STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		2/29/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/19/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to report an allegation of abuse within 24 hours to the State's Health Care Personnel Registry (HCPR) and failed to submit a 5 working day report to the HCPR for 1 of 1 resident with alleged staff to resident abuse. Resident # 149. The findings included: Resident #149 was admitted to the facility on 11/24/15 with diagnoses of Diabetes, depression, Lupus and history of falling. Resident #149 was discharged from the facility on 1/4/16. Review of the Minimum Data Set (MDS), an admission, dated 12/1/15 indicated Resident #149 was moderately impaired cognitively, required extensive assistance of two staff for transfers, toileting and personal hygiene and she was non ambulatory. The admission MDS indicated no behaviors were exhibited. Review of the allegation dated 12/8/15 revealed an interview was conducted with Resident #149 by administrative staff member #1. The interview indicated an aide " shoved her (Resident #149) into the rail in the bathroom while trying to transfer her to the toilet. Resident (#149) said that she had an accident because she couldn ' t stand right and get up fast enough out of the wheelchair. Later that same night resident (#149) stated that she kept pressing her call light and that c n a (aide) kept turning it out and told her ' you can do that all you want to but I ' m the only one working on the hall. ' Resident (#149) stated ' that c n a is scary and didn ' t want her in her room again ' . "	F 225	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 date or dates indicated. Tag- 0225 Corrective action: Resident #149 the 24 hour report and 5 day report was submitted on 2/4/2016 (24 hour)and 2/8/2016 (5 day) by the DON. The DON was in serviced by the Administrator to report alleged abuse and complete investigation utilizing the 24 hour and 5 day report. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by this practice. An audit was done on February 12, 2016, of the facility population, looking for any resident that might be in any endangering placement or situation. None were found.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 Interview with the administrator on 02/03/2016 at 8:10 AM revealed the facility had no abuse investigations for the past six months. Interview on 02/03/2016 at 3:47 PM with administrative nursing staff member #1 revealed Resident #149 had " complained " the aide had pushed her. The incident was not reported due to the allegation was not substantiated. This staff member explained a grievance and been completed. Interview with the administrator on 2/3/16 at 4:30 PM revealed he was aware of the accusation a staff member pushed Resident #149. His understanding was the incident was not abuse. The administrator referred questions of reporting as abuse to the Director of Nursing. Interview with the Director of Nursing (DON) on 02/04/2016 at 9:37 AM revealed she was aware of the incident involving Resident #149. The DON explained the aide got Resident #149 up to the bathroom. The resident ' s legs started to go out from under her. The aide pushed the resident against the wall to prevent her from falling until someone came to assist. The aide was suspended pending investigation. The DON further explained she did the investigation and determined it was not abuse, because it was not " willful. " The 24 hour and 5 day reports were not made due to the allegation was not " willful. "	F 225	Systemic Changes: All Nursing staff including Nursing Administration, RN's, LPN's and CNA's were in serviced on February 8, 2016 by the Staff Development Nurse. The abuse in service included: reporting allegations, investigation protocols, and reporting utilizing the 24 hour and 5 day report. Any in-house staff member who did not receive in service training will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monday through Friday at the daily leadership meeting all grievances, alleged abuse, injuries of unknown origins, and incidents will be reviewed for immediate investigation and reporting. The Leadership team includes the Administrator, DON, Social Service, Environmental Service, Dietary, H.I.M (Medical Records), Rehabilitation Director, Activities, Admissions, and Unit Managers. Monitoring: Utilizing the Survey QA Tool the Supervisors will review twenty four hour report for each unit along with any nursing grievances for alleged abuse or injury of unknown origin, five times a week for four weeks then monthly for two months. Any issues identified will be reported to the DON or Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3	F 225	immediately for investigation and submission of the 24 hour report. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA meeting. The monthly QA meeting is attended by the DON, MDS Coordinator, Unit Manager, Rehab, Director, HIM, Dietary Manager, administrator, Social Service and other members as needed.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to follow their abuse policy for reporting an allegation of staff to resident abuse for 1 of 1 sampled resident. Resident #149. The findings included: Review of the facility ' s policy " Abuse Prohibition " dated March 1, 2000 read in part " Reportable Incidents: Any ALLEGATIONS (regardless of whether the allegations are substantiated) against any personnel (including nurses), including injuries of unknown origin that appear to involve the conduct of abuse, neglect, misappropriating property of the patient or facility, committing fraud against a patient or facility or	F 226	Tag- 0226 Corrective action: Resident #149 the 24 hour report and 5 day report was submitted on 2/4/2016 (24 hour) and 2/8/2016 (5 day) by the DON. The DON was in serviced by the Administrator to report alleged abuse and complete investigation utilizing the 24 hour and 5 day report. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by this practice. An audit was done on	2/29/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 4 diverting drugs belonging to the patient or facility, MUST BE REPORTED to the Health Care Personnel Registry via the 24 hour and 5 day report ... " Resident #149 was admitted to the facility on 11/24/15 with diagnoses of Diabetes, depression, Lupus and history of falling. Resident #149 was discharged from the facility on 1/4/16. Review of the Minimum Data Set (MDS), an admission, dated 12/1/15 indicated Resident #149 was moderately impaired cognitively, required extensive assistance of two staff for transfers, toileting and personal hygiene and she was non ambulatory. The admission MDS indicated no behaviors were exhibited. Review of the allegation dated 12/8/15 revealed an interview was conducted with Resident #149 by administrative staff member #1. The interview indicated an aide " shoved her (Resident #149) into the rail in the bathroom while trying to transfer her to the toilet. Resident (#149) said that she had an accident because she couldn ' t stand right and get up fast enough out of the wheelchair. Later that same night resident (#149) stated that she kept pressing her call light and that c n a (aide) kept turning it out and told her ' you can do that all you want to but I ' m the only one working on the hall. ' Resident (#149) stated ' that c n a is scary and didn ' t want her in her room again ' . " Interview with the administrator on 02/03/2016 at 8:10 AM revealed the facility had no abuse investigations for the past six months. Interview on 02/03/2016 at 3:47 PM with administrative nursing staff member #1 revealed	F 226	February 12, 2016, of the facilities population, looking for any resident that might be in any endangering placement or situation. None were found. Systemic Changes: All Nursing staff including Nursing Administration, RN's, LPN's and CNA's were in serviced on February 8, 2016 by the Staff Development Nurse. The abuse in service included: reporting allegations, investigation protocols, and reporting utilizing the 24 hour and 5 day report. Any in-house staff member who did not receive in service training will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monday through Friday at the daily leadership meeting all grievances, alleged abuse, injuries of unknown origins, and incidents will be reviewed for immediate investigation and reporting. The Leadership team includes the Administrator, DON, Social Service, Environmental Service, Dietary, H.I.M (Medical Records), Rehabilitation Director, Activities, Admissions, and Unit Managers. Monitoring: Utilizing the Survey QA Tool the Supervisors will review twenty four	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 5 Resident #149 had " complained " the aide had pushed her. The incident was not reported due to the allegation was not substantiated. This staff member explained a grievance and been completed. Interview with the administrator on 2/3/16 at 4:30 PM revealed he was aware of the accusation a staff member pushed Resident #149. His understanding was the incident was not abuse. The administrator referred questions of reporting as abuse to the Director of Nursing. Interview with the Director of Nursing (DON) on 02/04/2016 at 9:37 AM revealed she was aware of the incident involving Resident #149. The DON explained the aide got Resident #149 up to the bathroom. The resident ' s legs started to go out from under her. The aide pushed the resident against the wall to prevent her from falling until someone came to assist. The aide was suspended pending investigation. The DON further explained she did the investigation and determined it was not abuse, because it was not " willful. " The 24 hour and 5 day reports were not made due to the allegation was not " willful. "	F 226	hour report for each unit along with any nursing grievances for alleged abuse or injury of unknown origin, five times a week for four weeks then monthly for two months. Any issues identified will be reported to the DON or Administrator immediately for investigation and submission of the 24 hour report. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA meeting. The monthly QA meeting is attended by the DON, MDS Coordinator, Unit Manager, Rehab, Director, HIM, Dietary Manager, administrator, Social Service and other members as needed.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314		2/29/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 6 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to implement interventions for treatment of pressure ulcers for one of four sampled residents with pressure ulcers. Resident #6. The findings included: Resident #6 was admitted to the facility on 3/31/14 with diagnoses including Alzheimer ' s Dementia, heart failure and hypertension. Record review revealed Resident #6 was receiving hospice services since 2014 for end stage Alzheimer ' s. Review of the Minimum Data Set (MDS) dated 5/13/15, an annual, revealed Resident #6 had no pressure ulcers, required extensive assistance of one to two staff for all activities of daily living (ADLs) and was incontinent of bladder and bowel. The MDS indicated there was limitation in functional movement of the lower extremity on one side. Resident #6 had severe impairment with cognition and exhibited no behaviors. The Care Area Assessments (CAAs) dated 5/13/15 assessed the risk factors for Resident #6 developing pressure ulcers. A decision to proceed to the care plan was made by the care plan team. The goal included avoid complications and minimize risks of pressure ulcers. Review of the MDS dated 11/5/15, a quarterly, revealed Resident #6 had 2 unstageable pressure ulcers and weight loss. There were no changes in ADLs status, functional movement of	F 314	Corrective Action for Resident Affected: Resident #6 was provided with pressure relieving boots for lower extremities to relieve pressure and adequately float heels off the mattress surface as care planned for preventative measures on 2/4/2016. Corrective Action for Residents Potentially Affected: All residents with pressure ulcers have the potential to be affected. All residents with pressure ulcers were reviewed by the Director of Nurses and Unit Managers on 2/5/2016 to ensure that pressure relieving devices were present for those residents care planned for preventative measures of pressure relief. Systemic Changes: An in-service was conducted between 2/5/2016 to 2/18/2016 by Director of Nurses, and Unit Managers. Those who attended the session and others in serviced were all RNs, LPNs, and CNAs, full time, part time and PRN. Hospice providers were included because they do provide wound care services in the facility. Any nursing staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included: Pressure Ulcer causes Pressure: Amount, duration, tolerance/interventions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 7 one lower extremity, bowel or bladder function. Medical record review revealed an order dated 11/13/15 to not use Kerlix with dressing change on the left heel. Review of the care plan updated on 12/6/15 included a problem of at risk for pressure ulcers with ulcers present on the right posterior heel and left lateral heel. Interventions included staff were to float heels on pillows when in bed. The monthly orders for January 2016 included treatment to the left lateral heel with instructions to " do not use Kerlix " and to float heels when in bed or recliner. The wound report dated 2/3/16 indicated the right and left heel wounds began 10/17/15 as unstageable pressure ulcers. Current measurements and assessment of the left heel wound was 0.4 centimeters (cm) by 0.5 cm by 0.2cm depth. The wound bed was 100% eschar (black/brown thick) with no drainage. The right heel wound measured 0.8 cm by 1.0 cm with no depth measured. The wound bed was 100% granulation (healing tissue) with no drainage. The wound report dated 2/3/16 included a new area of pressure on the left inner ankle that measured 2.0 cm by 1.0 cm. The wound was assessed as suspected deep tissue injury (purple or maroon intact skin). Observations on 02/02/2016 at 3:53 PM revealed Resident #6 was in bed and both heels were on the mattress. An air mattress was in place on the bed. A pillow was under the resident ' s legs, but the heels were not floated off the mattress.	F 314	Shear: Usually found on sacrum/coccyx and heels, deep tissue damage/interventions Friction: Skin pulled across a coarse surface/interventions Moisture: Over-hydration of skin cells/interventions Nutritional compromise: Interventions Other contributing factor and interventions Review of positioning of residents, floating heels and the proper use pillows and wedges. Report any changes in the resident's skin to nurse. Review of Care plans, know your care plans and refer to care plans for care and Kardex in Point of Care for interventions for residents with pressure ulcers. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nursing employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: The Administrative nurses and staff nurses will monitor this issue using the Survey QA tool for pressure relieving interventions for residents with pressure ulcers. The monitoring will include verifying that all residents with pressure ulcers have effective pressure relieving devices as care planned. This will be done daily Monday thru Friday for two weeks and then weekly times three months or until resolved by QA committee. Reports will be given to the weekly Quality of Life/QA committee and corrective action initiated as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 8 Observations on 02/03/2016 at 8:39AM with aide #1 revealed Resident #6 had the left leg crossed over the right at the ankles, the left heel was pressing onto the mattress. A red area was observed on the top of the right ankle. Interview with aide #1 during the observation revealed she tried to keep the pillow under her legs and float the heels, but the pillow would go flat. The resident would cross her legs due to contractures. Observations on 02/03/2016 at 9:47 AM revealed Resident #6 was out of bed in a personal recliner with no pillow support between legs or under legs to float heels. Observations on 02/03/2016 at 11:04 AM were made with the Treatment Nurse. The heel wounds were observed to be dry, thick scabbed area that was intact. The red area on the right ankle observed at 8:39 AM was resolved. The red area on the top of the left ankle was intact. Interview with the Treatment Nurse revealed the wounds were improving, but changes could be noted on a day to day basis due to circulation problems. At times her feet were purple/blue, the next day the discoloration would not be observed. Resident #6 had a terry cloth type of slipper that had been on both feet. Further interview with the Treatment nurse revealed the slippers would not cause pressure on the wounds. She explained it would be more important to not have something tight across the top of her foot. Observations on 2/3/16 at 11:30 AM revealed Resident #6 was in a personal recliner. She was observed with her legs crossed with the left foot over the right foot at the ankles. At this time, her heels were floated off the end of the footrest.	F 314	Results of the audits will then be shared in the Quarterly QA meeting with the Medical Director with verification of his attendance along with all members of the QA team and Department Heads.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 02/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 9 Interview with the Treatment Nurse on 02/04/2016 at 8:42 AM revealed she found the left foot with the Kerlix wrap on Monday (2/1/16) when she did the treatments. She removed the Kerlix and saw the reddened area on the ankle. She called the nurse who did the treatment on the weekend and was informed the hospice nurse had told the facility nurse she could wrap the wound with Kerlix. The Treatment Nurse informed the weekend nurse not to use Kerlix. During interview with the Treatment Nurse, she explained the Kerlix would have been binding at the ankle and caused the suspected deep tissue wound. Observations on 02/04/2016 at 9:01 AM Resident #6 was in bed with her heels pressing into the mattress on the bed. . Observations on 02/04/2016 at 11:02 Resident #6 was in bed with her heels pressing into the mattress. The left foot was turned outward with the outer ankle resting on the bed. Interview was conducted on 02/04/2016 at 12:18PM with aide #2 that provided care for Resident #6. Aide #2 explained Resident #6 as total care by staff. She knew what to do for the resident by the care plan and the information on the aide ' s computer. Aide #2 explained pillows should be used to float her heels. Further explanation provided indicated the pillows after a while would sink down and her heels would be on the bed. Aide #2 had not informed the nurse the pillows did not keep Resident #6 ' s heels floated.	F 314		