well as family and staff training. A physician 's order dated 12/11/19 indicated a PT evaluation and treatment after continued frequent falls in facility. A physician 's order dated 12/27/19 indicated a discontinuation of PT due to maximum functional potential. A physician 's order dated 12/27/19 indicated a discontinuation of PT due to maximum functional potential. An observation was conducted of Resident #60 in her room on 2/2/20 at 1:30 PM. She was alert but was unable to answer any questions related to her previous falls due to cognitive impairment and confusion. During an interview with the Administrator on 2/5/20 at 8:30 AM she reported the IDT members who reviewed falls were the DON, MDS Nurse, Support Nurse, and Rehab Director. She stated the DON was unavailable for interview and that questions related to falls could be directed to the

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			C 02/06/2020	
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From pa	ge 89	F 6	89			
	on 2/5/20 at 9:40 Al reviewed every Mor Support Nurse, DOI was asked what the PT evaluation if that developed through She stated that the meeting and he conhimself. She stated occurred within a da An interview was concurred within a the root cause analy the process for the evaluation himself with at the facility and the evaluation himself with a the facility and the evaluation of a PT were reviewed with screen and PT evaluation was reviewed and he stated that "on to stated that he Rehab Post Fall scrindicated he though appropriate for a PT He explained that the	anducted with the MDS Nurse M. She stated that falls were aday through Friday by herself, N, and Rehab Director. She a process was for completing a at was the intervention root cause analysis of the fall. Rehab Director was in the appleted the PT evaluation at that normally the evaluation at that normally the evaluation at the series when falls were ated he was involved in evising interventions based on ayis of the fall. When asked completion of PT evaluation if as selected by the IDT fall at he was the only full time PT at he would complete the within 1 to 2 days. The and the 11/26/19 IDT review falls that indicated the evaluation and/or treatment the Rehab Director. The PT uation that occurred on wed with the Rehab Director. The was unable to explain why a not completed until 12/11/19 there is no excuse". He went believed he had completed eens during November and at Resident #60 was not revaluation and/or treatment. The Rehab Post Fall Screen The PT Screen and PT					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NITIMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			02/0	06/2020	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, Z 310 COMMERCE DRIVE SANFORD, NC 27332	IP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICII	ACTION SHOULD BE TO THE APPROPRIA		(X5) COMPLETION DATE	
F 689	shared his viewpoint appropriate for Resid and 11/26/19 IDT fall intervention of a PT e was selected. The R recall if he shared his 11/7/19 or 11/26/19 ID asked why a PT screes ubsequent PT treatm 12/11/19. The Rehab was completed becaus had not stopped the f During an interview w 2/6/20 at 10:10 AM sl the interventions deve analysis of a fall to be	b Director was asked if he that a PT evaluation was not ent #60 during the 11/7/19 review in which the valuation and/or treatment ehab Director was unable to	F	589				
F 690 SS=D	members to express in order to develop the interventions. Bowel/Bladder Incont CFR(s): 483.25(e)(1). §483.25(e) Incontiner §483.25(e)(1) The factor resident who is continuous admission receives somaintain continence to condition is or become not possible to maintal factor possible to maintal section of the continence, based to comprehensive assesses the continence of the comprehensive assesses and the continence of the comprehensive assesses and the continence of the comprehensive assesses and the continence of the continence	their viewpoints to the team e most appropriate inence, Catheter, UTI -(3) nce. cility must ensure that hent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain.	F	690			3/3/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345532	B. WING _		02/06/2020
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	,
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 690	resident's clinical co- catheterization was (ii) A resident who e- indwelling catheter of is assessed for rem as possible unless to demonstrates that co and (iii) A resident who is receives appropriate prevent urinary trace continence to the ex- §483.25(e)(3) For an incontinence, based comprehensive assensure that a reside receives appropriate restore as much not possible. This REQUIREMEN by: Based on record re- interviews, the facili- indwelling urinary co reviewed for urinary The findings included Resident #66 was an 1/14/2020 with diag obstructive uropathy of urine is blocked) sacral area.	s not catheterized unless the andition demonstrates that necessary; inters the facility with an or subsequently receives one oval of the catheter as soon he resident's clinical condition atheterization is necessary; is incontinent of bladder the treatment and services to a infections and to restore infections and services to infection as incontinent of bowel infection and bowel infection and bowel infection and bowel infection as infection and infect	F 69	The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all feder and state regulations the facility has to or will take the actions set forth in this plan of correction. The plan of correct constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F690	d do ral aken s ion
	· ·	s revealed an order dated the catheter was secured in		The plan of correcting the specific deficiency. The plan should address t processes that lead to the deficiency	he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		C 02/06/2020	
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/00/2020	
				310 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND	REHAB CTR OF LEE COUNTY	,	SANFORD, NC 27332		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE.	
F 690	Continued From page 92					
	The manifest of Deed	dt #00l		cited:		
		dent #66's care plan revealed		Corrective action for resident(s)		
	·	iated on 1/15/2020 for a		affected by the alleged deficient practi		
		e to urine retention. One of cluded a leg band to secure		For resident #66: a leg band was appl on 02/24/2020 by the nurse manager.		
	catheter.	cluded a leg balld to secure		nurse consultant entered task and ord		
	Catricter.			for catheter leg band securement to		
	The admission Min	imum Data Set (MDS)		ensure it is in place on 02/24/2020.		
		1/21/2020 indicated Resident				
	#66 had severe cog	gnitive impairment, required		2. Corrective action for residents wit	h	
	extensive assistant	ce from staff for all Activities of		the potential to be affected by the alle	ged	
	Daily Living and used an indwelling urinary			deficient practice.		
	catheter.			Beginning on 02/18/2020, the nurse		
				manager audited all current residents	with	
		5pm Resident #66 was		a Foley catheter to ensure a Foley		
		ed with the bed covers		securement device was in place. This		
		egs. A catheter securement		audit was completed by 02/21/2020. 2		
	was underneath his	sent, and the catheter tubing		4 residents were noted without a leg b 1 resident refused the leg band stating		
	was underneall ins	s leit triigit.		did not want it. Care plan has been	J IIC	
	Resident #66 was d	observed lying in his bed on		updated on 02/24/2020 by the nurse		
		with the bed covers in		consultant with the resident's refusal a	and	
		served the urinary catheter		request to not use the leg band. 1 resi		
		disconnected from the		received the leg band on 02/24/2020.		
		g and the bed pad was		Orders and task to ensure the leg ban	d is	
	saturated with urine	e. A urinary catheter		in place will be updated by the nurse		
	securement device	was not present.		consultant by 02/25/2020.		
	On 2/3/2020 at 11:0	00am urinary catheter care		3. Measures /Systemic changes to		
		Nurse Aide #3 who confirmed		prevent reoccurrence of alleged defici	ent	
	the resident did not	t have securement device		practice:		
		er explained all resident with		Beginning on 02/19/2020 the nurse		
		hould have some type of		managers began educating all full time	-	
		present and could not explain		part time, and prn nurses and CNA's o	on	
	why Resident #66	did not.		the following topics:		
	N	· · · · · · · · · · · · · · · · · · ·		Foley catheter care, preventing		
		viewed on 2/3/2020 at		trauma, and ensuring the Foley		
		d the indwelling urinary be secured to the resident's		securement device is in place at all tin	ICS.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C 02/06/2020		
NAME OF P	ROVIDER OR SUPPLIER	L	1	STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2020	
				310 CC	DMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY			ORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
F 690	F 690 Continued From page 93 inner thigh to prevent friction/movement. She		F 6		nis information has been integrated in	nto		
	further stated the nur reported if there was device present and h	se aides should have not a catheter securement ad been unaware Resident was not secured to his leg.		the rec all rev	e standard orientation training and ir quired in-service refresher courses f staff identified above and will be viewed by the Quality Assurance	the		
	2/6/2020 at 10:10am expectation for indwe	d with the Administrator on , she stated it was her elling catheter tubing's to be anchored to the resident's dental pulling.		be in- Nu ca do tra	seen sustained. The facility specific service will be provided to all agencurses and CNA's who give residents are in the facility. Any nursing staff wees not receive scheduled in-service will not be allowed to work until the facility.	rho il		
				4. the sp an rec Th mo Qu the pla we the co app an rev Me ne ca	Monitoring Procedure to ensure the plan of correction is effective and the ecific deficiency cited remains correction in compliance with regulatory equirements. The Director of Nurses or designee with ponitor compliance utilizing the F690 and the procedure of the process of	nat hat cted I eks ved. ure is in by ored		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			1	C (06/2020	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2020	
				310 COM	MMERCE DRIVE			
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		SANFO	RD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 690	Continued From pag	e 94	F 690 Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.					
F 695 SS=D	Respiratory/Tracheos CFR(s): 483.25(i)	stomy Care and Suctioning	F 6	95			3/3/20	
	The facility must ensineeds respiratory care and tracheal succare, consistent with practice, the comprel care plan, the resider and 483.65 of this surfhis REQUIREMENT by: Based on observation and record reviews, the administer continuous ordered flow rate for #36. This was for 2 or respiratory care. The surfle of the surf	nd tracheal suctioning. ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of hensive person-centered hts' goals and preferences, bpart. It is not met as evidenced hts, staff, resident interviews he facility failed to soxygen at the Physician Resident #5 and Resident hof 2 residents reviewed for findings included htdmitted on 12/16/17 with his of Congestive Heart Failure hence. #5's care plan last revised uired continuous oxygen sincluded the administration hygen as ordered.		corr not alleg To r and or w plar con defii corr F69 1. affe For oxyg	e statements made on this plan of rection are not an admission to an constitute an agreement with the ged deficiencies. remain in compliance with all feder state regulations the facility has twill take the actions set forth in this not correction. The plan of correct stitutes the facility's allegation of repliance such that all alleged ciencies cited have been or will be rected by the dates indicated. Corrective action for resident(s) rected by the alleged deficient practive resident #5, the MD orders state gen at 2 liters per minute. On ervation on 02/18/2020 and 24/2020 by the nurse manager, the rate was on 2 lpm.	d do ral aken s ion		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		0.5	C 2/06/2020	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	'	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	.700/2020	
				310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 695	Continued From pag	e 95	F 69	95			
	orders included an o continuous oxygen a	#5's February 2020 Physician rder dated 12/18/17 for t 2.0 liters per minute (L/M). 2/2/20 at 3:39 PM, revealed		For resident #36, the MD orders oxygen at 2 lpm. On observation 02/18/2020 and 02/24/2020 by the manager, the o2 flow rate was or	on ne nurse		
	In an observation on 2/2/20 at 3:39 PM, revealed her continuous oxygen was running at 2.5 L/M via oxygen concentrator. In an observation on 2/3/20 at 10:15, revealed her continuous oxygen was running at 2.5 L/M via oxygen concentrator. In an interview on 2/3/20 at 2:30 PM, Nurse #5 stated she assessed Resident #5's oxygen saturation and the oxygen flow rate every shift.			Corrective action for residen the potential to be affected by the deficient practice.	e alleged		
				On 02/18 and 02/19/2020, the numanager began auditing all curre residents receiving oxygen. This completed by 02/19/2020. Oxyge	ent audit was		
				rate was observed for compliance MD order. 100% compliance note	ed.		
		2/3/20 at 4:20 PM, revealed en was running at 2.5 L/M via		 Measures /Systemic change prevent reoccurrence of alleged opractice: On 02/20/2020, the Nurse Manage 	deficient		
	In an observation on 2/4/20 at 8:30 AM, revealed her continuous oxygen was running at 2.5 L/M via oxygen concentrator. In an interview on 2/4/20 at 8:45 AM, Nurse #6 stated she assessed Resident #5's oxygen saturation and the oxygen flow rate every shift. In an observation on 2/4/20 at 11:40 AM, revealed her continuous oxygen was running at 2.5 L/M via oxygen concentrator. In an observation on 2/4/20 at 3:45 PM, revealed her continuous oxygen was running at 2.5 L/M via oxygen concentrator.			began education to all full time, p and PRN Nurses and CNA's on t following: Resident's liter flow of oxyge	part time, he		
				be set at the amount ordered by If the resident is bumping up the liters, then their respiratory status be assessed and notify the MD o	the MD. oxygen s should		
				findings. Residents should be rer not to tamper with the liter setting this should be documented in the notes.	gs and		
				This information has been integrated the standard orientation training a required in-service refresher could	and in the		
		2/5/20 at 9:25 AM, revealed en was running at 2.5 L/M via		all staff identified above and will be reviewed by the Quality Assurance process to verify that the change	ce		

SAME OF PROVIDER OR SUPPLIER	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332			345532	B. WING _	B. WING				
CAMPID SUMMARY STATEMENT OF DEFICIENCIES PREFIX SAMFORD, NC 27332 PROVIDER'S PLAN OF CORRECTION CAMPID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S PLAN OF CORRECTION CAMPID PREFIX PROVIDER'S PLAN OF CORRECTION COMPLETION DATE	NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2020	
CAN D PREFIX SUMMARY STATEMENT OF LEE COUNTY SANFORD, NC 27332									
FREFIX TAG REGULATORY OR LSC (IDENTIFYING INFORMATION) FOR SEGULATORY OR LSC (IDENTIFYING INFORMATION) NUTSES and CNA'S who give residents care in the facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility approvided to all agency Nurses and CNA's who give residents care in the facility approvided to all agency Nurses and CNA's who give residents care in the facility approvided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses	LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY						
been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020. In another interview on 2/5/20 at 1:15 PM, Nurse #6 confirmed working with Resident #5 on 2/4/20 and 2/5/20. Nurse #6 was asked to assess the oxygen flow rate on the concentrator at eye level. She confirmed the oxygen was running at 2.5 L/M. She stated she must have not assessed Resident #5's oxygen flow rate at eye level to verify the Physician ordered rate. Nurse #6 stated Resident #5 was unable to adjust her oxygen concentrator flow rate. In an interview on 2/5/20 at 3:40 PM, NA #8 stated nurses were the only staff that adjusted oxygen rates. NA #8 also stated Resident #5 was not capable of adjusting her own oxygen rate. In an interview on 2/6/20 at 10:11 AM, the	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
Resident #5's oxygen be administrated at the Physician ordered rate. 2) Resident #36 was originally admitted to the facility on 11/25/13 with diagnoses that included congestive heart failure (CHF), pulmonary hypertension and end stage renal disease on dialysis. A physician order dated 3/4/19 revealed to check oxygen saturation levels every shift for chronic renal failure, oxygen at 2 liters via nasal cannula as needed during the day to maintain pulse oximetry above 90% due to chronic renal failure Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance with oxygen liter flow according to MD orders. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, and the Dietary Manager. Manager.	F 695	In an interview on 2/5 Assistant (NA) #6 stated from the state of the confirmed working and 2/5/20. Nurse #6 confirmed working and 2/5/20. Nurse #6 confirmed the ox L/M. She stated she Resident #5's oxyger verify the Physician of Resident #5's oxyger verify the Physician of Resident #5 was una concentrator flow rate. In an interview on 2/5 stated nurses were the oxygen rates. NA #8 not capable of adjust. In an interview on 2/6 Administrator stated. Resident #5's oxyger Physician ordered rate. 2) Resident #36 was facility on 11/25/13 we congestive heart failt hypertension and endialysis. A physician order date oxygen saturation lever the state of the congestive heart failt hypertension and endialysis.	ated nurses were the only ygen rates. NA #6 also ras not capable of adjusting on 2/5/20 at 1:15 PM, Nurse g with Resident #5 on 2/4/20 as asked to assess the he concentrator at eye level. Aygen was running at 2.5 must have not assessed in flow rate at eye level to ordered rate. Nurse #6 stated also stated Resident #5 was ing her own oxygen rate. 6/20 at 3:40 PM, NA #8 he only staff that adjusted also stated Resident #5 was ing her own oxygen rate. 6/20 at 10:11 AM, the it was her expectation that he administrated at the te. originally admitted to the ith diagnoses that included are (CHF), pulmonary distage renal disease on the day to maintain pulse	F	595	been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff w does not receive scheduled in-service training will not be allowed to work untitraining has been completed by March 2020. 4. Monitoring Procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F695 Quality Assurance Tool weekly x 2 weet then monthly x 3 months or until resolv Monitoring will be rotated in order to include each shift and weekends. The Director of Nursing will monitor compliance with oxygen liter flow according to MD orders. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance we be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance with oxygen liter flow according to MD orde The weekly QA Meeting is attended by Administrator, Director of Nursing, MD Coordinator, Therapy Manager, Health Information Manager, and the Dietary	rho il 3, nat hat cted l eks red. e of ill ty the S		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345532	B. WING _	B. WING			C 02/06/2020	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		310 (EET ADDRESS, CITY, STATE, ZIP CODE COMMERCE DRIVE IFORD, NC 27332	1 021	00/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 695	Continued From page	e 97 s via nasal cannula every	F	895				
	night. The active care plan problem area for the included oxygen settion. The quarterly Minimulassessment dated 12 #36 was cognitively in vision where he could regular print in newspapervision to limited Daily Living and used. A physician progress indicated Resident #3 tended to use oxyger the day as he felt mon Resident #36 was to during the day and excannula. On 2/2/2020 at 1:15p of Resident #36 sittin oxygen regulator on tiliters flow by nasal care.	dated 12/5/19 revealed a use of oxygen. Interventions ngs at 2 liters as needed. m Data Set (MDS) 2/13/19 indicated Resident nact and had impaired disee large print but not papers/books. He received assistance with Activities of loxygen.						
	#36 was able to state and preferred to wea night. He further stat making sure the correconcentrator as he habubble in the oxygen On 2/3/2020 an obse Resident #36 at 9:50 revealed the oxygen	the used 2 liters of oxygen rit through out the day and ed the staff assisted with ect amount was on the ad difficulty seeing the regulator.						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345532	B. WING		C 02/06/2020	
	ROVIDER OR SUPPLIER	HAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 02/00/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 695	humidification when velovel. On 2/4/2020 at 3:30p observed sitting on the oxygen regulator on the liters flow by nasal can when viewed at horizon the liters flow by nasal can when viewed at horizon. An interview occurred at 3:45pm, who stated concentrator was set standing over the market standing over the market standing over the market stated when she of horizontally at eye level was set at 3 liters. Not rate to administer 2 liters of lite	m Resident #36 was e side of his bed. The he concentrator was set at 3 nnula with humidification ontal eye level. I with Nurse #2 on 2/4/2020 d the oxygen flow rate on the at 2 liters, as she was chine, looking down. Nurse bserved the flow rate rel, she could see the flow urse #2 adjusted the flow ters as ordered. am an interview was dministrator. She stated it or Resident #36's oxygen be hysician's ordered rate. Full Time DON c(3)	F 69	5	3/3/20	
	must designate a regi director of nursing on	this section, the facility stered nurse to serve as the a full time basis.				
		ector of nursing may serve ly when the facility has an				

		I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING			С		
NAME OF D		343532	B. WING_	OT	DEET ADDRESS SITV STATE ZID SODE	02/	06/2020	
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
LIBERTY	COMMONS NSG AND F	REHAB CTR OF LEE COUNTY			0 COMMERCE DRIVE			
				SA	ANFORD, NC 27332			
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OF	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 727	Continued From pag	ge 99	F 7	727				
	This REQUIREMEN by: Based on staff inter facility failed to staff 8 consecutive hours	ancy of 60 or fewer residents. T is not met as evidenced views and record review, the a Registered Nurse (RN) for daily for 3 of the last 6 days erage (1/31/20, 2/4/20, and d:			The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of correction	al ken		
	coverage on 1/31/20 (census of 70), and	staff posting, staff aily census, revealed no RN 0 (census of 68), 2/4/20 2/5/20 (census of 70). nducted with the MDS Nurse			constitutes the facility □s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F727 1. Corrective action for resident(s)			
	an RN and she used switched to MDS ful reported that on 1/3 was working as the working on the floor posting and staff ass	M. She stated that she was I to work on the floor until she I time after 1/17/20. She 1/20, 2/4/20, and 2/5/20, she MDS Nurse and was not She reviewed the staff signments for 1/31/20, 2/4/20, irmed there was no RN			affected by the alleged deficient practice. No residents were identified as affecte 2. Corrective action for residents with the potential to be affected by the alleg deficient practice.	d. n		
	2/6/20 at 10:10 AM s no RN coverage on She stated that the f period with the MDS that position full time RN who worked on s worked part time. S	with the Administrator on she acknowledged there was 1/31/20, 2/4/20, and 2/5/20. Facility was in a transition to Nurse recently switching to e. She indicated they had 1 the floor full time 2 RNs who he reported that they were in the for an additional RN to hire RN coverage for 8			On 02/24/2020 staffing sheets were reviewed by the Administrator from 02/06/2020 through 02/24/2020 to more that at least eight consecutive hours of registered nurse staffing was in place daily19 out of19 day had at least 8 consecutive hours of registered nurse hours in place. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 02/24/2020, the Nurse Consultant educated the Administrator	f ays ent		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345532	B. WING				С		
						02/	06/2020		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE				
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		310	0 COMMERCE DRIVE				
LIDLIKIT	COMMISSION NOC AND IN	ENABOR OF ELECTION		SA	ANFORD, NC 27332				
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRI		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU				(X5) COMPLETION DATE
F 727	Continued From page	e 100	F7	727	and Director of Nurses on the requirem of the facility to staff Registered Nurse Coverage for at least consecutive hour daily. Coverage by a Registered nurse a least eight consecutive hours will be maintained by 03/03/2020. This information has been integrated in the standard orientation training and in required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training who to be allowed to work until training has been completed by March 3, 2020. 4. Monitoring Procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F272 at 732 Quality Assurance Tool weekly for staffing of registered nurse hours daily weeks then monthly x 3 months. The Director of Nursing will monitor staffing compliance with the requirement for at least 8 hours of registered nurse staffing daily. Reports will be presented to the weekly Quality Assurance committee be the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitor and the ongoing auditing program reviewed at the weekly Quality Assurance reviewed at the weekly Quality Assurance reviewed at the weekly Quality Assurance reviewed at the weekly QA Meeting is	s for to the or ot will s at the oten of t			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION SUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C 02/06/2020		
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2020	
LIDEDTY	COMMONO NOO AND DE	CHAR OTR OF LEE COUNTY		31	10 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		S	ANFORD, NC 27332			
(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 727	Continued From page	e 101	F 7	727	attended by the Administrator, Director Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.			
F 732 SS=B	Posted Nurse Staffing CFR(s): 483.35(g)(1)		F 7	732			3/3/20	
	must post the following basis: (i) Facility name. (ii) The current date. (iii) The total number by the following categoral unlicensed nursing stresident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must perspecified in paragraph daily basis at the beging (ii) Data must be post (A) Clear and readab (B) In a prominent plaresidents and visitors §483.35(g)(3) Public staffing data. The fact written request, make	and the actual hours worked gories of licensed and aff directly responsible for t: In nurses or licensed defined under State law). Ides. I requirements. I						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345532	B. WING		C 02/06/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/06/2020	
				310 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 732	Continued From pag	e 102	F 73	2		
	posted daily nurse si 18 months, or as red is greater. This REQUIREMEN by: Based on record rev facility failed to have	acility must maintain the saffing data for a minimum of juired by State law, whichever T is not met as evidenced view and staff interview, the an accurate staff posting on		The statements made on this plan of correction are not an admission to a	nd do	
	census data for 01/0			not constitute an agreement with the alleged deficiencies. To remain in compliance with all federand state regulations the facility has or will take the actions set forth in the plan of correction. The plan of corrections to the facility □s allegation of constitutes the facility □s allegation of constitutes the facility □s allegation of constitutes the facility □s allegation of the facility □s allegation of constitutes the facility □s allegation of t	eral taken is ction	
	the actual census wa - 01/07/20 Staff post the actual census wa - 01/08/20 Staff post the actual census wa - 01/09/20 Staff post the actual census wa - 01/10/20 Staff post the actual census wa - 01/11/20 Staff post the actual census wa - 01/12/20 Staff post the actual census wa - 01/13/20 Staff post the actual census wa - 01/13/20 Staff post the actual census wa - 01/15/20 Staff post the actual census wa - 01/15/20 Staff post the actual census wa - 01/15/20 Staff post the actual census wa	ing census indicated 63 and as 64 ing census indicated 64 and as 65 ing census indicated 65 and as 63 ing census indicated 65 and as 64 ing census indicated 66 and as 65 ing census indicated 66 and		compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F732 1. Corrective action for resident(s) affected by the alleged deficient practice. On ozerotive action for residents with the potential to be affected by the alleged deficient practice. On 02/24/2020 the staffing sheets with reviewed by the Administrator from 01/06/2020 through 02/24/2020 to elet that daily nurse staffing postings reflet the correct daily census on each post The daily census was reviewed in Post and compared to the staffing sheet. Corrections were made at the time of audit by the Administrator. Completic date 02/24/2020.	ctice: cted. vith leged ere ensure ected sting. CC	
		ing census indicated 66 and		3. Measures /Systemic changes to		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
				2 1/4/10			С	
		345532	B. WING _			02/	06/2020	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LIDEDTY	COMMONE NEC AND D	FUAR CTR OF LEE COUNTY		31	10 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY		S	ANFORD, NC 27332			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE	
F 732	Continued From page	e 103	F i	732				
		ng census indicated 67 and			prevent reoccurrence of alleged deficie	nt		
	the actual census wa				practice:			
		ng census indicated 69 and			'			
	the actual census wa				On 02/24/2020, the nurse consultant			
	- 01/25/20 Staff posti	ng census indicated 69 and			began educating the administrator,			
	the actual census wa	s 67			Director of Nurses and Nursing Schedu	ıler		
	- 01/26/20 Staff posti	ng census indicated 69 and			on the requirement of the facility to			
	the actual census wa				document on the Daily Nurse Staffing			
	•	ng census indicated 69 and			Posting the current resident census ea	ch		
	the actual census wa				day.			
	· · · · · · · · · · · · · · · · · · ·	ng census indicated 69 and						
	the actual census wa				This information has been integrated in			
	· · · · · · · · · · · · · · · · · · ·	ng census indicated 69 and			the standard orientation training and in			
	the actual census wa	ng census indicated 69 and			required in-service refresher courses for all staff identified above and will be	"		
	the actual census wa	_			reviewed by the Quality Assurance			
		ng census indicated 69 and			process to verify that the change has			
	the actual census wa	_			been sustained. Any identified staff w	/ho		
		ng census indicated 69 and			does not receive scheduled in-service			
	the actual census wa	_			training will not be allowed to work until			
	- 02/03/20 Staff posti	ng census indicated 69 and			training has been completed by March			
	the actual census wa				2020.			
	- 02/04/20 Staff posti	ng census indicated 69 and						
	the actual census wa				4. Monitoring Procedure to ensure the			
	- 02/05/20 Staff posti	ng census indicated 69 and			the plan of correction is effective and th	ıat		
	the actual census wa	s 70			specific deficiency cited remains correct	ted		
					and/or in compliance with regulatory			
		ducted with Transportation			requirements.			
		2:35 PM. She stated that she			The Director of Nursing or designee wil	ı		
		staff posting. She indicated			monitor compliance utilizing the F732			
		as to complete the next day' s afternoon before she left			Quality Assurance Tool weekly for daily nursing staff postings that include the			
		ner that indicated that she			current resident census each day x 2			
	worked Monday throu				weeks then monthly x 3 months. Repor	ts		
	completed the staff p				weeks their monthly x 3 months. Report will be presented to the weekly Quality			
		fternoon. She revealed she			Assurance committee by the Director o			
	-	posting if any changes were			Nurses to ensure corrective action is	•		
		nformation or to staffing			initiated as appropriate. Compliance wi	11		
	information.	Ŭ			be monitored and the ongoing auditing			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED		
		345532	B. WING _	B. WING			C 02/06/2020	
NAME OF PR	ROVIDER OR SUPPLIER	*****		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2020	
LIBERTY C	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY		31	10 COMMERCE DRIVE			
				S	ANFORD, NC 27332			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	02/06/20 at 10:10 AM expected the staff postervised as required indicated she was new new Administrator, so of learning all of the reprocesses and system Drug Regimen Review CFR(s): 483.45(c)(1)(1)(1)(2)(2)(3)(3)(4)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	ith the Administrator on she stated that she sting to be accurate and to d by the regulations. She w to the facility and was a she was still in the process egulations and improving on an within the facility. w, Report Irregular, Act On 2)(4)(5) Immen Review. Ig regimen of each resident east once a month by a view must include a review cal chart. It armacist must report any tending physician and the stor and director of nursing, st be acted upon. Ide, but are not limited to, any riteria set forth in paragraph an unnecessary drug. In that is sent to the of the facility's medical of nursing and lists, at a t's name, the relevant drug, the pharmacist identified. It's name, the relevant drug, the pharmacist identified. It's name, the relevant in the store in the store in the store in the relevant in the store in the store in the relevant in the store in the store in the relevant drug, the pharmacist identified.		732	program reviewed at the weekly Qualit Assurance Meeting. The weekly QA Meeting is attended by the Administrate Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Heal Information Manager, and the Dietary Manager.	or,	3/3/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345532	B. WING _	B. WING			C 02/06/2020	
NAME OF P	ROVIDER OR SUPPLIER		_	STR	REET ADDRESS, CITY, STATE, ZIP CODE			
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				SA	NFORD, NC 27332			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 756	Continued From page	e 105	F 7	756				
		nedication, the attending ument his or her rationale in I record.						
	maintain policies and drug regimen review limited to, time frames the process and steps when he or she identify requires urgent action. This REQUIREMENT by: Based on record review interviews, the consuidentify incorrect med for 1 of 2 residents retube (Resident #11). The findings included Resident #11 was origon 10/11/19 with diag (impairment of languate cerebral vascular according assessment of the diagnostic part of the active of the active of #11 required tube fee fluids. The active physician and steps when the active of the active of fluids.	ginally admitted to the facility noses including aphasia age), gastrostomy and ident (CVA). sion Minimum Data Set ated 10/18/19 indicated she impairment. She required all Activities of Daily Living tion and fluids via a feeding care plan revealed Resident ding for all nutrition and			The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has tal or will take the actions set forth in this plan of correction. The plan of correctic constitutes the facility □s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F756 1. Corrective action for resident(s) affected by the alleged deficient practic For resident# 11, on 02/04/2020 the Claritin was discontinued due to completion of MD order. On 02/04/2020 the Glucophage route was changed to g-tube by the hall nurse. No other medications were affected for this resident. 2. Corrective action for residents with the potential to be affected by the alleged.	l ken on ee: O via		
	fluids. The active physician	•			Corrective action for residents with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	TE SURVEY MPLETED	
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TVAINE OF T	TO VIDER OR OUT FEET			, , ,			
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F 756	Continued From pag	ne 106	F 7	56			
	diabetes and an orde 10mg 1 tablet by mo days. Resident #11's media	of the two times a day for the dated 1/30/2020 for Claritin the day for 10 the cal record revealed monthly		Beginning on 02/25/2020 the p consultant began auditing all c residents orders to identify ar medication routes. This will be by 03/03/2020. Any medication with incorrect routes will be cor	urrent ny incorrect completed ns identified rrected by		
	consultant pharmacis	nad been completed by the st on 11/19/19, 12/19/19 and ws revealed no irregularities 11.		 the nurse manager by 03/03/20 3. Measures /Systemic changer prevent reoccurrence of allegen practice: 	ges to		
	Nurse #1 who was war for Resident #11's had medications earlier. It did not receive any made not provided the Glucophage or Clarif acknowledged the For Administration Recoil	am an interview occurred with vorking the medication cart all and had administered her She confirmed Resident #11 medications by mouth and morning doses of tin by mouth. Nurse #1 ebruary 2020 Medication rd (MAR) read for the lovided by mouth and was		On 02/25/2020 the nurse consisted acted the consultant pharm the following topics: "Drug regimen review show reviewing all current residents medications for correct drug administration routes. This information has been integrated the standard orientation trainin	nacist on uld include □ grated into		
	An interview was cor 3:50pm with Nurse # medication cart for R stated she was famil administered her me #2 acknowledged Re any medications by r	nducted on 2/4/2020 at #2 who was working on the Resident #11's hall. She liar with the resident and had edications many times. Nurse esident #11 did not receive mouth. She reviewed the and confirmed the order on		required in-service refresher co all staff identified above and wi reviewed by the Quality Assura process to verify that the chang been sustained. Any staff who receive scheduled in-service tr not be allowed to work until tra been completed by March 3, 2	ourses for ill be ance ge has o does not raining will ining has 020.		
	the MAR for the Gluc taken by mouth was On 2/5/2020 at 9:06a conducted with the fa pharmacist, who was and confirmed all he	cophage and Claritin to be inaccurate. am, a phone interview was acility's consultant s familiar with Resident #11		the plan of correction is effective specific deficiency cited remains and/or in compliance with regular requirements. The Director of Nurses will more compliance utilizing the F658, 757, and 758 Quality Assurance weekly x 2 weeks then monthly	ve and that ns corrected latory nitor 686, 756, se Tool		

D 147110	06/2020 (X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE	(X5) COMPLETION
	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 756 Continued From page 107 pharmacist stated the error in administration route should have been caught on the monthly medication reviews and was likely an oversight. In an interview with the Administrator on 2/6/2020 at 10:10am, stated she expected the facility's consultant pharmacist to alert staff to errors in administration routes during the monthly medication reviews. F 757 SS=D Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d) (1)-(6) \$483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- \$483.45(d)(1) in excessive dose (including duplicate drug therapy); or \$483.45(d)(3) Without adequate monitoring; or \$483.45(d)(4) Without adequate indications for its use; or \$483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this	3/3/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		C 02/06/2020	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/00/2020	
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F 757	F 757 Continued From page 108		F 757	,		
	by: Based on record revi	is not met as evidenced iew, staff interview, and		The statements made on this plan of		
		c medication as ordered		correction are not an admission to and not constitute an agreement with the	do	
	_	al administrations of the		alleged deficiencies.		
	medication for 1 of 2 residents reviewed for pain (Resident #46). The findings included: Resident #46 was admitted to the facility on			To remain in compliance with all federa and state regulations the facility has tall or will take the actions set forth in this		
				plan of correction. The plan of correction constitutes the facility sellegation of	on	
				compliance such that all alleged		
		ses that included end stage		deficiencies cited have been or will be		
	renal disease and ort	hopedic aftercare.		corrected by the dates indicated. F757		
	The hospital discharg	e summary for Resident		Corrective action for resident(s)		
	#46 dated 12/27/19 ir			affected by the alleged deficient practic		
		ioid medication) 5-325		For resident #46, on the Oxycodone wa	as	
	milligrams (mg) as ne days.	eeded (PRN) for up to 5		discontinued on 01/02/2020 due to automatic stop date.		
	A physician 's order for Resident #46 dated 12/27/19 at 1:12 PM indicated Percocet 5-325 mg every 4 hours PRN for pain for 5 days. This order was entered into the electronic medical record by MDS Nurse #1.			 Corrective action for residents with the potential to be affected by the alleg deficient practice. Beginning on 02/24/2020 the Nurse Consultant ran a report from Point Click Care to identify all current orders enter 	ed K	
	PRN Percocet was a	cated the 12/27/19 order for dministered 3 times after the /1/20 at 9:21 PM, 1/2/20 at		from 01/01/2020 to 02/24/2020 to identi any orders with automatic stop dates. Orders with a stop date entered will be reviewed for any input errors. This will completed by 02/28/2020.	ify	
	's cognition was intac	num Data Set (MDS) 3/20 indicated Resident #46 ct. She was administered ring the review period.		3. Measures /Systemic changes to prevent reoccurrence of alleged deficie practice: On 02/18/2020, the nurse managers	nt	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345532	B. WING				06/ 2020
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		310	REET ADDRESS, CITY, STATE, ZIP CODE D COMMERCE DRIVE NNFORD, NC 27332		
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F 757	on 2/5/20 at 1:10 PM Percocet order for Re The MDS Nurse revie and revealed she had duration which pulled She explained that sl 1/2/20 at 11:59 PM ra date of 1/1/20 at 1:12 stated that this was a acknowledged that th administrations were timeframe. During a phone interv 2/6/20 at 11:43 AM h orders to be followed PRN Percocet for Re of the ordered timefra physician. He indica the additional admini resident as he made Percocet after this tim The Administrator wa 10:10 AM and she re physician 's orders to	aducted with the MDS Nurse . The 12/27/19 PRN esident #46 was reviewed. ewed the electronic order d entered the incorrect I over to the MAR incorrectly. he entered a stop date of eather than the 5 day stop 2 PM. The MDS Nurse he error and she here of the PRN Percocet outside of the ordered view with the physician on he stated that he expected his . The 3 administrations of he sident #46 that were outside here were reviewed with the heted he had no concerns with he strations of Percocet for this hanother order for the PRN hereframe.	F	757	began educating all full time, part time, and PRN Nurses on the following topic: "Medication safety "Preventing medication errors wherentering stop dates This information has been integrated in the standard orientation training and in required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses who give residents care in the facility. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 3, 2020. 4. Monitoring Procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F658 Quality Assurance Tool weekly x 2 weethen monthly x 3 months. The Director Nursing will monitor compliance with medication stop dates. Reports will be presented to the weekly Quality Assurance committee by the Director on Nurses to ensure corrective action is initiated as appropriate. Compliance with be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator.	s: n to the or at hat bted	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2020
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F 757	Continued From page		F 7	757	Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.		
F 758 SS=E	l	chotropic Meds/PRN Use (e)(1)-(5)	F 7	758			3/3/20
	affects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe resident, the facility manual sychotropic drugs are unless the medication specific condition as on the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral intervention	notropic drug is any drug that associated with mental ior. These drugs include, drugs in the following ensive assessment of a must ensure that ints who have not used re not given these drugs in is necessary to treat a diagnosed and documented ints who use psychotropic I dose reductions, and					
	unless that medicatio	ursuant to a PRN order n is necessary to treat a undition that is documented					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			C 02/06/2020	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 758	F 758 Continued From page 111		F 7	58			
F 758	§483.45(e)(4) PRN of are limited to 14 days §483.45(e)(5), if the prescribing practition appropriate for the P beyond 14 days, he rationale in the reside indicate the duration §483.45(e)(5) PRN of drugs are limited to 12 renewed unless the apprescribing practition the appropriateness. This REQUIREMENT by: Based on observation interviews with reside facility failed to have indication for the use medication for 1 of 4 reviewed for psychotomy. The findings included Resident #28 was ac 3/29/19 with diagnoss s disease, dementia, disorder. A physician 's order 3/29/19 indicated Abmedication) 10 milling anxiety related to many properties.	arders for psychotropic drugs s. Except as provided in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order. Arders for anti-psychotic A days and cannot be attending physician or er evaluates the resident for of that medication. T is not met as evidenced on, record review, and ent, staff, and physician, the an adequate clinical of an antipsychotic residents (Resident #28) ropic medication use. d: Imitted to the facility on es that included Parkinson ' and major depressive for Resident #28 dated dilify (antipsychotic rams (mg) once daily for njor depressive disorder.	F 7	The statements made on this picorrection are not an admission not constitute an agreement with alleged deficiencies. To remain in compliance with all and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility's allegatic compliance such that all alleged deficiencies cited have been or corrected by the dates indicated F758 1. Corrective action for resider affected by the alleged deficient For resident # 28, the clinical indicated the Abilify is Depression with psy An MD note dated for 01/14/202 following diagnosis: Depression recurrent, severe with psychosis	to and do n the federal has taken in this orrection on of will be . nt(s) practice: dication for ychosis. 0 list the , major,		
	3/29/19 indicated do	for Resident #28 dated cumentation of the number of verbalizing depression, on was to be completed on		Identified target behaviors of vis auditory hallucinations are order monitored for the use of Abilify a	ual or ed to be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L' IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 758	58 Continued From page 112		F 75	8		
	the Medication Administration Record (MAR) every shift.			2/26/20.		
	4/4/19 indicated docubehaviors related to challucinations was to every shift. An antipsychotic review #28 dated 4/4/19 includestions and answered - Describe the behavior antipsychotic medical behaviors causing nedisturbing for the resinus New admit	ew assessment for Resident uded, in part, the following rs: fors or reason why the tion is being used. Are the egative outcomes or dent or other residents? The entions that have been attempted to try and rs.		 Corrective action for residents with the potential to be affected by the allege deficient practice. On 02/25/2020 the pharmacy consultation will review all current residents on anti-psychotic medications for approprical indication. Any concerns noted be reviewed with the MD for changes. This process will be completed by 03/03/2020. Measures /Systemic changes to prevent reoccurrence of alleged defici practice: Beginning on 02/24/2020 the nurse consultant will begin educating the Director of Nursing, MDS Nurse, and Administrator on the acceptable diagn for Anti-psychotic medication. 	ged ant riate I will	
	A physician 's order for Resident #28 dated 4/11/19 changed the diagnosis for Abilify 10 mg once daily to depression with psychosis related to restlessness and agitation. Resident #28's care plan included the focus area of antipsychotic medication with risk for adverse side effects. This area was last revised on 4/11/19. The interventions included, in part, administer medications as ordered, consulting pharmacist to review psychotropic medications quarterly and as needed, and mental health consult as needed. A pharmacy recommendation dated 9/26/19 indicated a Gradual Dose Reduction (GDR) was			This information has been integrated in the standard orientation training and in required in-service refresher courses all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does receive scheduled in-service training who to be allowed to work until training has been completed by March 3, 2020. 4. Monitoring Procedure to ensure the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.	n the for not vill as nat hat	
	indicated a Gradual D			and/or in compliance with regulatory requirements. The Director of Nurses or designee wi	II	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 758	"[history of] severe m psychosis requiring [i past dose reduction at An antipsychotic revi #28 dated 10/2/19 in- questions and answer - Describe the behave antipsychotic medical behaviors causing ned disturbing for the resi Dementia with behave - Describe staff intervantempted or may be minimize the behavior No behaviors - Describe when the were the results, and reduction trial? None A physician 's progres indicated Resident #2 no hallucinations or of She had no behavior a "distant reported hi	sician declined the dindicated the following, major depression [with] inpatient care]. Has failed attempts". ew assessment for Resident cluded, in part, the following ers: iors or reason why the tion is being used. Are the egative outcomes or ident or other residents? vioral disturbance ventions that have been attempted to try and	F	758	monitor compliance utilizing the F658, 686, 756, 757, and 758 Quality Assura Tool weekly x 2 weeks then monthly x months. The Director of Nursing will monitor for acceptable clinical indicatio and diagnosis for anti-psychotics. Repowill be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance wield be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance unnecessary medications and psychotropic medications. The weekly Meeting is attended by the Administrate Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	3 on orts of ill y		
	ago) and was actuall and psychosis in the reported that some o to go as far back as h neurology and/or psy be considered in the	y hospitalized for depression past". The physician f her symptoms were noted ner teens. He indicated a richiatric consultation would future if needed.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 758	no rejection of care, a active diagnoses inclis disease, depression agitation. Resident # antipsychotic medica Gradual Dose Reducattempted. Resident #28 's med was not followed by a facility. A review of Resident orders on 2/3/20 indicative. A review of behavior admission (3/29/19) to behaviors occurred. An interview and obs with Resident #28 on resident was alert antime, and situation. Such a such as a such	act. She had no behaviors, and no psychosis. Her uded dementia, Parkinson 'n, and restlessness and 28 received routine tion on 7 of 7 days and no tion (GDR) had been ical record indicated she a psychiatry provider at the #28 's active physician 's cated the Abilify 10 mg once on 3/29/19, continued to be documentation from hrough 2/3/20 revealed no ervation were conducted 2/2/20 at 3:40 PM. The doriented to person, place, she was noted with no dono signs or symptoms of red no issues with her mood sychosis.	F	758			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 758	PM she reported that oriented to person, pl She stated that Resid symptoms of psychos An interview was con 2/3/20 at 3:30 PM. Sfamiliar with Resident	e 115 with NA #12 on 2/3/20 at 3:20 Resident #28 was alert and ace, time, and situation. Ilent #28 had no signs or sis and no behavioral issues. ducted with Nurse #8 on he stated that she was #28 and that she had no id no signs or symptoms of	F	758				
	psychosis. When asl on Abilify she stated, An interview was con 2/4/20 at 10:40 AM. report that Resident # and no signs or sympasked why Resident that the diagnosis on with psychosis. Nursever seen any signs/s Resident #28 and she During a phone interv 2/6/20 at 11:43 AM R	ducted with Nurse #7 on She restated Nurse #8 's #28 had no behavioral issues stoms of psychosis. When #28 was on Abilify she stated the order was depression e #7 was asked if she had symptoms of psychosis for e revealed she had not.						
	since 3/29/19 was rev Resident #28 had no her admission to the past history of psycho Abilify 10 mg that she admission. He indica family had not wanted the resident reported psychosis about 5 ye was changed as well inpatient stay related confirmed there had lead	ted that Resident #28 ' s d the medication changed as						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		C 02/06/2020
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 02/03/2020
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)) BE COMPLÉTION
F 758		e 116 vith the Administrator on he indicated she expected a	F 75	8	
F 812 SS=E	the use of an antipsy	tore/Prepare/Serve-Sanitary (2)	F 81	2	3/3/20
	The facility must - §483.60(i)(1) - Procus approved or consider state or local authori (i) This may include a from local producers and local laws or reg (ii) This provision do facilities from using a gardens, subject to a safe growing and for (iii) This provision do from consuming food §483.60(i)(2) - Store serve food in accord standards for food se This REQUIREMENT by: Based on observation facility failed to discat food items in 2 refrig undated food items i storage, cooling devi included:	re food from sources red satisfactory by federal, ties. Food items obtained directly a subject to applicable State ulations. For each or prohibit or prevent produce grown in facility compliance with applicable ad-handling practices. For each or preclude residents als not procured by the facility. For prepare, distribute and ance with professional		The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all federand state regulations the facility has or will take the actions set forth in this plan of correction. The plan of corrections	eral taken s

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345532	B. WING			C 02/06/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	I	02/00/2020	
				310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND F	REHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 812	Continued From pag	ge 117	F 81	2			
	observation was con who accompanied the including storage. The plastic gallon storage brown stew, and stew in the size, open bags of fingurat size, open bags of fingurat size, open bags and 1 gallon size, oppatties undated. All were without the originate. Kitchen Staff #1 was observation and starting the kitchen for the check the stored for expiration date and opened items. On 2/3/2020 at 9:30 was interviewed and undated food items initiated for kitchen starting the starting starting the starting the starting starting the starting starting the starting star	inducted with Kitchen Staff #1 ine tour of the kitchen The walk-in refrigerator had be containers of tomato soup, own gravy with an expired they were not in their original their refrigerator had one ing bowel with tomato soup biled with mold and no labeled be walk-in freezer had 4 gallon rozen vegetables undated, 2 gags of waffles undated, 2 gags of French toast undated, bened bag of breaded chicken opened bag freezer items ginal manufacturer label and as interviewed during ted that whomever is on duty at day was responsible to ad and drink items for discard and date label am the Dietary Supervisor and informed of the expired and and stated a check list was staff to check for food and daily after surveyor red food items and undated and undated food and drink eck list will be assigned to a		constitutes the facility's allegat compliance such that all allegat deficiencies cited have been of corrected by the dates indicate F812 1. For dietary services; a conaction was obtained on 2/2/20 During initial walk through of the food items in the refrigerator a item in the freezer were found expired dates or found to have opened and without a date. The identified by surveyor were threby the Dietary Service Director 2. Corrective action for reside the potential to be affected by deficient practice. All residents have the potential affected by the alleged deficient On 2/3/2020, the Dietary Service completed a kitchen walk through the same all food items were with dates and dated properly. 3. Systemic changes In-service education was provefull time, part time, and as need Topics included: • Storage and dating policie regulations.	ed or will be ed. rrective 20. ne kitchen 2 nd 1 food to have e been nese items own away r. lents with the alleged If to be nt practice, ice Director ugh to hin their ided to all eded staff.		
	staff to check all sto	r and will be used to remind rage. 0 am the Administrator was		 Inspections on shifts to obtain food are within their dates and out of date. 			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING			1	06/ 2020
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332			00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	was responsible to er for expiration when o an alternate storage when expired on a da	mented that all kitchen staff insure food items were dated pened and when placed in container and discarded aily basis.		812	This information has been integrated in the standard orientation training and in required in-service refresher courses for all staff and will be reviewed by the Qual Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director will monitor procedures by kitchen inspections 5 times weekly x 4 weeks, then weekly x 2 months, and then monthly x 3 months using the Dietary Quality Assurance Autonitoring will include kitchen inspection by the dietary manager to ensure food stored and dated properly. An inspection checklist has been added to the log notebook for every shift to complete (to completed by designated cook on shift) the inspection checklist includes assessing foods items to ensure they added and stored properly. Reports will presented to the weekly Quality Assurance committee by the Administration to ensure corrective action initiated as appropriate. Compliance will be monitor and ongoing auditing program reviewed the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting. The weekly QA Meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	the or ality or nes udit. ons are on be be ator ored dat	2/2/20
F 867 SS=D	QAPI/QAA Improvem CFR(s): 483.75(g)(2)		F	867			3/3/20
	§483.75(g) Quality as	sessment and assurance.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X*		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345532	B. WING			C 2/06/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/06/2020	
				310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 867	Continued From pag	e 119	F 8	67			
	assurance committe (ii) Develop and implaction to correct ider This REQUIREMEN by: Based on observation interview, the facility Committee (QA) faile and monitor interven into to place followin survey dated 2/28/19 deficiencies in the ar F550-dignity previous of Care at F688-splin The findings included This citation is cross F550-Based on obseresident interview, a failed to treat Resider respect causing her "inconvenience". The Resident #66's urina promote dignity. This reviewed for dignity. F688- Based on obseresident reviewed for dignity falleft elbow splint as or resident reviewed for dignity falleft elbow splint as or resident reviewed for dignity at the second reviewed for dignity falleft elbow splint as or resident reviewed for dignity reviewed for dignity falleft elbow splint as or resident reviewed for dignity falleft elbow splint as or resident reviewed for dignity.	dement appropriate plans of ontified quality deficiencies; T is not met as evidenced ons, record review and staff is Quality Assurance and to maintain procedures attions that the committee put ig the annual recertification of this was for two recited areas of Resident Rights at saly cited 2/28/19 and Quality onting previously cited 2/28/19. In tervation, record review, and staff interview, the facility and to feel as if she was an are facility also failed to cover any catheter drainage bag to so was for 2 of 2 residents are revations, staff and apply Resident #35's ardered. This was for 1 of 1 ar range of motion.		The statements made on this p correction are not an admission not constitute an agreement with alleged deficiencies. To remain in compliance with all and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility sallegat compliance such that all alleged deficiencies cited have been or corrected by the dates indicated F867 1. Corrective action for reside affected by the alleged deficient For resident #28: Resident was interviewed on 02/17/2020 by the Worker regarding any care conconcerns of feeling like an incorn Resident denied any concerns. For resident #66: On 02/24/202 resident was audited by the Nur Consultant and noted with a Fol catheter Fig Leaf privacy bag in For resident #35, on OT worked resident for splinting of the left end/o/14/10/2020. On 02/24/2020.	to and do h the I federal has taken in this correction ion of will be d. htt(s) practice: he Social beens or hvenience. O the se ley place. d with the elbow from 2020 the		
	Administrator stated	2/6/20 at 10:40 AM, the there had been some nent recently and the new		resident⊡s task and orders were with application of the splint and guard per therapy recommenda	d palm		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _	G		C 02/06/2020	
NAME OF PROVIDER OR SUPPLIER			<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>	
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY				310 COMMERCE DRIVE			
				SANFORD, NC 27332			
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F 867			F 8	,	the allege have the leficient deficient derivation of the leficient derivation of the leficient deficient	nts ng ut of ed vas	
				privacy bag. This audited was c by 02/21/2020. 2 out of 6 reside			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			1	06/2020	
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY				STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332			00/2020	
(X4) ID PREFIX TAG			EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 867	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	noted without corrected by 02/21/2020. Beginning of manager autorders for sprease auditing order those devices who needed ensured the MD order, Correcess will 3. Measure prevent recorrectice: Beginning of Consultant preducation to Director of Notes included: "Prevent" Quality F550 and 68 This information to the standard required inest administrated identified about the Quality Athat the charts aff who do in-service training and required inest aff who do in-service training and required inest administrated identified about the charts aff who do in-service training and required inest administrated inest and and inest and and inest and i	an 02/18/2020 the nurse redited all current residents we plint use to ensure the splint as accomplished beers and care plan task for es. Once it was determined a splint the nurse manage a device was in place, had a CNA task, and care plan. The be completed by 03/03/2020 ares /Systemic changes to occurrence of alleged deficient of 02/24/2020, the Nurse provided an in-service of the Administrator and Nursing Service. Topics thing repeat survey tags assurance monitoring for F88 action has been integrated in derivation training and in service refresher courses for and Director of Nursing a pove and will be reviewed by Assurance process to verifyinge has been sustained. A pes not receive scheduled aining will not be allowed to aining has been completed	with out by der an ais 20. The tag of the bor is y / nny by contract of th		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _				C 06/2020	
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY				STREET ADDRESS, CIT 310 COMMERCE DRIV SANFORD, NC 273	VE	, 02.	00/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION :		OULD BE COMPLI		
F 867	Continued From page	e 122	FS	4. Monitoring the plan of corn specific deficie and/or in comprequirements. The Administration of ongoing audition months. Any numediately be with the facility for intervention Reports will be Quality Assura Director of Nuraction is initiate Compliance with ongoing auditing weekly Quality weekly QA Me Administrator, Coordinator, Tunformation Manager.	g Procedure to ensure the rection is effective and the ency cited remains correction of the ency cited remains correction of the ency cited remains correction of the ency cited regulatory. The ency cited its for F550 and 688 for the ency cited in the ency cited in the ency consultants or additional training. The ency committee by the ency committee by the ency committee in the ency cited i	nat cted on 6 ed int y the e	3/3/20	
SS=B	CFR(s): 483.95(g)(1) §483.95(g) Required aides. In-service training mu §483.95(g)(1) Be suff continuing competen be no less than 12 ho §483.95(g)(2) Include training and resident	in-service training for nurse ust- ficient to ensure the ce of nurse aides, but must					G/ 6/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _				06/2020
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY				31	REET ADDRESS, CITY, STATE, ZIP CODE 10 COMMERCE DRIVE ANFORD, NC 27332	, , ,	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 947	determined in nurse aides' performance reviews		F 9	947			
	and facility assessme address the special n determined by the fac						
	to individuals with cog address the care of the	rse aides providing services gnitive impairments, also ne cognitively impaired. is not met as evidenced					
	facility failed to ensur	ew and staff interview, the e Nursing Assistants (NA's) entia management training. A's reviewed for staffing. The			The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has ta	ıl	
	#1's Education/In-ser evidence of dementia	vas 10/12/14 . Review of NA vices records indicated no training.			or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be		
	#2's Education/In-ser evidence of dementia	vices records indicated no training.			corrected by the dates indicated. F947 The plan of correcting the specific		
		he facility did not have a pordinator. She confirmed			deficiency. The plan should address th processes that lead to the deficiency cited: The facility failed to provide nursing	e	
	dementia training and any evidence of demo were hired. She state	I she was unable to provide entia training since they d the Director of Nursing lired in October 2019 and			assistant annual dementia training. 1. Corrective action for resident(s) affected by the alleged deficient practic Nursing Assistants #1 and 2 will compl		
	of duties and task tak ensure staff education date. The Administrat				Dementia Training (Care of the Cognitively Impaired Resident) in Heal Care Academy online training by 03/03/2020.	th	
	dementia training.	ctive aides be up to date with			Corrective action for residents with the potential to be affected by the alleg		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345532 B. WING			С		
		345532	D. WING _		02/06/2020	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY		310 COMMERCE DRIVE		
				SANFORD, NC 27332		
(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 CORRECTIC ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION	N
F 947	Continued From page	e 124	F 9	deficient practice. Beginning on 02/24/2020 the Nurse consultant began auditing all nursing assistants to identify completion of a Dementia training. This audit will be completed by 03/03/2020. Any CNA identified without completed Dement training will complete the course Car the Cognitively Impaired Resident in Health Care Academy online training 03/03/2020. 3. Measures /Systemic changes to prevent reoccurrence of alleged defic practice: Beginning on 02/24/2020, the Nurse Consultant fired Dementia Training (Health Care Academy on line training all full time, part time and as needed nursing assistants that did not have the annual education documented. Alled identified nursing assistants will com the Dementia training by 03/03/2020 which time all identified nursing assistants will com the Dementia training by 03/03/2020 which time all identified nursing assistants will com the Dementia training by 03/03/2020 which time all identified nursing assistants will com the Dementia training by 03/03/2020 which time all identified nursing assistants will com the Dementia training by 03/03/2020 which time all identified nursing assistants will com the process to verify that the change has been sustained. Any of the identified nursing staff who does not receive scheduled in-service training will not allowed to work until training has been completed by March 3, 2020.	ia e of by cient in) via g to the plete at stants into in the for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245522	B. WING			С	
		345532	B. WING _		<u> </u>	02/06/2020	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	:		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE			
				SANFORD, NC 27332			
(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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 947	Continued From page	e 125	F9	4. Monitoring Procedure to e the plan of correction is effective specific deficiency cited remain and/or in compliance with regular requirements. The Director of Nurses will molecular compliance utilizing the Demer Quality Assurance Tool weekly then monthly x 3 months. The Nursing will monitor all nursing for compliance with the completannual Dementia training. Repuresented to the weekly Quality Assurance committee by the Engliance with the ongoing presented to the weekly Quality Assurance committee by the Engliance with the ongoing program reviewed at the week Assurance Meeting. The week Meeting is attended by the Adin Director of Nursing, MDS Cool Therapy Manager, Health Informal Manager, and the Dietary Manager, and the Dietary Manager, and the Dietary Manager.	ve and that his corrected illatory nitor nitia Training of x 2 weeks Director of grassistants etion of horts will be hy Director of etion is liance will auditing ly Quality ely QA ministrator, redinator, remation		