STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 12/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R CTR OF COLUMBUS CTY	1402 PINCKNEY STREET WHITEVILLE, NC 28472

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 12/10/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# YCX311	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 12/10/20. Event ID#YCX311. One of eight allegations was substantiated. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code a resident ' s impairment status on the minimum data set (MDS) assessment for 1 of 4 residents (Resident #1) reviewed. Findings included: Resident #1 was admitted to the facility on 10/29/20 and discharged on 11/24/20. Diagnoses included, in part, encounter for orthopedic following surgical amputation for right above the knee amputation and a previous left above the	F 641	F641 Accuracy of Assessments For resident #1, a corrective action was obtained on 12/22/20. • The specific deficiency was corrected on 12/22/20 by modifying the Minimum Data Set assessment with an Assessment Reference Date of 11/05/20 in order to correct miscoding of question G0400B (Functional Mobility). This correction was completed by the Regional Minimum Data Set Education and Regulatory Consultant. The corrected assessment was re-submitted and accepted by the state	12/23/20

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

Electronically Signed | 12/25/2020

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F 641	Continued From page 1 knee amputation. The Minimum Data Set (MDS) 5 day assessment dated 11/05/20 revealed the resident was mildly cognitively impaired, required extensive assistance with two staff physical assistance with bed mobility, transfers, and toileting, and extensive assistance with one staff physical assistance with dressing and personal hygiene. Resident #1 was coded as having no impairments and used a wheelchair. A review of a skilled nursing review dated 10/30/20 revealed in part, the resident required nursing care as it related to the staples at the above the knee amputation (AKA) to the right side. A review of a skilled nursing review dated 10/20/20 revealed in part the resident was receiving skilled coverage due to encounter for orthopedic aftercare following surgical amputation to right above the knee and an acquired absence of left leg knee amputation. An interview was conducted with the MDS Nurse on 12/10/20 at 2:30 PM. The MDS nurse reported the resident should have been coded as having lower extremity impairment to both sides due to her bilateral knee amputations. An interview was conducted with the Director of Nursing (DON) on 12/10/20 at 4:00 PM. The DON reported her expectation was that the MDS nurses accurately coded the MDS information to reflect the care being provided for Resident #1.	F 641	database on 12/22/20 in Batch #1729. 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 practice. A 100% audit of all current residents will be conducted in order to identify any other resident who may have been affected by this alleged deficient practice. All current residents' most recent Omnibus Budget Reconciliation Act Minimum Data Set assessment will be reviewed in order to determine if the G0400B was accurately coded. These audits will be completed by Liberty Commons and will be completed no later than 12/25/2020. Any coding errors that are identified during the audit will be immediately modified and corrected and re-submitted to the state database. Systemic Changes On 12/23/20, the Regional Minimum Data Set Education and Regulatory Consultant completed an in-service training for the facility Minimum Data Set Coordinator(s) that included the importance of thoroughly reviewing the medical record and assessing resident's functional abilities prior to completion of G0400B of the Minimum Data Set Assessment. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators.	

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F 641	Continued From page 2	F 641	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing will begin auditing the coding of MDS item G0400B using the quality assurance audit tool entitled "Accurate Minimum Data Set Coding Audit Tool." This audit 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 as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Crystal Hagood Date of Compliance: 12/23/20	
F 926 SS=D	Smoking Policies CFR(s): 483.90(i)(5) §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. This REQUIREMENT is not met as evidenced by:	F 926		12/25/20

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F 926	Continued From page 3 Based on record review and staff interviews, the facility failed to update a smoking assessment for 1 of 1 residents assessed for smoking (Resident #4). Findings included: Resident #4 was originally admitted to the facility on 09/29/17. Diagnoses included, in part, chronic obstructive pulmonary disease, stroke with right side weakness, and tobacco use. A review of the Smoking Policy effective date February, 2020, revealed in part B. 1) If a resident desires to smoke, a smoking assessment found in the electronic medical record must be completed by facility staff; and 2) This is completed on admission, quarterly and with any change in resident condition. The assessment will evaluate the residents ' ability to understand the rules, physically light the cigarette, safely smoke, safely extinguish the cigarette and implement any strategies that might be required for additional safety. The Minimum Data Set (MDS) quarterly assessment dated 11/19/20 revealed Resident #4 was cognitively aware. The resident required supervision with set up only with locomotion on / off unit. Resident #4 had an impairment to one side to upper and lower extremity, used a wheelchair and was not oxygen dependent. A review of Resident #4 ' s care plan revealed the resident was at risk for injury related to her preference to smoke with interventions to include, in part, perform safe smoking assessment upon admission, quarterly and as needed with change in condition and an intervention for the	F 926	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F926 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #4, the completed the smoking UDA on 12/10/2020. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 12/10/2020 the MDS completed an audit of all current residents who smoke to ensure their smoking UDA was completed on admission and quarterly. This audit will be completed by MDS 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/10/2020, the DON educated the MDS Coordinator and all full time, part time, and PRN nurses on the following topics: • If a resident desire to smoke, a smoking assessment found in the electronic medical record must be completed before allowing the resident to smoke independently. This is completed	

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F 926	Continued From page 4 interdisciplinary team to determine for possible need for supervised smoking. A review of the quarterly smoking assessments for Resident #4 revealed the last quarterly smoking assessment was completed on 07/01/20. An interview was conducted with the MDS Nurse #1 on 12/10/20 at 2:30 PM. The MDS nurse indicated the MDS nurses were responsible for updating the smoking assessments. The MDS nurse stated the assessments should be done upon admission and quarterly to determine if the resident was a safe smoker independently or if the resident would require supervision with smoking. The MDS stated she was new to this role of MDS Nurse and did not know why Resident #4 ' s smoking assessment was not completed in October, 2020, when the next quarterly assessment was due. An interview was conducted with the Director of Nursing (DON) who reported the MDS nurses were required to complete the quarterly smoking assessments. The DON stated her expectation was that the MDS nurses complete the smoking assessments to reflect the description of care being provided with regard to smoking.	F 926	on admission and quarterly. This is completed by the hall nurse on admission and quarterly by the MDS nurse. In order to complete the assessment, the nurse must visualize the resident lighting, smoking and extinguishing the cigarette. If any safety concerns are identified, the DON must immediately be notified and the resident cannot smoke alone until reviewed by the care plan team. • Once this UDA is completed the care plan team must review to determine if the resident is safe to smoke independently. Rules for safe smoking must be discussed with the resident. This information has been integrated into the standard orientation training and in the 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 will not be allowed to work until training has been completed by SDC. 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 DON or designee will monitor compliance utilizing the F926 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The DON will monitor to ensure the smoking UDA's are completed on admission and quarterly for all smoking residents. Reports will be	

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F 926	Continued From page 5	F 926	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 the 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. Date of Compliance: 12/25/2020	