PRINTED: 05/23/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
345496		B. WING	B. WING		04/06/2017			
NAME OF PROVIDER OR SUPPLIER			1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-1/	00/2017	
				7	91 BOONE STATION DRIVE			
LIBERTY	COMMONS N&R ALAMA	NCE			BURLINGTON, NC 27215			
(X4) ID	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)	
PREFIX TAG			PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 282 SS=D			F:	282			5/3/17	
	(b)(3) Comprehensive	e Care Plans						
		d or arranged by the facility,						
		mprehensive care plan,						
	must-	npronono saro piani,						
	(ii) Be provided by qu	alified persons in						
	accordance with each	resident's written plan of						
	care.	· :						
		is not met as evidenced						
	by:	:			The state was at a sea this release of			
		iews and record review, the			The statements made on this plan of	-1-		
		the plan of care intervention			correction are not an admission to and	do		
	sampled residents (R	kin assessments for 1 of 3			not constitute an agreement with the			
	Sampled residents (R	esident #1).			alleged deficiencies.			
	Findings included:				To remain in compliance with all federa	ıl		
					and state regulations the facility has ta			
	1. Resident # 1 was	admitted to the facility			or will take the actions set forth in this			
		ses that included Type 2			plan of correction. The plan of correction	on		
		nign prostatic hyperplasia			constitutes the facility's allegation of			
		ase. Resident #1 discharged			compliance such that all alleged			
	to the hospital 3/18/1				deficiencies cited have been or will be			
	•				corrected by the dates indicated.			
	A review of the admis	sion Minimum Data Set			_			
	(MDS) comprehensiv	e assessment dated 1/6/17			F 282			
	revealed Resident #1	had severe cognitive						
	impairment and did n	ot have a pressure ulcer but			A corrective action for the Affected			
		e ulcer development. A			Resident/s has been accomplished by:			
		y MDS assessment dated			Resident #1 discharged on 3/18/17.			
		age 2 pressure ulcer to the						
	_	ulation tissue not present on			A corrective action has been			
	admission.				accomplished on all residents with the			
					potential to be affected by the alleged			
	A review of the admis				deficient practice by:			
	1/19/17 revealed a pr				All current residents with a careplan for	r		
	pressure ulcer develo				weekly skin assessments have the			
	intervention dated 1/1	19/17 indicated "weekly full			potential to be affected by the alleged			
ADODATODY	DIDECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITI F		(X6) DATE	

**Electronically Signed** 

04/27/2017

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  A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BOILDI	A. BOILDING			С
	<b>345496</b> B. WING		04/06/2017				
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04	700/2017
				79	91 BOONE STATION DRIVE		
LIBERTY	COMMONS N&R ALAMA	ANCE		В	URLINGTON, NC 27215		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLÉTION DATE
F 282	Continued From pag	e 1	F:	282			
	body skin assessmer				deficient practice. All current residents		
					were audited by 4/26/17 to ensure wee		
	A review of the media	cal record revealed a weekly			skin assessments had been completed	-	
		oleted 1/6/17 and weekly			Residents without a weekly skin		
	pressure ulcer reviews were completed 1/12/17, 1/19/17 and 1/23/17. No other skin checks or				assessment had a skin assessment		
					completed by 4/26/17. This audit was		
	• · · · · · · · · · · · · · · · · · ·	vs were documented after			completed by the Administrator and		
	1/23/17.				Director of Nursing.		
	An intorviou was con	aploted with the Director of			Systemic changes made were:		
	An interview was completed with the Director of Nursing (DON) on 4/5/17 at 12:43 PM. She stated the nurses completed weekly skin				By 4/29/17, the Staff Development		
					Coordinator in-serviced all current nurs	sina	
	assessments and they were charted in the				staff (RN, and LPN) both full time, par	-	
	computer.				time, agency and PRN. The in-service	•	
	•				included the following topics: following	the	
	Nurse #1 was intervi	ewed on 4/5/17 at 12:58 PM			individualized careplan for weekly skin		
	and she reported she	e completed weekly skin			assessments, schedule and assignment	nt	
		residents and entered the			of weekly skin assessments, and how		
	information into the o			document weekly skin assessments in Point Click Care Electronic Record.	the		
	An interview with Nu	rse #2 on 4/5/17 at 2:15PM					
	revealed that skin as			Any in-house staff member who did no	t		
	completed weekly. She indicated that skin				receive in-service training by 4/29/17 w	/ill	
	assessments were n			not be allowed to work until training ha	S		
	Resident #1 after 1/2	23/17.			been completed. This information has		
					been integrated into the standard		
		vas completed with the DON			orientation training and in the required		
		I. She stated she thought the			in-service refresher courses for all		
		ere completed for Resident te the assessments in the			employees and will be reviewed by the Quality Assurance process to verify that		
		er stated she had a retired			the change has been sustained.		
	RN on staff who cam				and change had been sustained.		
	completed wound tre						
	assessments.				The facility plans to monitor its		
					performance by: The Administrator or		
	An interview with the	Administrator on 4/6/17 at			Director of Nursing will monitor this iss	ue	
	3:52 PM revealed sh	e had looked at Resident's			using the Weekly Skin Assessments Q		
	#1 paper medical red	cord for additional skin			Tool to audit 10 residents to ensure ski	n	
1		s unable to locate any more			assessments are completed weekly		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345496 B. WING		C <b>04/06/2017</b>				
NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS N&R ALAMANCE				79	TREET ADDRESS, CITY, STATE, ZIP CODE 91 BOONE STATION DRIVE URLINGTON, NC 27215	1 04/	00/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUT FAG CROSS-REFERENCED TO THE APPRIDEFICIENCY)			(X5) COMPLETION DATE	
F 282 F 309 SS=D	assessments.  Nurse #5 was intervied She stated her role at consultant. She repowhen she was onsite facility nurses were reskin assessments. Swere responsible and something nurses negurther stated, "staff viskin assessments."  An interview with the 4:09 PM revealed her should follow interver care plan.  483.24, 483.25(k)(l) FFOR HIGHEST WELL 483.24 Quality of life Quality of life is a fundapplies to all care and residents. Each residents. Each residents. Each residents all care and residents are sidents. Each residents to attain or in practicable physical, well-being, consistent comprehensive assess 483.25 Quality of care is a fundapplies to all treatment facility residents. Bas	ewed on 4/6/17 at 4:01 PM. It the facility was a wound rted she looked at wounds at the facility but that the esponsible for the weekly he stated "nurses on the hall we identified that this was eded to work on." Nurse #5 were inconsistent in doing  Administrator on 4/6/17 at rexpectation was that staff ations documented on the  PROVIDE CARE/SERVICES L BEING  damental principle that d services provided to facility lent must receive and the he necessary care and maintain the highest mental, and psychosocial to with the resident's esment and plan of care.		309	according to the individualized careplar This audit will be completed weekly x 4weeks then monthly x 2 months or un resolved by QOL/QA committee. Repowill be presented to the weekly QA committee by the Administrator or DON ensure corrective action initiated as appropriate. Compliance will be monitor and ongoing auditing program reviewer the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Therapy, HIM, Staff Development Coordinator, and the Administrator.	til orts I to red d at	5/3/17	
	483.25 Quality of care Quality of care is a fu applies to all treatment facility residents. Bas assessment of a resident residents receive accordance with professional profes	e ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	COMPLETED	
		345496	B. WING		C 04/06/2017
NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS N&R ALAMANCE				STREET ADDRESS, CITY, STATE, ZIP CODE 791 BOONE STATION DRIVE BURLINGTON, NC 27215	04/00/2017
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 309	but not limited to the  (k) Pain Managemen The facility must ensign provided to residents consistent with profess the comprehensive pand the residents' go  (l) Dialysis. The facil residents who require services, consistent wof practice, the comprehensive pand the residents who require services, consistent wof practice, the comprehences. This REQUIREMENT by:  Based on staff and for review, the facility fair assessments for a reat risk for pressure ultimew pressure area for #1) reviewed for provimell-being.  Findings included:  1. Resident # 1 was 12/30/16 with diagnor diabetes mellitus, being and Alzheimer's disect to the hospital 3/18/1  A review of the admiss (MDS) comprehensive revealed Resident #1 impairment and did not the side of the s	sidents' choices, including following:  t.  ure that pain management is who require such services, esional standards of practice, erson-centered care plan, als and preferences.  ity must ensure that e dialysis receive such with professional standards rehensive person-centered sidents' goals and  is not met as evidenced amily interviews and record led to complete weekly skin sident with a history of and cers and failed to assess a ir 1 of 3 residents (Resident ision of care to maintain  admitted to the facility ses that included Type 2 nign prostatic hyperplasia ase. Resident #1 discharged	F 3	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 fede and state regulations the facility has or will take the actions set forth in this plan of correction. The plan of correctionstitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.  F 309  A corrective action for the Affected Resident/s has been accomplished be Resident #1 discharged on 3/18/17.	ral taken s tion f

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345496  (X2) MULT A. BUILDIN		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
				B. WING		C 04/06/2017
NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS N&R ALAMANCE				STREET ADDRESS, CITY, STATE, ZIP CODE 791 BOONE STATION DRIVE BURLINGTON, NC 27215		- 1.00. <u>-</u> 011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI' CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page review of the quarterless	e 4 y MDS assessment dated	F3	09 accomplished on all r	esidents with the	
	1/12/17 revealed a stage 2 pressure ulcer to the left buttock with granulation tissue not present on admission.			potential to be affected deficient practice by: All current residents we pressure ulcers and/or	with a history of or residents that are	
	•	y's Risk Assessment revealed Resident #1 was n risk for pressure ulcer		high risk for pressure potential to be affected deficient practice. All were audited by 4/26, skin assessments had	ed by the alleged current residents /17 to ensure week	ıly
	A review of the admis 1/19/17 revealed a properssure ulcer develor intervention dated 1/2 body skin assessmen	roblem of "at risk for opment." A care plan 19/17 indicated "weekly full		Residents without a vassessment had a sk completed by 4/26/17 completed by the Adr Director of Nursing.	in assessment 7. This audit was	
	skin check was comp pressure ulcer review 1/19/17 and 1/23/17.	cal record revealed a weekly bleted 1/6/17 and weekly vs were completed 1/12/17, No other skin checks or vs were documented after		Systemic changes may By 4/29/17, the Staff Coordinator in-service staff (RN, and LPN) time, agency and PR included the following the weekly skin asses	Development ed all current nursin both full time, part N. The in-service propries to utili	ze
	family member on 4/5 stated she had visited	npleted with Resident's #1 5/17 at 10:23 AM. She d the resident on 3/5/17 and n, observed a wound on his Nurse #2.		new areas of skin bre the individualized car assessments, schedu of weekly skin assess document weekly skin Point Click Care Elec	eakdown, following eplan for weekly sk ale and assignment sments, and how to n assessments in the	sin :
	Nursing (DON) on 4/s stated the nurses cor	npleted with the Director of 5/17 at 12:43 PM. She npleted weekly skin by were charted in the		Any in-house staff me receive in-service trainot be allowed to wor been completed. This been integrated into t	ember who did not ining by 4/29/17 wil k until training has s information has	
An interview with Nurse #2 on 4/5/17 at 2:15PM revealed that Resident #1 was admitted with some excoriation on his bottom but did not have any wounds on his feet. She stated when the			orientation training ar in-service refresher c employees and will be Quality Assurance pro	nd in the required ourses for all e reviewed by the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		<b>345496</b> B. W		B. WING			C 04/06/2017	
NAME OF PROVIDER OR SUPPLIER			1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	04/	06/2017	
TO WILL OF T	WANTE OF THOUBERON OUT FIELD				91 BOONE STATION DRIVE			
LIBERTY	COMMONS N&R ALAM	ANCE			URLINGTON, NC 27215			
				ы	<u> </u>			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 309	Continued From pag	e 5	F3	309				
		ed her of the area on his foot			the change has been sustained.			
		calloused area on the ball of						
	the left foot. She sa	iid it was "a tiny spot on the						
	foot, where the footb	oard hit the foot." She			The facility plans to monitor its			
		ent #1 was frequently			performance by: The Administrator or			
	repositioned after he			Director of Nursing will monitor this issu				
	where his foot touch			using the Weekly Skin Assessments Q				
	reported skin assess			Monitoring Tool to audit 10 residents to ensure skin assessments are complete				
	weekly. She indicate were not being comp			weekly according to the individualized	:u			
	1/23/17.			careplan. This audit will be completed				
	1,20,11.				weekly x 4weeks then monthly x 2 mor	ıths		
	An interview with Nu			or until resolved by QOL/QA committee				
	9:32AM revealed hea			Reports will be presented to the weekly	/			
	were completed whe			QA committee by the Administrator or				
	· ·	not observed any skin issues			DON to ensure corrective action initiate	ed .		
		he stated when the resident			as appropriate. Compliance will be			
		soft, protective boots on both			monitored and ongoing auditing progra			
		ated the boots always stayed			reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the	ie		
	foot."	him and didn't know how he "got a sore on his			DON, MDS Coordinator, Therapy, HIM			
	1001.				Staff Development Coordinator, and th			
	A second interview w	vas completed with the DON			Administrator.	J		
	on 4/6/17 at 3:34 PM							
	admission a risk ass	essment was completed and						
	if the assessment sc	ored high and a resident was						
		facility either placed soft,						
	l ·	oated a residents' heels.						
		cored high on the risk						
		N stated soft, protective						
		n both of his feet. She ought the weekly skin						
		ompleted for Resident #1 but						
		the assessments. She						
		etired Registered Nurse (RN)						
	I -	the facility and completed						
		nd skin assessments.						
	An interview with the	Administrator on 4/6/17 at						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION  NG	(X3	(X3) DATE SURVEY COMPLETED	
		345496	B. WING _			C 04/06/2047	
NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS N&R ALAMANCE				STREET ADDRESS, CITY, STATE, ZIP CODE 791 BOONE STATION DRIVE BURLINGTON, NC 27215	I	04/06/2017	
(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 COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	3:52 PM revealed sh #1 paper medical recassessments but was assessments.  Nurse #5 was intervished stated her role as consultant and that is she was onsite at the nurse aides assesse bathed and notified to changes in skin concwere responsible for assessments. She is were responsible and something nurses new further stated, "staff is skin assessments."  An interview with the 4:09 PM revealed her	e had looked at Resident's cord for additional skin s unable to locate any more  ewed on 4/6/17 at 4:01 PM. at the facility was a wound the looked at wounds when be facility. She reported the d a resident's skin when the charge nurse of any dition. The facility nurses	F3	309			