STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NURSING & REHAB ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

(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
E 000	Initial Comments An unannounced recertification and compliant investigation survey was conducted on 10/11/21 through 10/14/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # P6SJ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/11/21 through 10/14/21. Event ID# P6SJ11 1 of the 6 complaint allegations was substantiated resulting in deficiencies.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		11/11/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/03/2021

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F 657	Continued From page 1 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to review and revise the care plan for activities of daily living for two of eighteen sampled residents (Resident #60 and Resident # 46). The findings included: 1. Resident #60 was admitted to the facility on 11/7/19 with diagnoses that included ataxia (the loss of full control of bodily movements) and dementia. The quarterly Minimum Data Set (MDS) assessment dated 9/3/21 indicated Resident #60's cognition was severely impaired. Resident was assessed as needing extensive to total assistance of one-to-two-person physical assist for activities of daily living (ADLs). Eating was assessed as total assistance with one-person physical assist. Review of the care plan dated 8/28/21 revealed Resident #60 was care planned for ADL self-care performance deficit related to dementia and impaired movement. Interventions indicated Resident #60 was independent with eating, and able to feed self with setup help only On 10/11/21 at 1:30 PM during lunch meal observation, Resident # 60 was observed to be	F 657	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. F657 Care Plan Timing and Revision 1. Corrective Action: Resident #60: Resident discharged 10/24/2021. Resident #46: Care plan revised and updated on 10/14/2021. 2. Identification of other residents who may be involved with this practice: All current residents requiring assistance with eating have the potential to be affected by the alleged practice. On 10/28/2021 through 11/11/2021 an audit was completed by the Minimum Data Set (MDS) Nurse Consultant and MDS Support Nurse, to ensure that a care plan	

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F 657	Continued From page 2 assisted with eating by Nurse #3. On 10/12/21 at 8:15 AM during breakfast meal observation, Resident #60 was observed to be assisted with eating by Nursing Assistant (NA) #1. During an interview on 10/12/21 at 10:15 AM, NA #1 stated the resident needed total assistance with ADL care and needed assistance with eating. NA #1 indicated the resident could not feed herself. During an interview on 10/13/21 at 1:07 PM, NA #2 stated the resident needed total assistance with one-person physical assist with ADL care including eating. During an interview on 10/14/21 at 12:58 AM, Nurse #3 stated Resident # 60 was alert and was able to move her upper extremities. Nurse #3 further stated Resident #60 could feed herself, however, does not have the motivation to eat. The resident would leave the tray untouched if placed in front of her. Resident needed encouragement and assistance with eating from staff. During an interview on 10/14/21 at 1:05 PM, the MDS Nurse stated based on the resident's MDS assessment, Resident #60 needed extensive assistance with one-person physical assist for eating. MDS Nurse further stated even though the MDS assessment indicates the resident was extensive assistance with eating, this does not mean Resident #60 could not feed herself. MDS coordinator confirmed she reviews and updates the care plans based on her observation and interviews from the staff assigned to the residents. MDS Nurse stated she does not think	F 657	was implemented for current residents who require assistance with eating. All current residents who require assistance with eating, have updated care plans. This was completed on 11/11/2021. 3. Systemic Changes: By 11/11/2021 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a resident□s medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident□s highest practicable physical, mental, and psychosocial wellbeing; and any services that would otherwise be required but are not provided due to the resident□s exercise of rights , including the right to refuse treatment ; and any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations, and after consultation with the resident and the resident□s representative□s on the residents goals for admission and	

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F 657	Continued From page 3 the care plan needed to be updated based on her observation. During an interview on 10/14/21 at 1:14 PM the Director of Nursing (DON) stated it was her expectation that the care plans were updated to reflect the actual status of the resident based on the MDS assessment. 2. Resident #46 was admitted to the facility on 3/8/21 with diagnosis that included dementia and dysphagia. Review of the quarterly MDS assessment dated 8/20/21 revealed Resident #46's cognition was assessed as severely impaired and needed extensive assistance of one-to-two-person physical assist for Activities of Daily Living (ADLs) including eating. Review of the care plan dated 8/14 /21 revealed Resident #46 was care planned for ADL self-care performance deficit related to dementia, confusion, musculoskeletal impairment, and pain. Interventions indicated Resident #46 was independent with eating, and able to feed self with setup help only. On 10/11/14 at 1:25 PM during meal observation, Resident #46 was observed to be assisted with eating by Nursing Assistant (NA) #1. During an interview on 10/11/21 at 1:25 PM, NA #1 stated Resident #46 was totally dependent with one-person physical assist with ADL care and needed assistance with eating. NA #1 stated the resident could not feed herself. During an interview 10/14/21 at 11:13 AM, NA #2 stated the resident needed extensive assistance	F 657	desired outcomes, the resident□s preference and potential for future discharge, and discharge plans. A comprehensive person centered care plan must be implemented for all residents requiring catheter care and must be developed for all resident□s receiving activities of daily living that identifies the type of care needed for activities of daily living. This in service was completed by 11/11/2021. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is 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. 4. Monitoring: To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will observe 5 resident□s who require assistance with eating to ensure that care plan is implemented. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the	

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F 657	Continued From page 4 with eating. NA #2 stated the resident was able to feed herself finger food like a burger cut in quarters or a sandwich cut in bite size pieces, however if utensils were needed to eat, the resident could not feed self. NA #2 indicated Resident #46 was closely monitored during eating due to dysphagia and risk for aspiration. During an interview on 10/14/21 at 12:58 PM, Nurse #3 stated Resident #46 could sometimes feed herself if the food served was finger foods. Resident #46 could not feed herself with utensils due to poor hand coordination, confusion, and hand muscle impairment. Nurse #3 indicated the resident had a high risk for aspiration and needed to be closely monitored. During an interview on 10/14/21 at 01:05 PM, the MDS Nurse stated based on the resident's MDS assessment, Resident #46 needed extensive assistance with one-person physical assist for eating. MDS Nurse further stated even though the MDS assessment indicates the resident was extensive assistance with eating, this does not mean Resident #46 could not feed herself. MDS Nurse confirmed she reviews and updates the care plans based on her observation and interviews with staff assigned to the residents. MDS coordinator stated she does not think the care plan needed to be updated as the resident was able to feed herself. During an interview on 10/14/21 at 1:14 PM the Director of Nursing (DON) stated it was her expectation that the care plans were updated to reflect the actual status of the resident based on the MDS assessment.	F 657	Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse.	
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON	F 727		11/11/21

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F 727	Continued From page 5 CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 17 of the past 45 days reviewed. The findings included: A review of the facility's Daily Schedules for the past 45 days was conducted. The Daily Schedules indicated a Registered Nurse (RN) was not scheduled for at least 8 consecutive hours a day on the following dates: 9/1/21, 9/2/21, 9/6/21, 9/7/21, 9/9/21, 9/10/21, 9/15/21, 9/16/21, 9/20/21, 9/21/21, 9/29/21, 9/30/21, 10/1/21, 10/4/21, 10/5/21, 10/6/21 and 10/7/21 On 10/14/21 at 12:00 PM, during an interview, the Director of Nursing (DON) revealed she was responsible in collaboration with the Administrator to review the Daily Nurse Staffing form prior to posting it. DON indicated she was aware a RN	F 727	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. F727 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to staff Registered	

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F 727	Continued From page 6 needs to be scheduled 8 consecutive hours a day, however it was hard for the facility to acquire registered nurse to work for the days indicated. DON stated she was a RN, and could assist nurses if needed. During an interview on 10/14/21 at 1:39 PM, Administrator stated he was aware that on some days there were no RN in the facility. Administrator stated the facility had contacted the contract agencies and they were unable to provide RN. Administrator stated he preferred to have RN for 8 hours but on some days could not acquire them. Administrator stated the facility DON was a RN and full-time employee. He further stated the DON does not work on the cart but available when needed. Administrator indicated the facility has been hiring RN and other staffing and this was continuous process.	F 727	Nurse coverage for 8 consecutive hours daily. 1. Corrective action for resident(s) affected by the alleged deficient practice: No residents were affected. At least eight consecutive hours of registered nurse staffing will be maintained daily by 11 /11 / 2021. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 11/01/2021 staffing sheets were reviewed by the Director of Nurses from 10/01/2021 through 11/01/2021 to monitor that at least eight consecutive hours of registered nurse staffing was in place daily. 27 out of 31 days had at least 8 consecutive hours of registered nurse hours in place. An on call process to maintain eight consecutive hours of registered nurse staffing daily and use of a contracted agency for registered nurses will be developed and in use by 11/11/2021. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 11/01/2021, the Nurse Consultant educated the Administrator and Director of Nurses on the requirement of the facility to staff Registered Nurse Coverage for at least consecutive hours daily. Coverage by a Registered nurse for a least eight	

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F 727	Continued From page 7	F 727	consecutive hours will be maintained by 11/11/2021. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nurses will monitor compliance utilizing the F272 Quality Assurance Tool weekly for staffing of registered nurse hours daily x 2 weeks then monthly x 3 months. The Director of Nursing will monitor staffing for compliance with the requirement for at least 8 hours of registered nurse staffing daily. 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.	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;	F 806		11/11/21

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F 806	Continued From page 8 §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to honor the food preferences for 1 of 4 resident observed during dining (Resident #23). Findings included. Resident # 23 was admitted to the facility on 3/20/19 with diagnoses that included adult failure to thrive, dysphagia, and moderate protein calorie malnutrition. Dietary note dated 7/7/21 revealed Resident #23 was on a soft and biter size texture, thin liquid diet. Gravy or sauce to be provided with meals. The resident disliked tomato soup. Resident's tray card was updated. Review of the quarterly minimum data set (MDS) assessment dated 7/16/21 for Resident #23 revealed the resident was assessed as cognitive intact, independent with eating and received a mechanically altered diet. A review of the October 2021 physician orders for Resident #23 read in part "regular diet, soft & bite sized texture, thin consistency. may have bread and cake textures, may have straws, no tomato soup, may have crackers, may have chicken noodle soup, provide sauce/gravy with meals." During an observation on 10/11/21 at 11:00 AM, the resident's breakfast tray was on the side	F 806	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. F806 1. Corrective action: On 10/11/2021 during meal observations, it was observed at more than one meal a resident was served minced and moist consistency instead of ordered diet of Soft and Bite Sized. It was also noted during observation resident did not receive soup or gravy per traycard documented preferences nor had traycard been updated to reflect residents dislike of fish or desire of syrup. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents have the potential to be	

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F 806	Continued From page 9 table. Observations of the food served on the resident's meal tray revealed some ground, brown food, that looked like ground meat, and which was not eaten by the resident. There was no sauce or gravy on the tray. An interview with Resident #23 on 10/11/21 at 11:00 AM revealed she could not eat the meat as it was too dry and would prefer to have some gravy to soften it. An observation of Resident #23 on 10/11/21 01:11 PM revealed the resident was served her lunch meal. Observations of the food served on the resident's meal tray revealed she had been served ground fish, mashed potatoes, chopped zucchini, bite size corn nuggets, 8 fluid ounce (fl. oz.) iced tea, and a can of tomato juice. Resident had not eaten the fish served on her tray. An interview with Resident #23 on 10/11/21 01:13 PM revealed she does not like fish, and it was too dry eat. There was no gravy on her tray. Resident indicated she was not served warm soup which she likes. Resident further indicated she dislikes tomatoes and tomato juice. Resident stated she was not served ice cream. Review of the tray card that was present on Resident #23's lunch meal tray on 10/11/21 revealed she was on a soft/ bite size diet. Fish was identified as a dislike on the tray card. Standing orders on the card read in part "½ Cup ice cream (do not send fat free), 6-ounce soup of the day (no tomato)." Tray card also indicated to send gravy for meats. During an interview on 10/11/21 01:16 PM, Nurse aide (NA) #1 indicated she had served Resident	F 806	affected by the alleged deficient practice. All dietary staff in-serviced by 11/11/2021 regarding accuracy of meals served and diet consistency policies. All dietary staff are to have competencies evaluated. All current entries in Traycard will be reviewed for accuracy and modified as needed. All nursing and nursing assistants in-serviced by 11/11/2021 regarding meal service policies. All nursing and nursing assistants are to have competencies evaluated. 3. Systemic changes: In-service education was provided to all full time, part time, and as needed staff by the Dietary Services Director. Topics included: "Tray Accuracy Education "Diet Consistency Policies "Meal Service Policies This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Traycard to be reviewed and modified on admissions, quarterly, and as needed. Menus to be reviewed daily and modified per diet preferences as needed. 4. Quality Assurance monitoring procedure: The Dietary Services Director and Nursing staff will monitor accuracy of completed	

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F 806	Continued From page 10 #23 her lunch meal. NA #1 stated she did not look at the tray card on resident meal tray prior to serving the resident her meal to see if the resident's meal tray contained any food she dislikes. An observation of Resident #23 on 10/12/21 08 :15 AM revealed the resident was consuming her breakfast. Observation of the food served on the resident's meal tray revealed she was served a bowl of oatmeal, pancakes cut bite size, scrambled eggs, and ground sausage. The tray also contained 8-ounce juice, coffee, and condiments. The resident had not consumed her pancakes and sausage. Resident #23 during an interview on 10/12/21 at 8:17AM, stated it would be nice if the pancakes were served with some syrup. She indicated the pancakes and sausage were too dry for her to eat. Review of the tray card that was present on Resident #23's breakfast meal tray on 10/11/21 revealed standing order: sausage patty with gravy. During an interview on 10/12/21 at 8:22 AM, Nurse #2 stated there must have been an error on the part of kitchen that tray did not contain syrup for the pancakes and gravy for the meats. Nurse #2 indicated the kitchen staff should be checking trays prior to be sent to the residents. During an interview on 10/14/21 at 9:00 AM, Dietary Manager stated all resident's food preferences were taken at admission, quarterly and as needed. Dietary Manager indicated Resident #23's food preferences were recently	F 806	trays served to residents daily. Meals will be audited using the QA Audit tool to observe meals for accuracy weekly x4 and then monthly x 2.Traycard will be audited monthly and test trays completed monthly per policy. Reports will be presented to the weekly Quality Assurance committee. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Services Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 806	Continued From page 11	F 806		

updated. Dietary Manager indicated there were 3 staff on the tray line to assist with plating of meals according to resident's diet and preferences. Tray accuracy was checked prior to placing the tray in the cart. She stated few of her dietary aides were new and were been trained on the tray line. The Dietary Manager verbalized that her expectations were that employees were reading the tray tickets to ensure resident food preferences were honored and diet served was per orders.

During an interview on 10/14/21 at 1:14 PM, the Director of Nursing (DON) indicated the kitchen staff should be checking all meal trays for tray accuracy prior to be placed in the cart. All resident's meal preferences should be honored as long as the food preferences did not conflict with the diet order. DON further stated it was her expectation that the NAs check the trays for accuracy when setting up the tray for residents during meals.

During an interview on 10/14/21 01:52 PM, the Administrator indicated the meal trays should be reviewed by staff for accuracy, diet, and preferences. Residents should be served meals based on their preferences. Care should be taken to accommodate the likes and dislikes of the residents.