

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345496</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/26/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIBERTY COMMONS N&amp;R ALAMANCE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>791 BOONE STATION DRIVE</b> <b>BURLINGTON, NC 27215</b>		
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F 000	INITIAL COMMENTS  An on-site complaint investigation survey was conducted on 10/20/20 through 10/21/20. The survey was extended to 10/26/20 for completion of interviews. Event ID # Q4C711. One (1) of 2 allegations was substantiated. Citations were identified at F607 and F689.	F 000			
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)  §483.12(b) The facility must develop and implement written policies and procedures that:  §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,  §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and  §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interviews and hospital and facility record reviews, the facility failed to implement their Abuse Prohibition policy to investigate and report an allegation of an injury of unknown origin to the Health Care Personnel Registry (HCPR) for 1 of 1 resident (Resident #1) reviewed for an injury of unknown origin.  The findings included:  The facility ' s Policy and Procedure entitled, "Abuse Prohibition" was dated 3/1/2000 and last revised 11/2017. The Policy read, in part, "It is the responsibility of our employees, facility	F 607	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.  F607	11/23/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/12/2020

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.

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F 607	<p>Continued From page 1</p> <p>consultants, attending physicians, family member, visitors, etc. to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown source and theft or misappropriation of resident property, to facility management." The Investigation Guidelines included the following statement: "The administrator, or designee, will conduct investigation of any areas of concern. Resident interviews, family interview, and staff interviews may be used to investigate an incident. Investigations will be individualized to determine if abuse, neglect or misappropriation of property has occurred. If abuse is suspected, reports according to state guidelines will be completed. In the following list are some examples of allegations ... (r) injuries of unknown origin (typed in capital letters)." Under the subheading of Reportable Incidents, the Policy/Procedure noted, "Reports of alleged incidents of abuse, neglect, exploitation, involuntary seclusion, and misappropriation of resident 's property should be reported to the Administrator immediately. Reports must be submitted to the state agency via the Healthcare Personnel Registry (HCPR)."</p> <p>Resident #1 was discharged from a hospital to the facility on 6/2/20. Her cumulative diagnoses included a lower urinary tract infection (UTI), acute on chronic renal failure, malnutrition of moderate degree, dementia, and a history of colon and rectal cancer, and cancer of the hypopharynx (throat).</p> <p>Resident #1 's admission Minimum Data Set (MDS) assessment was dated 6/9/20. The MDS revealed the resident had moderately impaired cognitive skills for daily decision making. She required extensive assistance with one-person</p>	F 607	<p>1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #01, the Director of Nursing was notified of the bruising on 7/2/20 and initiated an investigation into the cause of the injury by interviewing nursing staff and reviewing the medical record. This investigation was not documented.</p> <p>2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 11/9/20, the Director of Nursing initiated an audit of all current residents for injuries by having charge nurse to complete a full body skin assessment to identify bruises, skin tears, and other injuries. This will be completed by 11/11/20. If any injuries origin is unknown, a 24-hour report will be initiated by the Director of Nursing and an investigation into the cause of the injury will be completed and documented. This audit will be completed by 11/12/20.</p> <p>3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 11/12/20, the administrator educated Nursing Management: Director of Nursing, Unit Manager, MDS Nurse, and Support Nurse on the following topics: "Investigations into injuries and injuries of unknown origin "Initiating a 24-hour report for injuries of unknown origin On 11/9/20, the Director of Nursing initiated education to the Nursing</p>		

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F 607	<p>Continued From page 2</p> <p>physical assistance for bed mobility, transfers, walking in her room, locomotion on the unit, dressing and toileting. She required supervision with setup help only for eating and was independent with personal hygiene with setup help only. Resident #1 utilized a walker and wheelchair for mobility. Section J of the MDS indicated the resident had no falls since her admission.</p> <p>The resident ' s individualized Care Plan (undated) included an area of focus which addressed her increased risk for falls related to confusion, de-conditioning, gait/balance problems, and incontinence.</p> <p>Review of Resident #1 ' s Interdisciplinary Team (IDT) Progress Notes and Assessments was conducted. There was no documentation to indicate the resident had a fall or other incident during her stay in the facility. No bruising of Resident #1 ' s skin was reported in her medical record.</p> <p>A Nurse Practitioner (NP) Progress Note dated 6/29/20 reported the resident had acute kidney injury (a condition where the kidneys suddenly stop working properly) as evidenced by lab results collected and reported on 6/29/20. The NP noted the resident was sent to the hospital Emergency Department (ED) for treatment upon request of her family.</p> <p>The Emergency Medical Service (EMS) Patient Care Record of Resident #1 ' s 6/29/20 transport to the hospital was reviewed. EMS reported arriving at the facility on 6/29/20 at 5:13 PM. The resident was transported and care was transferred to the hospital ED on 6/29/20 at 5:40</p>	F 607	<p>Department staff: RNs, LPNs, CNA. Med Aide s, and Med Tech s on the following topics:</p> <ul style="list-style-type: none"> <li>"Injury prevention</li> <li>"Documenting injuries</li> <li>"Completing an incident report</li> <li>"Abuse reporting</li> </ul> <p>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 11/16/2020.</p> <p>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.</p> <p>The Administrator or designee will monitor compliance utilizing the F607 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Administrator will monitor to ensure injuries of unknown origin are investigated, investigation documented, and reported to the Health Care Personnel Register via the 24-hour report and 5 day follow up. 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 the weekly Quality</p>		

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F 607	Continued From page 3 PM.  Resident #1 ' s ED records and records from her hospital stay were reviewed. These included the following notations: --On 6/29/20 at 8:59 PM, an Emergency Department to In Patient Handoff Report written by a Registered Nurse (RN) included, "Additional Notes: Memory loss noted upon assessment. Old bruise, hematoma noted to left forehead; pt (patient) unable to recall incident." --A consultation note from nephrology (kidney specialists) dated 6/30/20 at 4:24 PM reported upon physical exam, the resident was reported to have "left eye ecchymosis (a discoloration of the skin, typically caused by bruising) noted." --Results of a computerized tomography (CT) scan of Resident #1 ' s head completed on 7/2/20 indicated she had a "Mild left forehead scalp hematoma. No underlying skull fracture." --A nephrology Rounding Note dated 7/2/20 at 2:03 PM reported a physical exam of her head indicated, "L (left) eye ecchymosis." --An MD Progress Note written on 7/3/20 at 12:49 PM included a Physical Exam which reported Resident #1 had a "left frontal scalp hematoma; present on admission." --A nephrology Rounding Note dated 7/3/20 at 1:58 PM reported the resident had "L (left) eye ecchymosis." --An MD Progress Note written on 7/4/20 at 9:36 AM included a Physical Exam which reported the resident had a "left frontal scalp hematoma; present on admission." --A nephrology Rounding Note dated 7/4/20 at 2:51 PM reported Resident #1 had "L (left) eye ecchymosis."  A review of the facility ' s Incident Log from 6/2/20	F 607	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.		

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F 607	<p>Continued From page 4</p> <p>- 6/29/20 was conducted. No injuries, bruising, or incidents were reported for Resident #1 during her stay at the facility. Additionally, no incident reports of injuries of unknown origin (including bruises) or falls were reported for any female residents in the facility from 6/26/20 - 6/29/20.</p> <p>A telephone interview was conducted on 10/22/20 at 2:00 PM with Nurse #3. Nurse #3 was identified by the facility ' s schedule as working with the nurses on Resident #1 ' s hall for orientation from 7:00 AM to 7:00 PM on 6/26/20 and from 7:00 AM to 7:00 PM on 6/27/20. During the interview, the nurse recalled seeing a female resident the morning of 6/27/20 who had a "huge knot with a bruise around it on her head." She recalled the injury was not present when she worked the previous day (6/26/20). Nurse #3 stated she was new to the facility and not yet familiar with the residents. She could not recall the female resident ' s name. She reported the hall nurse (Nurse #4) was with her at the time when she first saw the bruise the morning of 6/27/20. She stated the resident was, "very confused and couldn ' t tell us what happened."</p> <p>An interview was conducted on 10/20/20 at 2:42 PM with Nurse #4. Nurse #4 was the hall nurse who was assigned to care for Resident #1 from 7:00 AM - 7:00 PM on 6/27/20 and 6/28/20. During the interview, the nurse recalled caring for this resident. When asked, the nurse stated the resident did not experience any falls or incidents that she was aware of. Upon further inquiry, she did not recall seeing any bumps or bruising on Resident #1 ' s face or head.</p> <p>A telephone interview was conducted on 10/22/20 at 12:41 PM with NA #6. NA #6 was identified by</p>	F 607			

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F 607	<p>Continued From page 5</p> <p>the facility ' s schedule as having worked on Resident #1 ' s hall from 7:00 AM - 7:00 PM on 6/27/20 and 6/28/20. During the interview, the NA reported she did recall this resident and described her as, "really weak and confused." NA #6 recalled staff did have an issue of the resident trying to get up by herself to go to the bathroom. The NA reported she seemed to recall that one day when she came in for her shift the resident had a "knot" on her forehead. She stated this was the first time she had seen it and staff couldn ' t figure out where it came from. The NA indicated she "thought" it was Resident #1 who had that bump on the head, but could not be certain of the resident or the date this may have been observed. Upon further inquiry, NA #1 stated she was fairly certain she would have noted such a bruise in the NA progress notes (under alerts/new alerts) for the Resident #1.</p> <p>A telephone interview was conducted on 10/23/20 at 10:39 AM with NA #7. NA #7 was identified by the nursing schedule as having worked on Resident #1 ' s hall from 7:00 AM - 3:00 PM on 6/27/20 and from 7:00 AM - 7:00 PM on 6/28/20. NA #7 recalled this resident. When asked, the NA recalled Resident #1 did attempt to get out of bed on her own a few times on her shift. She stated, "One time I caught her trying to stand up between the wall and bed using the window sill." NA #7 reported one day when she came in to work a weekend shift, "She (Resident #1) had a giant knot on her head." The NA stated from what she could remember, she thought the resident had fallen on 3rd shift when she was trying to get out of bed. However, she could not recall for certain if the injury was discussed in report or who may have told her about a fall. Upon further inquiry as to the location of Resident</p>	F 607			

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F 607	<p>Continued From page 6</p> <p>#1 ' s injury, the NA reported she thought it was above the resident ' s left eye.</p> <p>An interview was conducted on 10/21/20 at 10:47 AM with the facility ' s Administrator. Upon inquiry, the Administrator reported he first became aware of the concern regarding bruising of Resident #1 ' s face during an initial complaint investigation conducted on 9/17/20 - 9/18/20. He stated, "That (the injury) didn ' t happen here." He reported it was his understanding the bruising was not noted initially in the resident ' s hospital admission records. When asked who would be responsible for investigating an allegation of Abuse, the Administrator reported it would be both he and the facility ' s Director of Nursing (DON), with the DON investigating the nursing side of it.</p> <p>An interview was conducted on 10/21/20 at 11:30 AM with the facility ' s DON. During the interview, the DON recalled she first found out about the concern of bruising on Resident #1 ' s face 3-4 days after she was discharged from the facility to the hospital. At that time, the resident ' s Responsible Party (RP) called the facility to inquire about the bruising and to find out what had happened to cause it. When asked, the DON stated she could not recall if she herself talked with the RP or if someone else did. The DON reported after the phone call from the RP, she did an informal investigation at the facility. When asked, she stated there was no documentation of the investigation. The DON stated she reviewed Resident #1 ' s records and interviewed nursing staff. She stated no falls or reports of bruising had been reported for the resident while she was in the facility. The DON reported she had access to Resident #1 ' s</p>	F 607			

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F 607	Continued From page 7 hospital records. When she reviewed these records, she did not see any reports of bruising until approximately 4 days after the resident was discharged from the facility.  Follow-up telephone interviews were conducted with the DON on 10/22/20 at 1:05 PM and 1:20 PM. A request was made to review the NA progress note charting (under alerts/new alerts) for Resident #1 from 6/26/20 through 6/29/20. The DON reported such notes from the NAs were deleted by the electronic system after 90 days and were no longer available.  A follow-up telephone interview was conducted on 10/26/20 at 1:45 PM with the DON. During the interview, the DON recalled when Resident #1 ' s RP contacted the facility a few days after her discharge from the facility. The RP said the resident had a fall at the facility and was upset he wasn ' t informed of it. The DON confirmed an Initial Report and 5-day Investigation Report were not submitted to the State regarding Resident #1 ' s injury of unknown origin because, "We didn ' t see that she had one (injury) before she left." When asked what types of injuries of unknown origin were expected to be reported, she stated examples would include a fracture or a suspicious looking bruise where the cause could not be pinpointed or explained. The DON reported she was not aware Resident #1 ' s hospital records documented the resident had a bruise on her face the day she was discharged from the facility. When asked, the DON also stated she was not aware nursing staff members had observed bruising on Resident #1 ' s face during her stay at the facility.	F 607			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		11/23/20	

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F 689	<p>Continued From page 8 CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and hospital and facility record reviews, the facility failed to evaluate the potential causes of an injury and implement safety interventions to prevent further injuries for 1 of 1 resident (Resident #1) reviewed for an injury of unknown origin.</p> <p>The findings included:</p> <p>A review of Resident #1 ' s hospital records revealed she was hospitalized from 5/29/20 to 6/2/20 prior to her facility admission date of 6/2/20. Her 6/2/20 hospital Discharge Summary reported her discharge diagnoses included a lower urinary tract infection (UTI) and acute on chronic renal failure. The resident ' s past medical history included, in part: colon and rectal cancer, cancer of the hypopharynx (throat), malnutrition of moderate degree, and dementia. Upon discharge from the hospital on 6/2/20, Resident #1 was admitted to the facility for rehabilitation.</p> <p>A Risk Assessment completed on 6/2/20 indicated the resident was at a high risk for falls.</p> <p>A review of the physician ' s admission orders</p>	F 689	<p>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.</p> <p>F689</p> <p>1. Corrective action for resident(s) affected by the alleged deficient practice : For resident #01, the Director of Nursing was notified of the bruising on 7/2/20 and initiated an investigation into the cause of the injury by interviewing nursing staff and reviewing the medical record. This investigation was not documented. Resident #01 was discharged from the facility on 06/29/2020 to the hospital.</p> <p>2. Corrective action for residents with the</p>		

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F 689	<p>Continued From page 9</p> <p>dated 6/2/20 included bilateral grab bars for bed mobility. Physician ' s orders dated 6/2/20 indicated Occupational Therapy (OT) and Physical Therapy (PT) were to evaluate and treat the resident.</p> <p>Resident #1 ' s medical record included an Informed Consent for Use of Bed Rails dated 6/3/20. The medical need for the use of grab bars was reported to be weakness with a possible benefit of improved mobility for this resident. Potential risks and negative outcomes were described and included, in part: "The use of bed rail(s) may involve risks such as ...hitting against the rail(s) causing bruising and/or skin tears ...Bed rail(s) can present a hazard to certain individuals, particularly those residents with physical limitations or altered mental status, such as dementia or delirium ..."</p> <p>Resident #1 ' s admission Minimum Data Set (MDS) assessment was dated 6/9/20. The MDS revealed the resident had moderately impaired cognitive skills for daily decision making. She required extensive assistance with one-person physical assistance for bed mobility, transfers, walking in her room, locomotion on the unit, dressing and toileting. The resident required supervision only for eating and was independent with personal hygiene with setup help. Section G of the MDS also indicated Resident #1 was not steady. The resident was only able to stabilize with staff assistance when moving from a seated to standing position, walking, turning around/facing the opposite direction while walking, moving on and off the toilet, and with surface-to-surface transfers.</p> <p>The resident ' s Care Area Assessments (CAAs)</p>	F 689	<p>potential to be affected by the alleged deficient practice.</p> <p>On 11/9/20, the Director of Nursing initiated an audit of all current residents for injuries by having charge nurse to complete a full body skin assessment to identify bruises, skin tears, and other injuries. This will be completed by 11/11/20. If any injuries origin is unknown, a 24-hour report will be initiated by the Director of Nursing and an investigation into the cause of the injury will be completed, documented and interventions will be placed to prevent reoccurrence. This audit will be completed by 11/12/20.</p> <p>3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 11/12/20, the administrator educated Nursing Management: Director of Nursing, Unit Manager, MDS Nurse, and support nurse on the following topics: "Investigations into injuries and injuries of unknown origin "Initiating a 24-hour report for injuries of unknown origin "Identifying cause of injury and initiating interventions to prevent reoccurrence</p> <p>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</p>		

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F 689	<p>Continued From page 10 included: --Falls (CAA worksheet dated 6/19/20) read, in part: "Resident triggered due to balance and unsteadiness ...Resident requires extensive assistance with her ambulation and transfers. Resident is ambulatory with assistance using a walker and or wheelchair. Resident has had no falls since admission here to this facility. Resident has poor balance and unsteady gait. Resident is currently on therapy case load. Resident remains at risk for falls and injuries related to falls."</p> <p>The resident ' s individualized Care Plan (undated) included an area of focus related to her increased risk for falls due to confusion, de-conditioning, gait/balance problems, and incontinence. Interventions on the care plan included the following, in part: Anticipate and meet my needs as much as possible; Assist me to bed when I am tired or drowsy; Check on me frequently throughout the shift; Encourage me to use my walker when ambulating; Ensure that call light is within my reach; Keep frequently used objects within my reach as much as possible; Monitor for and document for 72 hours post fall following signs/symptoms: pain, bruising, mental status change, or new onset of confusion, sleepiness, inability to maintain posture, agitation, and report to the Medical Doctor (MD) any of the above signs/symptoms.</p> <p>Resident #1 was discharged from receiving therapy services on 6/24/20. Resident #1 ' s PT Discharge Summary dated 6/24/20 reported Resident #1 required contact guard assistance to ambulate 25-70 feet on a level surface using a rolling walker. Contact guard assistance was required due to the resident ' s unsteadiness. Resident #1 required stand by assistance from</p>	F 689	<p>been completed by 11/16/2020.</p> <p>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 Administrator or designee will monitor compliance utilizing the F689 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Administrator will monitor to ensure injuries of unknown origin are investigated, investigation documented, reported to the Health Care Personnel Register via the 24-hour report and 5 day follow up, and interventions were placed after cause was determined to prevent reoccurrence. 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 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.</p>		

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F 689	<p>Continued From page 11</p> <p>staff to safely transfer from sitting to standing, standing to sitting, bed to the wheelchair, and the wheelchair to the bed. PT notes indicated the care provider needed to be close enough to reach the resident if needed when providing stand by assistance.</p> <p>A Nurse Practitioner (NP) Progress Note dated 6/29/20 reported the resident had acute kidney injury (a condition where the kidneys suddenly stop working properly) as evidenced by lab results collected and reported on 6/29/20. The NP noted the resident was sent to the hospital Emergency Department (ED) for treatment upon request of her family.</p> <p>The Emergency Medical Service (EMS) Patient Care Record of Resident #1 ' s 6/29/20 transport to the hospital was reviewed. EMS reported arriving at the facility on 6/29/20 at 5:13 PM. The resident was transported and care was transferred to the hospital ED on 6/29/20 at 5:40 PM.</p> <p>Resident #1 ' s ED records and records from her hospital stay were reviewed. These included the following notations: --On 6/29/20 at 8:59 PM, an Emergency Department to In Patient Handoff Report written by a Registered Nurse (RN) included, "Additional Notes: Memory loss noted upon assessment. Old bruise, hematoma noted to left forehead; pt (patient) unable to recall incident." --A consultation note from nephrology (kidney specialists) dated 6/30/20 at 4:24 PM reported the resident had "left eye ecchymosis (a discoloration of the skin, typically caused by bruising) noted." --Results of a computerized tomography (CT)</p>	F 689			

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F 689	<p>Continued From page 12</p> <p>scan of Resident #1 ' s head completed on 7/2/20 indicated she had a "Mild left forehead scalp hematoma. No underlying skull fracture." --A nephrology Rounding Note dated 7/2/20 at 2:03 PM reported a physical exam of her head indicated, "L (left) eye ecchymosis." --An MD Progress Note written on 7/3/20 at 12:49 PM included a Physical Exam which reported Resident #1 had a "left frontal scalp hematoma; present on admission." --A nephrology Rounding Note dated 7/3/20 at 1:58 PM reported the resident had "L (left) eye ecchymosis." --An MD Progress Note written on 7/4/20 at 9:36 AM reported the resident had a "left frontal scalp hematoma; present on admission." She was diagnosed with thrombocytopenia (low blood platelets) likely due to underlying liver cirrhosis. The heparin (an anticoagulant) used for deep vein thrombosis (DVT) prophylaxis (prevention) while hospitalized was discontinued. --A nephrology Rounding Note dated 7/4/20 at 2:51 PM reported Resident #1 had "L (left) eye ecchymosis."</p> <p>Resident #1 ' s Interdisciplinary Team (IDT) Progress Notes and Assessments at the facility were reviewed. There was no documentation to indicate the resident had any incident or fall during her stay in the facility. No bruising of the skin was reported in Resident #1 ' s medical record.</p> <p>A review of the facility ' s Incident Log from 6/2/20 - 6/29/20 was conducted. No injuries, bruising, or incidents were reported for Resident #1 during her stay at the facility. Additionally, no incident reports of injuries of unknown origin (including bruises) or falls were reported for any female</p>	F 689			

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F 689	<p>Continued From page 13 residents in the facility from 6/26/20 - 6/29/20.</p> <p>An interview was conducted on 10/20/20 at 2:30 PM with Nursing Assistant (NA) #1. NA #1 was identified to have worked on Resident #1 ' s hall from 7:00 AM - 3:00 PM on 6/26/20 and 6/29/20. The NA recalled Resident #1 and reported she could reposition herself in bed. She stated the resident loved to slide down on the bed and on her side. The NA reported she did not remember the resident having any bruising or discolorations on her skin.</p> <p>An interview was conducted on 10/21/20 at 10:32 AM with NA #2. NA #2 was identified to have worked on Resident #1 ' s hall from 7:00 AM - 3:00 PM on 6/26/20 and 6/29/20. The NA recalled Resident #1 and reported sometimes she would try to get out of bed by herself and staff would find her with her feet hanging off the bed. However, staff knew they needed to hurry to get into her room quickly because she might try to get up without assistance. While the NA stated she did not recall seeing any bruising on the resident ' s head, she reported it may have been possible for Resident #1 to bump her head on the grab bar as she turned herself or slid down in the bed.</p> <p>An interview was conducted on 10/20/20 at 3:20 PM with NA #3. NA #3 was identified to have worked on Resident #1 ' s hall from 3:00 PM - 11:00 PM on 6/26/20 and 6/29/20. This NA did not recall the resident.</p> <p>A telephone interview was conducted on 10/22/20 at 8:20 PM with Nurse #2. Nurse #2 was identified as the hall nurse who was assigned to care for Resident #1 from 7:00 PM on 6/26/20 to 7:00 AM (on 6/27/20); from 7:00 PM on 6/27/20 to</p>	F 689			

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F 689	<p>Continued From page 14</p> <p>7:00 AM (on 6/28/20); and, on 7:00 PM on 6/28/20 to 7:00 AM (on 6/29/20). During the interview, the nurse stated he was able to remember the resident but could not recall any details of her stay. The nurse was asked to describe what he would typically do if a resident was observed to have a bruise on his/her skin. He reported he would complete an Incident Report for both a bruise from a known cause and a bruise of unknown origin. If the bruise was on the head, he would initiate neurochecks. Additionally, Nurse #2 reported he would notify the resident ' s Medical Doctor (MD) and Responsible Party (RP).</p> <p>A telephone interview was conducted on 10/23/20 at 11:25 PM with NA #4. NA #4 was assigned to work on Resident #1 ' s hall from 11:00 PM on 6/26/20 - 7:00 AM (on 6/27/20). During the interview, the NA reported she was typically assigned to care for Resident #1 on her shift but stated she "vaguely" recalled this resident. She stated Resident #1 could roll back and forth in bed by herself but needed a little assistance for other positioning. The NA stated she did have grab bars on her bed and recalled the resident favored the foot of the bed and would tend to scoot down towards it. Upon inquiry, the NA reported Resident #1 did not have an incident or fall on her shift; she did not recall seeing any bruising on the resident. The NA also stated if a resident fell or if she saw a new bruise on a resident, she would immediately alert the hall nurse.</p> <p>A telephone interview was conducted on 10/22/20 at 2:00 PM with Nurse #3. Nurse #3 was identified by the facility ' s schedule as working with the nurses on Resident #1 ' s hall for</p>	F 689			

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F 689	<p>Continued From page 15</p> <p>orientation from 7:00 AM to 7:00 PM on 6/26/20 and from 7:00 AM to 7:00 PM on 6/27/20. During the interview, the nurse recalled seeing a female resident the morning of 6/27/20 who had a "huge knot with a bruise around it on her head." She recalled the injury was not present when she worked the previous day (6/26/20). Nurse #3 stated she was new to the facility and not yet familiar with the residents. She could not recall the female resident ' s name. She reported the hall nurse (Nurse #4) was with her at the time when she first saw the bruise the morning of 6/27/20. She stated the resident was, "very confused and couldn ' t tell us what happened."</p> <p>An interview was conducted on 10/20/20 at 2:42 PM with Nurse #4. Nurse #4 was the hall nurse who was assigned to care for Resident #1 from 7:00 AM - 7:00 PM on 6/27/20 and 6/28/20. During the interview, the nurse recalled caring for this resident. She reported Resident #1 could use the call light when she wanted staff assistance. Upon inquiry, the nurse stated the resident did not have any bumps, falls, or incidents that she was aware of. She did not recall seeing any bumps or bruising on Resident #1 ' s face or head.</p> <p>A telephone interview was conducted on 10/22/20 at 12:41 PM with NA #6. NA #6 was identified by the facility ' s schedule as having worked on Resident #1 ' s hall from 7:00 AM - 7:00 PM on 6/27/20 and 6/28/20. During the interview, the NA reported she did recall this resident and described her as, "really weak and confused." NA #6 recalled staff had an issue of the resident trying to get up by herself to go to the bathroom. The NA reported she seemed to recall that one day when she came in for her shift Resident #1</p>	F 689			

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F 689	<p>Continued From page 16</p> <p>had a "knot" on her forehead. She stated this was the first time she had seen it and staff couldn't figure out where it came from. The NA indicated she "thought" it was Resident #1 who had that bump on the head, but could not be certain of the resident or the date this may have been observed. Upon further inquiry, NA #6 stated she was fairly certain she would have noted such a bruise in the NA progress notes (under alerts/new alerts) for Resident #1.</p> <p>A telephone interview was conducted on 10/23/20 at 10:39 AM with NA #7. NA #7 was identified by the facility's schedule as having worked on Resident #1's hall from 7:00 AM - 3:00 PM on 6/27/20 and from 7:00 AM - 7:00 PM on 6/28/20. NA #7 recalled this resident. When asked, the NA recalled Resident #1 did attempt to get out of bed on her own a few times on her shift. She stated, "One time I caught her trying to stand up between the wall and bed using the window sill." NA #7 reported one day when she came in to work a weekend shift, "She (Resident #1) had a giant knot on her head." The NA stated from what she could remember, she thought the resident had fallen on 3rd shift when she was trying to get out of bed. However, she could not recall for certain if the injury was discussed in report or who may have told her about a fall. Upon further inquiry as to the location of Resident #1's injury, the NA reported she thought it was above the resident's left eye.</p> <p>A telephone interview was conducted on 10/21/20 at 4:52 PM with NA #8. NA #8 was identified as having worked from 3:00 PM - 7:00 AM on 6/27/20 and 6/28/20. When asked, the NA stated she could not recall this resident.</p>	F 689			

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F 689	<p>Continued From page 17</p> <p>A telephone interview was conducted on 10/22/20 at 1:40 PM with NA #9. NA #9 was identified as having worked on Resident #1 ' s hall from 3:00 PM on 6/28/20 - 7:00 AM (on 6/29/20). Upon inquiry, the NA reported she could not recall this resident or any details of her stay.</p> <p>An interview was conducted on 10/20/20 at 3:07 PM with Nurse #5. Nurse #5 was assigned to care for Resident #1 from 7:00 AM - 7:00 PM on 6/29/20. During the interview, the nurse recalled the resident would try to get out of bed on her own. However, she did not recall the resident having a fall. Nurse #5 confirmed she was the nurse who sent Resident #1 out to the hospital on 6/29/20. When asked, the nurse stated she did not do a skin assessment on Resident #1 when she was discharged to the hospital. She did not recall the resident having any bruising on her face or head. However, the nurse stated, "I do remember that she tossed and turned in the bed. She did have the grab bars up." Nurse #5 reported the resident had the ability to turn and reposition herself in bed for the duration of her stay at the facility. She also recalled, "Sometimes she went to the bathroom by herself and you would catch her coming back." The nurse also reported she thought she had found the resident ' s head at the foot of the bed on one occasion.</p> <p>An interview was conducted on 10/21/20 at 10:47 AM with the facility ' s Administrator. Upon inquiry, the Administrator reported he first became aware of the concern regarding bruising of Resident #1 ' s face during an initial complaint investigation conducted on 9/17/20 - 9/18/20. He stated, "That (the injury) didn ' t happen here." He reported it was his understanding the bruising was not noted initially in the resident ' s hospital</p>	F 689			

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F 689	<p>Continued From page 18 admission records.</p> <p>An interview was conducted on 10/21/20 at 11:30 AM with the facility ' s Director of Nursing (DON). During the interview, the DON recalled she first found out about the concern of bruising on Resident #1 ' s face 3-4 days after the resident was discharged from the facility to the hospital. At that time, the resident ' s Responsible Party (RP) called the facility to inquire about the bruising and to find out what had happened to cause it. When asked, the DON stated she could not recall if she herself talked with the RP or if someone else did. The DON reported after the phone call from the RP, she did an informal investigation at the facility. When asked, she stated there was no documentation of the investigation. The DON stated she reviewed Resident #1 ' s records and interviewed nursing staff. She stated no falls or reports of bruising had been reported for the resident while she was in the facility. The DON reported she had access to Resident #1 ' s hospital records. When she reviewed these records, she did not see any reports of bruising until approximately 4 days after the resident was discharged from the facility.</p> <p>Follow-up telephone interviews were conducted with the DON on 10/22/20 at 1:05 PM and 1:20 PM. A request was made to review the NA progress note charting (under alerts/new alerts) for Resident #1 from 6/26/20 through 6/29/20. The DON reported such notes from the NAs were deleted by the electronic system after 90 days and were no longer available.</p> <p>A follow-up telephone interview was conducted on 10/26/20 at 1:45 PM with the DON. During the interview, the DON again recalled Resident #1 ' s</p>	F 689			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345496</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/26/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIBERTY COMMONS N&amp;R ALAMANCE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>791 BOONE STATION DRIVE</b> <b>BURLINGTON, NC 27215</b>		
(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 689	Continued From page 19 RP contacted the facility a few days after her discharge from the facility. The RP said the resident had a fall at the facility and was upset he wasn ' t informed of it. When asked, the DON reported she was not aware Resident #1 ' s hospital records documented the resident had a bruise on her face the day she was discharged from the facility. Upon further inquiry, the DON also stated she was not aware nursing staff members had observed bruising on Resident #1 ' s face during her stay at the facility.	F 689			