PRINTED: 03/16/2022 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<br>COMPLETED |  |                                   |                            |
|---|---|--|-------------------------------|--|-----------------------------------|----------------------------|
|   |   | 345532   | B. WING _                     |  | 0                                 | C<br>2/17/2022             |
|   | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY   |                               | STREET ADDRESS, CITY, STATE, ZIP OF STATE ADDRESS, CITY, STATE AD | •                                 |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF<br>X (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN   | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| E 000   | Initial Comments  |  | EC                            | 000  |                                   |                            |
|   | conducted 2/14/22 th<br>was found out of con<br>CFR 483.73, Emerg<br>E0004. See Event II<br>Develop EP Plan, Re     | certification survey was<br>nrough 2/17/22. The facility<br>npliance with the requirement<br>tency Preparedness at<br>D #2BPO11.<br>eview and Update Annually    | E                             | 004  |                                   | 3/29/22                    |
| SS=F  | §403.748(a), §416.5   | 4(a), §482.15(a), §483.73(a),<br>02(a), §485.68(a),<br>27(a), §485.920(a),   |                               |  |                                   |                            |
|   | Federal, State and lo<br>preparedness require<br>develop establish an<br>emergency prepared<br>requirements of this | ements. The [facility] must d maintain a comprehensive lness program that meets the section. The emergency am must include, but not be                           |                               |  |                                   |                            |
|   | and maintain an emethat must be [reviewe  | The [facility] must develop ergency preparedness plan ed], and updated at least plan must do all of the  |                               |  |                                   |                            |
|   | CAH] must comply w<br>State, and local eme<br>requirements. The [I<br>develop and maintain                          | ency Plan. The [hospital or<br>vith all applicable Federal,<br>rgency preparedness<br>hospital or CAH] must<br>n a comprehensive<br>Iness program that meets the |                               |  |                                   |                            |

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

Electronically Signed 03/10/2022

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<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | I ` ′               | IPLE CONSTRUCTION  |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|---------------------|--|--|-------------------------------|--|
|   |   | 345532   | B. WING _           |  |  | C<br><b>02/17/2022</b>        |  |
| NAME OF PI  | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | <u> </u>   | <u> </u>                      |  |
| LIBERTY   | COMMONS NSG AND RE  | HAB CTR OF LEE COUNTY  |                     | 310 COMMERCE DRIVE   |  |                               |  |
| LIBERTT   | COMMONS NSS AND RE  | THAD CIR OF ELE COUNTY   |                     | SANFORD, NC 27332  |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR  (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)   | HOULD BE   | (X5)<br>COMPLETION<br>DATE    |  |
| E 004   | Continued From page all-hazards approach  * [For LTC Facilities a Plan. The LTC facility an emergency prepar reviewed, and update  * [For ESRD Facilities Plan. The ESRD facil maintain an emergen must be [evaluated], a years.  . This REQUIREMENT by: Based on record revifacility failed to ensur Preparedness (EP) pupdated at least annument of the facility's EP Plan. | at §483.73(a):] Emergency must develop and maintain redness plan that must be ad at least annually.  So at §494.62(a):] Emergency ity must develop and cy preparedness plan that and updated at least every 2  The is not met as evidenced few and staff interview, the effect the Emergency lan was reviewed and ually. | E O                 | DEFICIENCY)  | lan of to and do n the federal has taken in this orrection on of |                               |  |
|   | he had been acting a<br>since December 202 <sup>o</sup><br>EP manual. He com  | Administrator was 2 at 12:40 PM. He indicated s the interim Administrator 1 and had not reviewed the mented that he didn't know hinistrators had not updated   |                     | 1. Administrator updated Eme Operations Plan (EOP) with current vendors on 3/1/2022. Ecreviewed at standup meeting on with IDT.  2. On 3/1/2022, the Administrateducated on 3/1/2022 regarding requirement for annual review a of the EOP by the Inter-disciplin | rgency<br>rent key<br>and<br>DP Plan<br>3/2/2022<br>ator was     |                               |  |

|                          | DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 |     | CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>PLETED           |
|--------------------------|--|--|---------------------|-----|---|-------------------|----------------------------|
|                          |  | 345532   | B. WING             |     |   |                   | C                          |
|                          | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY   |                     | 310 | REET ADDRESS, CITY, STATE, ZIP CODE  O COMMERCE DRIVE  ANFORD, NC 27332   | 02/               | 17/2022                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |                   | (X5)<br>COMPLETION<br>DATE |
| E 004                    | Continued From page  | ÷ 2  | EC                  | 004 | (IDT) by the Regional Director of Operations (RDO.) 3. IDT was educated regarding facilit requirement to review and update EOF annually by the RDO on 3/11/2022. 4. Administrator will monitor new changes established by rule or regulati and discuss with IDP as needed. The facility will incorporate necessary chan in the EOP after review by the IDT. RD will monitor annually to ensure sustaine compliance. | on<br>ges<br>O    |                            |
| F 000                    | survey was conducted<br>Event ID #2BPO11<br>13 of the 29 complain  | complaint investigation<br>d from 2/14/22 to 2/17/22.<br>It allegations were   | FC                  | 000 |   |                   |                            |
| F 550<br>SS=E            | self-determination, an access to persons an outside the facility, incertain this section.  §483.10(a)(1) A facility with respect and digneresident in a manner promotes maintenance. | cise of Rights (2)(b)(1)(2)  Rights. ght to a dignified existence, and communication with and discrete services inside and cluding those specified in  ry must treat each resident ity and care for each and in an environment that the or enhancement of his or | F 5                 | 550 |   |                   | 3/29/22                    |

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|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  G  |  | OMPLETED                   |
|--------------------------|---|--|--------------------------|--|--|----------------------------|
|                          |   | 345532   | B. WING _                |  |  | C<br><b>02/17/2022</b>     |
|                          | ROVIDER OR SUPPLIER   | REHAB CTR OF LEE COUNTY  | ,                        | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332   | '  | <b>V</b>                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY)   | IOULD BE                                     | (X5)<br>COMPLETION<br>DATE |
| F 550                    | access to quality ca severity of condition must establish and in practices regarding provision of services residents regardless. §483.10(b) Exercises The resident has the rights as a resident or resident of the Urresident can exercise interference, coercist interference, coercist from the facility. §483.10(b)(2) The refree of interference, reprisal from the facility. This REQUIREMEN by:  Based on observation interviews and recontreated residents in responding to call liganger and frustration #31, Resident #4, Rand Resident #54) of dignity. The findings. | acility must provide equal re regardless of diagnosis, or payment source. A facility maintain identical policies and transfer, discharge, and the sunder the State plan for all sof payment source.  If of Rights. It right to exercise his or her of the facility and as a citizen nited States.  In acility must ensure that the left his or her rights without on, discrimination, or reprisal esident has the right to be coercion, discrimination, and illity in exercising his or her ported by the facility in the er rights as required under this left is not met as evidenced ons, residents and staffed review, the facility failed to a dignified manner by not ghts resulting in feeling of the included of the sadmitted on 1/27/16 with a lal Vascular Accident (CVA) | F 5                      | The statements made on this pl correction are not an admission not constitute an agreement with alleged deficiencies. To remain i compliance with all federal and s regulations the facility has taken take the actions set forth in this p correction. The plan of correction constitutes the facility's allegatio compliance such that all alleged deficiencies cited have been or corrected by the dates indicated F550 | to and do the the state or will blan of n of |                            |

Facility ID: 980156

|                          | OF DEFICIENCIES CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTI<br>A. BUILDIN | IPLE CONSTRUCTION  | , ,  | DATE SURVEY<br>COMPLETED   |
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|                          |  | 345532  | B. WING _                |  |  | C<br><b>02/17/2022</b>     |
| NAME OF PI               | ROVIDER OR SUPPLIER  | l   |                          | STREET ADDRESS, CITY, STATE, ZIP   | CODE   | 02/1//2022                 |
|                          |  |   |                          | 310 COMMERCE DRIVE   |  |                            |
| LIBERTY                  | COMMONS NSG AND R  | EHAB CTR OF LEE COUNTY  |                          | SANFORD, NC 27332  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF<br>( (EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIEN  | TION SHOULD BE<br>THE APPROPRIATE  | (X5)<br>COMPLETION<br>DATE |
| F 550                    | Continued From pag   | e 4   | F 5                      | 550  |  |                            |
|                          | (MDS) dated 1/30/22 intact, exhibited no b   | erly Minimum Data Set  indicated he was cognitively behaviors and coded as staff assistance with his ng (ADLs).   |                          | The facility failed to treat redignified manner by not relights in a timely manner.  1. Corrective action for raffected by the alleged determined to the second sec | sponding to call resident(s)   |                            |
|                          | indicated he required ADLs. Interventions use his call light for a Review of a resident dated 1/20/22 read F about being left sittin long. The form read   | ed care plan dated 1/18/21 d staff assistance with his included encouraging him to assistance.  council communication form Resident #31 complained g up in his wheelchair too Resident #31 was reminded ather than yelling out to staff   |                          | On 2/17/2022 resident #3 <sup>o</sup> and #54 were given hand addition to their call lights of Nurses. They were instructed both to alert staff to the neassistance.  2. Corrective action for restriction the potential to be affected deficient practice. All residents have the potential on 2/17/2022 the  | bells to use in by the Director ructed to use ed for residents with d by the alleged ential to be  |                            |
|                          | 2/14/22 at 11:55 AM to wait sometimes for assistance after present this has been a problementioned it during a He stated if he did not know he wanted it made him very and his call light. The call in the bathroom did not he bat | nducted with Resident #31 on . He stated he frequently had r up to an hour for staff ssing his call light. He stated lem for months and he had a resident council meeting. but yell out to staff, they would to go back to bed. He stated gry. Resident #31 pressed I light system in the room and not make an audible sound.  on on 2/14/22 at 12:30 PM, ght was observed on. A) #4 was observed entering M and turned off the call light. #31 what he needed, and he testing out his call light.  inducted on 2/14/22 at 1:00 |                          | Nurses and Nursing super residents, in addition to the hand bell to be used if staff was needed. In addition he of all residents was initiated by the assigned hall nurse nursing assistant's, Regist Manager and Support Nureducation was initiated by Nurses and Nurse Consulprocess. Hourly rounding is shifts and days of the weelight system is fully function rounding log was created rounding and any areas of need addressing and will be daily Monday through Frid Daily Stand Up, which is a department managers and administrator. All new administrator.  | eir call light, a  ff assistance ourly rounding ed on 3/ 11/2022 es, certified tered Nurse se and the Director of tant on the is to occur on all k until the call nal. An hourly to document the f concern that be reviewed ay as part of ittended by all the facility |                            |
|                          |  | stated she was an agency  |                          | provided a hand bell in ad   |  |                            |

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE  |  | SURVEY              |     |  |                                |                            |
|--------------------------|---|--|---------------------|-----|--|--------------------------------|----------------------------|
|                          |   | 345532   | B. WING _           |     |  |                                | C<br><b>17/2022</b>        |
| NAME OF P                | ROVIDER OR SUPPLIER   | ı  |                     | STR | REET ADDRESS, CITY, STATE, ZIP CODE  |                                |                            |
|                          |   |  |                     | 310 | COMMERCE DRIVE   |                                |                            |
| LIBERTY                  | COMMONS NSG AND RI  | EHAB CTR OF LEE COUNTY   |                     | SA  | NFORD, NC 27332  |                                |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | <   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |                                | (X5)<br>COMPLETION<br>DATE |
| F 550                    |   | orking at the facility since   | F 5                 |     | call light and will also be rounded on   |                                |                            |
|                          | November 2021. She has never made an a need to be on the 300 above a resident's do residents have voiced and she felt it was du sounding. She stated the problem to her known and bell was observations small bell was observations small bell was observated bell a few minutes ago bell if staff did not residents with calling stated he was new to the call light system of stated apparently the August 2021, but the minutes rounds on earlight responses for the facility as the interpression of the call had implemented medelays. | e stated the call light system udible sound and staff would to hall to observe the light for. NA #4 stated the doing call light wait times to the call light system not amanagement was aware of lowledge.  In on 2/16/22 at 3:47 PM, a red on Resident #31's bed staff provided him with the orand told him to use the spond timely.  In on 2/16/22 at 3:47 PM, a red on Resident #31's bed staff provided him with the orand told him to use the spond timely.  In on 2/16/22 at 3:47 PM, a red on Resident #31's bed staff provided him with the orand told him to use the spond timely.  In on 2/16/22 at 3:47 PM, a red on Resident #31's bed staff provided him with the orand told him to use the spond timely.  In on 2/16/22 at 3:47 PM, a red on Resident #31's bed staff provided him with the orand told him to use the spond timely.  In on 2/16/22 at 3:47 PM, a red on Resident #31's bed staff provided him with the orand told him to use the spond timely.  In on 2/16/22 at 3:47 PM, a red on Resident #31's bed staff provided him with the orand told him to use the spond timely.  In on 2/16/22 at 3:47 PM, a red on Resident #31's bed staff provided him with the orand told him to use the spond timely.  In on 2/16/22 at 3:47 PM, a red on Resident #31's bed staff provided him with the orand told him to use the spond timely.  In on 2/16/22 at 3:47 PM, a red on Resident #31's bed staff provided him with the orand told him to use the spond timely. |                     |     | call light and will also be rounded on hourly.  3. Measures /Systemic changes to prevent reoccurrence of alleged deficie practice:  On 3/09/22, the Director of Nurses and Nurse Consultant, RN Supervisor bega education of all full time, part time, as needed, agency nurses and CNA's, department managers, housekeeping, activities and therapy staff on facility poon assuring that residents are rounded hourly and call devices answered timel along with applicable resident rights related to dignity. Education will be completed by 3/28/22 at which time all the above must be in-serviced prior to working.  4. Monitoring Procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements.  The Director of Nurses or Designee will monitor compliance utilizing the F550 Resident Rights Quality Assurance Too weekly x 2 weeks then monthly x 3 months or until resolved. Audits will occon various shifts and days of the week include weekends to assure that reside are being rounded on hourly, they have access to a call device and that their dignity is being maintained as it pertain to the timely response to the need for second that their dignity is being maintained as it pertain to the timely response to the need for second that their dignity is being maintained as it pertain to the timely response to the need for second that their dignity is being maintained as it pertain to the timely response to the need for second that their dignity is being maintained as it pertain to the timely response to the need for second that their dignity is being maintained to the need for second that their dignity is being maintained to the need for second that their dignity is being maintained to the need for second that their dignity is being maintained to the need for second that their dignity is being maintained as it pertain to the timely response to the need for second that their dignity is being maintained as it pertain to the timely response to the need f | on policy on y, of at mat cted |                            |
|                          |   | 4's quarterly Minimum data<br>dicated he was cognitively   |                     |     | assistance. The administrator/designe will monitor that residents are being  | е                              |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '               | TIPLE CONSTRUCTION NG   |  | (X3) DATE SURVEY<br>COMPLETED           |  |
|---|---|--|---------------------|---|--|---|--|
|   |   | 345532   | B. WING _           |   | 02   | C<br>2/17/2022                          |  |
| NAME OF PI  | ROVIDER OR SUPPLIER   |  | <u> </u>            | STREET ADDRESS, CITY, STATE, Z  |  | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |  |
| LIDEDTY   | COMMONS NSC AND E   | DELIAD CTD OF LEE COUNTY   |                     | 310 COMMERCE DRIVE  |  |   |  |
| LIDERIT   | COMMONS NSG AND R   | REHAB CTR OF LEE COUNTY  |                     | SANFORD, NC 27332   |  |   |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED DEFICI  | ACTION SHOULD BE<br>TO THE APPROPRIATE   | (X5)<br>COMPLETION<br>DATE              |  |
| F 550   | Continued From pag  | ge 6   | F 5                 | 550   |  |   |  |
| F 550   | intact, exhibited no be independent to exter activities of daily living Resident #4's comparevised 1/25/22 did it staff assistance with (ADLs).  Review of a resident dated 1/20/22 read if staff member not to Resident #4 was in a Council meeting on stated he mentioned resident council meetimes, but nothing havery frustrating where or follow up about we respond to call light.  During an observation Resident #4's call light was no audible sour answered his call light requested to get up wheelchair. NA #1 so 200 hall, you would pressed their call light also due to the breathall.  During an observation of the present hall. | pehaviors and coded as ansive staff assistance with his ang (ADLs).  The hensive care plan last and include a care plan for this activities of daily living a council communication form a cou | F                   | treated in a dignified maresident satisfaction with response time weekly x 3. This will include audi residents on various hal 2 Responsible Parties for with a Brief Interview for below 13. Reports will be weekly Quality Assurant the Director of Nurses to corrective action is initial appropriate. Compliance and the ongoing auditing reviewed at the weekly Quattended by the Adminis Nursing, MDS Coordinal Manager, Health Informand the Dietary Manager. | n call bell 2 and monthly x ting 4 alert Is and contacting or those residents or Mental Status e presented to the ce committee by o ensure sted as e will be monitored g program Quality Assurance A Meeting is strator, Director of tor, Therapy ation Manager, |   |  |
|   |   | I staff provided him with the noon and told him to use the spond timely.   |                     |   |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE<br>A. BUILDING _   | CONSTRUCTION  | (X3) DATE SURVEY COMPLETED |  |
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|  | ROVIDER OR SUPPLIER  COMMONS NSG AND   | REHAB CTR OF LEE COUNTY   | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332 |   | ,                          |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIEI   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORREC'<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE COMPLETION          |  |
| F 550  | AM with the Admini passed out the bell residents with callir stated he was new the call light system stated apparently the August 2021, but the minutes rounds on light responses for the facility as the in December 2021. Heresponse was a dighad implemented in delays.  3. Resident #26 was diagnosis of paraple Review of Resident Data Set (MDS) da cognitively intact ar rejection of his care independent to extend activities of daily live Resident #26's revisindicated he require ADLs. Interventions use his call light for An interview was compared to the state of t | onducted on 2/17/22 at 10:35 strator. He stated the facility is on 2/16/22 to assist and for staff assistance. He to the facility and aware that in did not have any sound. He he system went down in the staff had been doing 10 leach hall to ensure timely call the residents since he came to terim Administrator in the stated timely call light guity concern and the facility the saures to avoid prolonged as admitted 3/5/21 with a legia.  It #26's quarterly Minimum the ted 1/2/22 indicated he was and exhibited the behaviors of the was coded as the same staff assistance with his sing (ADLs). | F 550  |   |                            |  |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDI |     | ONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>PLETED           |
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|                          |  | 345532  | B. WING                |     |  |                   | C<br>17/2022               |
|                          | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY  |                        | 310 | REET ADDRESS, CITY, STATE, ZIP CODE  COMMERCE DRIVE  NFORD, NC 27332   | 1 02/             | 11/2022                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG     | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 550                    | Resident #26's call limus no audible soun Assistant (NA) #5 was call light.  An interview was core PM with NA #5. She some residents were responses to call light round on her halls eviduring meals and moto ensure call lights was atted the call light system last summing was aware.  During an observation small bell was observation small bell was observated bell yesterday and to did not respond time.  An interview was core AM with the Administ passed out the bells residents with calling stated he was new to the call light system of the call li | nn on 2/16/22 at 11:00 AM, ght was observed on. There d. At 12:18 PM, Nursing as observed answering his observed answering his aducted on 2/16/22 at 12:20 stated she was aware that upset over long waits for ats. She stated she tried to very 10 minutes or so but orning ADLs, she was unable over answered timely. NA #5 system lost the audio feature er and that management and that management wed on Resident #26's bed staff provided him with the lid him to use the bell if staff by. | F                      | 550 | DEFICIENCY)  |                   |                            |
|                          | minutes rounds on elight responses for the the facility as the interpolation December 2021. He response was a dign   | staff had been doing 10 ach hall to ensure timely call be residents since he came to erim Administrator in stated timely call light ity concern and the facility easures to avoid prolonged   |                        |     |  |                   |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION   | (X                                | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------------------|---|-----------------------------------|-------------------------------|--|
|   |  | 345532   | B. WING _           |   |                                   | C<br><b>02/17/2022</b>        |  |
|   | ROVIDER OR SUPPLIER  | REHAB CTR OF LEE COUNTY  | '                   | STREET ADDRESS, CITY, STATE, ZIP OF 310 COMMERCE DRIVE SANFORD, NC 27332        | CODE                              | <b>V2</b> 2V22                |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE  | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF<br>( (EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATI | (X5)<br>COMPLETION<br>DATE    |  |
| F 550   | diagnosis of Ceret with right sided he Review of Resider Set (MDS) dated cognitive impairms supervision to total activities of daily light Resident #29's revindicated he required ADLs. Intervention use his call light for An interview was compared to wait sometimes assistance after put his has been a profrustrated him that Resident #26 pressystem in the room make an audible sometimes and within the supervision of the supervision | vas admitted on 7/6/17 with a bral Vascular Accident (CVA) miplegia.  Int #29's annual Minimum Data 1/5/22 indicated moderate ent, no behaviors and I staff assistance with his ving (ADLs).  Vised care plan dated 2/27/21 red staff assistance with his is included encouraging him to or assistance.  Conducted with Resident #29 on M. He stated he frequently had for up to an hour for staff ushing his call light. He stated oblem for months and it there was no improvement. Sed his call light. The call light in and in the bathroom did not ound. Nursing Assist (NA) #4 is minutes.  Conducted on 2/14/22 at 1:00 he stated she was an agency in working at the facility since She stated the call light system in audible sound and staff would 300 hall to observe the light door. NA #4 stated the ced long call light wait times due to the call light system not ted management was aware of | F                   | 550   |                                   |                               |  |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDII | TIPLE CONSTRUCTION  NG   |                             | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|-------------------------|--|-----------------------------|-------------------------------|
|                          |   | 345532   | B. WING _               |  |                             | C<br><b>02/17/2022</b>        |
|                          | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY   | •                       | STREET ADDRESS, CITY, STATE, ZIP COE<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332              | DE .                        | -                             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CO<br>X (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIAT | DATE                          |
| F 550                    | Continued From pag  | e 10   | F t                     | 550  |                             |                               |
|                          | small bell was obserside table. He stated bell yesterday and to did not respond time.  An interview was cor AM with the Administ passed out the bells residents with calling stated he was new to the call light system of stated apparently the August 2021, but the minutes rounds on elight responses for the facility as the interpose was a dign had implemented medelays.  5) Resident #54 was 9/1/17 with diagnose heart failure (CHF), go 2.  Resident #54's active 12/6/21, included a for Daily Living (ADL) set The interventions incomplete the call light for assist A quarterly Minimum assessment dated 1/1/17 | aducted on 2/17/22 at 10:35 crator. He stated the facility on 2/16/22 to assist for staff assistance. He to the facility and aware that did not have any sound. He is system went down in a staff had been doing 10 fach hall to ensure timely call the residents since he came to be sim Administrator in stated timely call light the ity concern and the facility cascures to avoid prolonged admitted to the facility on a sthat included congestive glaucoma and diabetes type the care plan, last reviewed focus area for Activities of elf-care performance deficit. Ituded to encourage use of stance. |                         |  |                             |                               |
|                          | to total assistance fro<br>On 2/14/22 at 9:30 A   | om staff for ADL's. M, Resident #54 was  |                         |  |                             |                               |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | ` IDENTIFICATION NI IMBED:  |                     | PLE CONSTRUCTION  |             | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|---|---------------------|---|-------------|-------------------------------|--|
|  |  | 345532  | B. WING_            |   |             | C<br>2/17/2022                |  |
|  | ROVIDER OR SUPPLIER  | REHAB CTR OF LEE COUNTY   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332        |             |                               |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 550  | chest and stated "this something" but in the been waiting longer call light was turned he had visual deficits which, he had notice had stopped hearing Resident #54 stated wait time felt like an 45 minutes to an howard of the was observed on wit light visible at the top hallway. Nursing Asswithin 5 minutes.  An interview was con PM with NA #4 who aide and had been a November 2021. Shad never made an abeen working at the to be on the specific station to observe th door was on. NA #4 had voiced long call was due to the call limanagement was as The Registered Nursobserved providing hell with a long black PM. She was heard the bell for assistant functioning call light. | ing the call light close to his is is my life line if I need e past "few" months he had for staff assistance when the on. Resident #54 explained is and relied on his hearing, to ed, along with the wait time, if the audible sound as well. It due to his visual deficit the "eternity" but was more like fur most of the time.  AM, Resident #54's call light the no audible sound only a co of the room's door in the sistant (NA) #4 responded  Inducted on 2/14/22 at 1:00 explained she was an agency assisting the facility since he stated the call bell system audible sound since she had facility and staff would need hallway or at the nurses' e light above Resident #54's further stated the residents light wait times which she felt ght system not sounding and ware of the issue.  See (RN) supervisor was Resident #54 a small silver to handle on 2/16/22 at 3:45 telling Resident #54 to use | F 5                 | 50  |             |                               |  |

PRINTED: 03/16/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                           |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING                                    |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|--|---|-------------------------------|--|
|   |   | 345532   | B. WING  |   | C<br><b>02/17/2022</b>        |  |
| NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332 | ,   |                               |  |
| (X4) ID<br>PREFIX<br>TAG  | REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) |                               |  |
| F 554<br>SS=D   | 2/17/22 at 10:35 AM, passed out the silver assist residents with the stated he had bee Administrator since D aware the call light sybut the staff had beer each hall to ensure tir while he was getting the Administrator added the was a dignity concerninglemented measured delays.  Resident Self-Admin CFR(s): 483.10(c)(7)  §483.10(c)(7) The rig medications if the interest defined by §483.21(b) this practice is clinical this REQUIREMENT by:  Based on record revision record revision for 2 of 2 (Residents #1.) with medications at bedsice Findings included:  1. Resident # 1 was a 1/25/21 with multiple Hypertension. The quite size of the si | I with the Administrator on who explained the facility hand bells on 2/16/22 to calling for staff assistance. In acting as the interim ecember 2021 and was stem did not have sound, a doing 10-minute rounds on mely call light responses the system repaired. The imely call light response and felt the facility had es to avoid prolonged  Meds-Clinically Approp  that to self-administer endisciplinary team, as 0(2)(ii), has determined that ally appropriate. It is not met as evidenced  ew, observation and staff ailed to assess whether the medications was clinically sampled residents who were observed to have determined that ally sampled residents who were observed to have determined that ally sampled residents who were observed to have determined that ally sampled residents who were observed to have determined that ally sampled residents who were observed to have determined that all all and the facility on diagnoses including unarterly Minimum Data Set ated 11/3/21 indicated that | F 5  |   | :                             |  |

|                   |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:     | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |                                |  | (X3) DATE SURVEY<br>COMPLETED |                    |
|-------------------|---|--|---|--------------------------------|--|-------------------------------|--------------------|
|                   |   | 245522   | D WING                                  |                                |  | С                             |                    |
|                   |   | 345532   | B. WING _                               |                                |  | 02/                           | 17/2022            |
| NAME OF P         | ROVIDER OR SUPPLIER   |  |   | S                              | TREET ADDRESS, CITY, STATE, ZIP CODE                               |                               |                    |
| LIBERTY           | COMMONS NSG AND R   | REHAB CTR OF LEE COUNTY                                |   | 31                             | 10 COMMERCE DRIVE  |                               |                    |
| LIDLINI           | OOMINIONO NOO AND N   | CHAB OTK OF LEE GOOK!                                  |   | S                              | ANFORD, NC 27332   |                               |                    |
| (X4) ID<br>PREFIX |   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL   | ID<br>PREFI                             | x                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE | Ē                             | (X5)<br>COMPLETION |
| TAG               | REGULATORY OR   | R LSC IDENTIFYING INFORMATION)                         | TAG                                     |                                | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                   |                               | DATE               |
| F 554             | Continued From pag  | ge 13  | F 5                                     | 554                            |  |                               |                    |
|                   |   |  |   |                                | self-administration of medications was                             |                               |                    |
|                   | Review of Resident  | #1's medical records                                   |   |                                | clinically appropriate for resident #1 and                         | d                             |                    |
|                   | including physician's   | orders, assessments and                                |   |                                | #46 who had meds at bedside.                                       |                               |                    |
|                   | care plan, revealed i   | no order to leave the                                  |   |                                | Corrective action for resident(s)                                  |                               |                    |
|                   | medications at beds   | ide and there was no                                   |   |                                | affected by the alleged deficient practic                          | e:                            |                    |
|                   | assessment and car  | e plan for self-administration                         |   |                                | For resident #46 the Director of Nurses                            |                               |                    |
|                   | of medications.   |  |   |                                | completed a self- administration                                   |                               |                    |
|                   |   |  |   | assessment on 2 /23/2022 and a |  |                               |                    |
|                   |   | hysician's order for Tylenol                           |   |                                | physician order was obtained to keep the                           | ne                            |                    |
|                   | (used to treat aches  | and pains) 325 milligrams                              |   |                                | med at bedside and the resident was                                |                               |                    |
|                   | (mgs) tablet - give 3 tablets three times a day for                               |  |   |                                | educated by the Director of Nurses. The                            | е                             |                    |
|                   | pain.   |  |   |                                | medication was removed from the                                    |                               |                    |
|                   |   |  |   |                                | bedside on 2/14/2022 by the nurse                                  |                               |                    |
|                   | Resident #1 was observed up in wheelchair in her                                  |  |   |                                | manager.   |                               |                    |
|                   | room eating lunch on 2/14/22 at 1:10 PM. On top                                   |  |   |                                | For resident #1 the medication was                                 |                               |                    |
|                   |   | able, there was a medicine                             |   |                                | removed from bedside on 2/14/2022 ar                               | ıd                            |                    |
|                   |   | white colored tablets. When                            |   |                                | a physician order was obtained for the                             |                               |                    |
|                   |   | nt #1 stated that the tablets                          |   |                                | medication to be administered on a per                             |                               |                    |
|                   | _   | eported that the Nurse usually                         |   |                                | need basis rather than a scheduled bas                             |                               |                    |
|                   | left them for her to ta   | ake after lunch.                                       |   |                                | The resident was educated on the char                              | nge                           |                    |
|                   | N "0 ' I  | . B : L : 1//4   |   |                                | to PRN availability by the Director of                             |                               |                    |
|                   | Nurse #3, assigned  |  |   |                                | Nurses.  |                               |                    |
|                   |   | 22 at 1:15 PM. She verified                            |   |                                | 2. Corrective action for residents with the                        | ıe                            |                    |
|                   |   | rse who administered the                               |   |                                | potential to be affected by the alleged                            |                               |                    |
|                   | l * <u>.</u>  | #1. She indicated that she                             |   |                                | deficient practice. On 3/04/2022 the RN Supervisor audite          | nd.                           |                    |
|                   |   | nol at bedside for the resident shed eating her lunch. |   |                                | all resident rooms to assure that no                               | u                             |                    |
|                   | וט נמגב מונכו אוב ווווג   | shou eathly her fullon.                                |   |                                | medications were found at bedside that                             | +                             |                    |
|                   | The MDS Nurse was   | s interviewed on 2/17/22 at                            |   |                                | had not been assessed for resident sel                             |                               |                    |
|                   |   | Nurse stated that she started                          |   |                                | -administration with no other concerns                             | •                             |                    |
|                   |   |  |   |                                | identified and there were no other                                 |                               |                    |
|                   | as the MDS Nurse 4-5 months ago. She stated that Resident #1 was not assessed for |  |   |                                | residents who were requesting to                                   |                               |                    |
|                   | self-administration o   |  |   |                                | self-administer medications or to keep                             |                               |                    |
|                   |   |  |   |                                | meds at bedside. No other medications                              |                               |                    |
|                   | The Director of Nurs  | sing (DON) was interviewed                             |   |                                | were found at bedside.   |                               |                    |
|                   |   | M. The DON stated that she                             |   |                                | Measures /Systemic changes to                                      |                               |                    |
|                   |   | not to leave medications at                            |   |                                | prevent reoccurrence of alleged deficie                            | nt                            |                    |
|                   | bedside unattended.   |  |   |                                | practice:  |                               |                    |
|                   |   |  |   |                                | On 3/09/2022 the Director of Nurses, R                             | N                             |                    |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | TIPLE CONSTRUCTION NG  | (X3) DATE SURVEY<br>COMPLETED  |
|--|---|---|---------------------|--|--|
|  |   | 345532  | B. WING _           |  | C<br><b>02/17/2022</b>   |
| NAME OF P  | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP   | •  |
|  |   |   |                     | 310 COMMERCE DRIVE   |  |
| LIBERTY  | COMMONS NSG AND   | REHAB CTR OF LEE COUNTY   |                     | SANFORD, NC 27332  |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICI  | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>X (EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN   | TION SHOULD BE COMPLETION THE APPROPRIATE DATE   |
| F 554  | Continued From p  | age 14  | F 5                 | 554<br>Supervisor and Nurse Co   |  |
|  | 1/10/22 with multi  | ras admitted to the facility on ple diagnoses including anxiety arterly Minimum Data Set (MDS) I 11/3/21 indicated that gnition was intact.   |                     | education of all Full Time,<br>and agency nurses on fac<br>related to medication safe<br>resident assessment for s<br>-administration of medicat<br>safely securing and storing  | ility policy<br>ty that included<br>elf<br>ion process and   |
|  | Resident #46 did<br>plan to self-admin  | not have an assessment or care ister medications.   |                     | Education will be completed. This information has been the standard orientation tr   | ed by 3/28/2022.<br>integrated into  |
|  | 1/10/22 for Calciu  | a physician's order dated<br>m Carbonate (Tums) (a calcium<br>mgs by mouth twice a day (9AM   |                     | required in-service refresh<br>all staff identified above at<br>reviewed by the Quality As<br>process to verify that the of<br>been sustained. The facil   | nd will be<br>ssurance<br>change has   |
|  | closed on 2/14/22<br>the bed table, ther<br>with 2 colored tab<br>Resident #46 stat                   | observed in bed with eyes at 1:12 PM. On top of the over was a medicine cup observed lets. When interviewed, ed that the tablets were Tums. the Nurse usually left them for                       |                     | in-service will be provided Nurses and CNA's who gi care in the facility. Any nursing staff who doe scheduled in-service train allowed to work until traini completed by March 28, 2   | to all agency ve residents s not receive ing will not be ng has been   |
|  | interviewed on 2/1 that she was not t morning medication observed the mediconfirmed that the          | ed to Resident #46 was 4/22 at 1:15 PM. She stated the Nurse who passed the tens for Resident #46. She tications at bedside and ty were Tums. Nurse #3 denied to 46 medications at bedside.       |                     | 4. The monitoring procedulation that the plan of correction that specific deficiency citrorrected and/or in complication regulatory requirements:  Quality assurance audits to completed by the Director designee to assess that the | is effective and ed remains ance with the will be of Nurses or   |
|  | 1:16 PM. She ver<br>who passed the m<br>Resident #46. Sh<br>resident's bedside<br>the night shift who | e was interviewed on 2/14/22 at ified that she was the nurse norning medications for e denied leaving the Tums at She indicated that it might be left the Tums at bedside, but them that morning. |                     | self- administration process compliance and that no ot bedside if the resident is r for self-administration. At weekly for 2 weeks, then months or until resolved for with facility policy on self-of medication process. Re         | es is in ther meds are at the appropriate the addits will be done monthly for 3 or compliance administration |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|---|-----|---|-------------------------------|----------------------------|
|   |  | 345532  | B. WING                                 |     |   |                               | C                          |
| NAME OF PE  | ROVIDER OR SUPPLIER  | 34300Z  |   |     | TREET ADDRESS, CITY, STATE, ZIP CODE  | 02/                           | 17/2022                    |
| LIBERTY   | COMMONS NSG AND RE   | HAB CTR OF LEE COUNTY   |   |     | IO COMMERCE DRIVE<br>ANFORD, NC 27332   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                        | ID<br>PREFI)<br>TAG                     | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  |                               | (X5)<br>COMPLETION<br>DATE |
| F 554   | 2:15 PM. The MDS N<br>as the MDS Nurse 4-<br>that Resident #46 wa<br>self-administration of<br>The Director of Nursin  | interviewed on 2/17/22 at<br>urse stated that she started<br>5 months ago. She stated<br>s not assessed for | F                                       | 554 | presented to the weekly QA committee<br>the Director of Nursing to ensure<br>corrective action is initiated as<br>appropriate. Compliance will be monito<br>and the ongoing auditing program<br>reviewed at the weekly QA Meeting. The<br>weekly QA Meeting is attended by the<br>Administrator, acting Residential Care  | red                           |                            |
| F 558<br>SS=D   | bedside unattended.  Reasonable Accomm   | not to leave medications at odations Needs/Preferences  | F                                       | 558 | Coordinator, Activity Director and the Dietary Manager. Deficiencies that are identified during the monitoring proceswill be addressed through the facility Quality Assurance process.  | 5                             | 3/29/22                    |
| 33-0  | services in the facility accommodation of repreferences except wendanger the health cother residents.  | sident needs and  |   |     |   |                               |                            |
|   | and staff interviews, tresident's call light wiresidents reviewed for (Resident #35).  The findings included Resident #35 was ad 2/12/20 with diagnose palsy, asthma, and resident #35 was ad 2/12/20 with diagnose palsy, and and 2/12/20 with diagnose palsy, asthma, and resident #35 was ad 2/12/20 with diagnose palsy, and and 2/12/20 with diagnose palsy, and 2/12/20 with diagnose palsy, and 2/12/20 with diagnose palsy, and 2/12/20 with diagnose | r accommodation of needs : mitted to the facility on es that included cerebral                              |   |     | The statements made on this plan of correction are not an admission to and 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. |                               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | PLE CONSTRUCTION  G   | (X3) DATE SURVEY<br>COMPLETED  |                            |
|---|--|--|---------------------|---|--|----------------------------|
|   | <b>345532</b> B. WING  |  |                     | C<br>   |  |                            |
| NAME OF PR  | ROVIDER OR SUPPLIER  | •  | •                   | STREET ADDRESS, CITY, STATE, ZIP CODE   |  |                            |
|   |  |  |                     | 310 COMMERCE DRIVE  |  |                            |
| LIBERTY (   | COMMONS NSG AND R  | EHAB CTR OF LEE COUNTY   |                     | SANFORD, NC 27332   |  |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)   | SHOULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 558   | Continued From page  | e 16   | F 5                 | 58  |  |                            |
|   | assistance with the control Daily Living (ADL) take A quarterly Minimum assessment dated 1/  |  |                     | The facility failed to place a caresident reach.  1. Corrective action for residaffected by the alleged deficie  On 2/17/2022 resident #35 calplaced within resident's reach  | lent(s)<br>nt practice:<br>Il light was  |                            |
|   | assistance with bed  |  |                     | Registered Nurse Supervisor.  | by tile  |                            |
|   | included the following<br>- Actual fall with risk<br>balance/unsteady ga<br>to ensure the call ligh<br>- ADL self-performan  | for more due to poor it. The interventions included it was within reach. ce deficit related to cerebral ons included to encourage  |                     | <ol> <li>Corrective action for resid<br/>the potential to be affected by<br/>deficient practice.</li> <li>All residents have the potential<br/>affected. On 3/04/2022 the RN<br/>audited all residents for reached<br/>to a call device with no other of<br/>found.</li> </ol>  | the alleged  If to be If supervisor the same access  |                            |
|   | On 2/14/22 at 9:40 AM, an observation occurred of Resident #35 while she was lying in bed. The call light was under her bed out of reach.  Resident #35 stated the call light was there most of the time and she would yell out when she |  |                     | Measures /Systemic char prevent reoccurrence of allege practice:  On 3/09/22, the Director of Nu  | ed deficient<br>rses and   |                            |
|   | 9:28 AM. Resident #: word puzzles. Her ca of reach. When aske assistance, she state when they entered th passing by or by yelli  Resident #35 was ob PM, sitting up in a wh call light was observe reach.                                | was made on 2/15/22 at 35 was in her bed working on all light was under the bed out d how she would request ad she would let staff know he room, when they were ng out for assistance.  Served on 2/15/22 at 12:03 heelchair in her room. The hed to be under her bed out of M, Resident #35 was |                     | Nurse Consultant, RN Supervieducation of all full time, part that agency nurses and CNA's, ad housekeeping, activities and thousekeeping, activities and that they need assist Education will be completed by which time all of the above multin-serviced prior to working.  4. Monitoring Procedure to eather plan of correction is effecting specific deficiency cited remained and/or in compliance with regular requirements. | ime, PRN, ministrator, herapy staff nat residents all device to stance. y 3/28/22 at ust be ensure that we and that ns corrected |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |   |         | (X3) DATE SURVEY<br>COMPLETED  |           |                     |
|--|--|---|---|---------|--|-----------|---------------------|
|  |  | 345532  | B. WING _   | B. WING |  |           | C<br><b>17/2022</b> |
|  | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY  | •   | 31      | REET ADDRESS, CITY, STATE, ZIP CODE<br>10 COMMERCE DRIVE<br>ANFORD, NC 27332   | , , ,     |                     |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH  |   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |         | (X5)<br>COMPLETION<br>DATE   |           |                     |
| F 558  |  | r bed completing a word   | F 5   | 558     | The Director of Nurses or Designee wil   | I         |                     |
|  | of reach.  | remained under the bed out  vas interviewed on 2/16/22 at   |   |         | monitor compliance utilizing the Call Device Quality Assurance Tool weekly weeks then monthly x 3 months or untiresolved.  |           |                     |
|  | 2:00 PM and indicate agency and had been since November 2027 resident and indicated was under Resident # placed it within reach why the call light had |   |   |         | Audits will occur on various shifts and days of the week to include weekends assure that residents are able to acces reachable call device to request staff assistance. Reports will be presented the weekly Quality Assurance committed by the Director of Nurses to ensure   | s a<br>to |                     |
|  | 2/17/22 at 5:33 PM, a  | hts to be within reach of all   |   |         | corrective action is initiated as appropriate. Compliance will be monitorand the ongoing auditing program reviewed at the weekly Quality Assurar Meeting. The weekly QA Meeting is attended by the Administrator, Director Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. | of        |                     |
| F 561<br>SS=E  | Self-Determination<br>CFR(s): 483.10(f)(1)-  | (3)(8)  | F 5   | 561     | and the blottery manager.  |           | 3/29/22             |
|  | promote and facilitate through support of res  | right to and the facility must<br>resident self-determination<br>sident choice, including but<br>is specified in paragraphs (f) |   |         |  |           |                     |
|  | activities, schedules (<br>waking times), health   |   |   |         |  |           |                     |

| NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS NS AND REHAB CTR OF LEE COUNTY    SUMMARY STATEMENT OF DEFICIENCES   SAMFORD, NC 27332   | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |                                | ` ′      | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|---|--------------------------------|----------|--|-------------------------------|--|
| STREET ADDRESS. CITY. STATE. ZIP CODE   310 COMMERCE DRIVE   SANFORD, NC 27332   |  | 345532  |                                | B. WING  |  |                               |  |
| LIBERTY COMMONS NS AND REHAB CTR OF LEE COUNTY    KENDER   SUMMARY STATEMENT OF DEFICIENCIES   | NAME OF P  | ROVIDER OR SUPPLIER                             |                                | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODE  | 1 02/11/2022                  |  |
| SAMORD, No. 27332   DePRICIPATION   PREFIX TAG   PROVIDERS PLAN OF CORRECTION   PROVIDERS PLAN OF COMPITION   PROVIDERS PLAN OF CORRECTION   PROV   |  |   |                                |          | 310 COMMERCE DRIVE   |                               |  |
| FREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  FS61  Continued From page 18 \$483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.  \$483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.  \$483.10(f)(8) The resident has a right to interact with members of the community activities that do not interfere with the rights of other residents in the facility.  This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to honor residents' choices related to showers and shampoos. This was for 3 of 4 residents reviewed for choices (Residents #35, #44 and #1).  The findings included:  1) Resident #35 was admitted to the facility on 2/12/20 with multiple diagnoses that included cerebral palsy, osteoarthritis, and restless leg syndrome.  The annual Minimum Data Set (MDS) assessment dated 1/1/2/22 revealed Resident #35 was cognitively intact, displayed no rejection of care and was coded as it being very important to choose between a bed bath or shower.  A quarterly MDS assessment dated 1/31/22 indicated Resident #35 was cognitively intact and   | LIBERTY  | LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY |                                |          | SANFORD, NC 27332  |                               |  |
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| 2/12/20 with multiple diagnoses that included cerebral palsy, osteoarthritis, and restless leg syndrome.  F561 The facility failed to provide showers for the below residents:  1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #35, on 03/03/2022 the choose between a bed bath or shower.  A quarterly MDS assessment dated 1/31/22 indicated Resident #35 was cognitively intact and deficiencies cited have been or will be corrected by the dates indicated.  F561 The facility failed to provide showers for the below residents:  1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #35, on 03/03/2022 the Director of Nurses updated the resident's shower task to Tuesday/Friday evening shift. A shower/shampoo was received by the resident on 3/08/2022.   |  | 1) Resident #35 was                             | admitted to the facility on    |          | , ,  |                               |  |
| syndrome.  The annual Minimum Data Set (MDS) assessment dated 1/12/22 revealed Resident #35 was cognitively intact, displayed no rejection of care and was coded as it being very important to choose between a bed bath or shower.  A quarterly MDS assessment dated 1/31/22 indicated Resident #35 was cognitively intact and  F561 The facility failed to provide showers for the below residents:  1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #35, on 03/03/2022 the Director of Nurses updated the resident's shower task to Tuesday/Friday evening shift. A shower/shampoo was received by the resident on 3/ 08 /2022.   |  | •   |                                |          |  | e                             |  |
| The annual Minimum Data Set (MDS) assessment dated 1/12/22 revealed Resident #35 was cognitively intact, displayed no rejection of care and was coded as it being very important to choose between a bed bath or shower.  A quarterly MDS assessment dated 1/31/22 indicated Resident #35 was cognitively intact and  F561 The facility failed to provide showers for the below residents:  1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #35, on 03/03/2022 the Director of Nurses updated the resident's shower task to Tuesday/Friday evening shift. A shower/shampoo was received by the resident on 3/ 08 /2022.  |  | cerebral palsy, osteo                           | arthritis, and restless leg    |          | corrected by the dates indicated.  |                               |  |
| The annual Minimum Data Set (MDS) assessment dated 1/12/22 revealed Resident #35 was cognitively intact, displayed no rejection of care and was coded as it being very important to choose between a bed bath or shower.  A quarterly MDS assessment dated 1/31/22 indicated Resident #35 was cognitively intact and  for the below residents:  1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #35, on 03/03/2022 the Director of Nurses updated the resident's shower task to Tuesday/Friday evening shift. A shower/shampoo was received by the resident on 3/ 08 /2022.  |  | syndrome.                                       |                                |          |  |                               |  |
| assessment dated 1/12/22 revealed Resident #35 was cognitively intact, displayed no rejection of care and was coded as it being very important to choose between a bed bath or shower.  A quarterly MDS assessment dated 1/31/22 indicated Resident #35 was cognitively intact and  1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #35, on 03/03/2022 the Director of Nurses updated the resident's shower task to Tuesday/Friday evening shift. A shower/shampoo was received by the resident on 3/ 08 /2022.  |  |   |                                |          |  | owers                         |  |
| was cognitively intact, displayed no rejection of care and was coded as it being very important to choose between a bed bath or shower.  A quarterly MDS assessment dated 1/31/22 indicated Resident #35 was cognitively intact and affected by the alleged deficient practice: For resident #35, on 03/03/2022 the Director of Nurses updated the resident's shower task to Tuesday/Friday evening shift. A shower/shampoo was received by the resident on 3/ 08 /2022.   |  |   |                                |          |  |                               |  |
| care and was coded as it being very important to choose between a bed bath or shower.  A quarterly MDS assessment dated 1/31/22 indicated Resident #35 was cognitively intact and  For resident #35, on 03/03/2022 the Director of Nurses updated the resident's shower task to Tuesday/Friday evening shift. A shower/shampoo was received by the resident on 3/ 08 /2022.  |  |   |                                |          | , ,  |                               |  |
| choose between a bed bath or shower.  Director of Nurses updated the resident's shower task to Tuesday/Friday evening shift. A shower/shampoo was received by indicated Resident #35 was cognitively intact and the resident on 3/ 08 /2022.   |  |   |                                |          |  | tice:                         |  |
| A quarterly MDS assessment dated 1/31/22 shift. A shower/shampoo was received by indicated Resident #35 was cognitively intact and the resident on 3/ 08 /2022.  |  |   |                                |          |  | ont's                         |  |
| A quarterly MDS assessment dated 1/31/22 shift. A shower/shampoo was received by indicated Resident #35 was cognitively intact and the resident on 3/ 08 /2022.  |  | choose between a be                             | eu baill of Shower.            |          | ·  |                               |  |
| indicated Resident #35 was cognitively intact and the resident on 3/ 08 /2022.   |  | Δ quarterly MDS asse                            | essment dated 1/31/22          |          |  |                               |  |
|  |  |   |                                |          | The state of the s | ,u by                         |  |
| LUISDIAYEU NO DENAYOLS OF TELEGION OF GALE, ONE TO THE TOTAL TESTOREN #44 ON US/US/ZUZZ INC.   |  |   |                                |          | For resident #44, on 03/03/2022 the  |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | I DENTIFICATION NUMBER:   |                     | 2) MULTIPLE CONSTRUCTION BUILDING |  |                              | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|---|---------------------|-----------------------------------|--|------------------------------|-------------------------------|--|
|   |   | 345532  | B. WING _           |                                   |  |                              | C<br>17/2022                  |  |
| NAME OF PR  | ROVIDER OR SUPPLIER   | <u> </u>  |                     | ST                                | TREET ADDRESS, CITY, STATE, ZIP CODE   | 1 02/                        | 1772022                       |  |
|   |   |   |                     |                                   | 0 COMMERCE DRIVE   |                              |                               |  |
| LIBERTY (   | COMMONS NSG AND R   | EHAB CTR OF LEE COUNTY  |                     |                                   | ANFORD, NC 27332   |                              |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | ×                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  |                              | (X5)<br>COMPLETION<br>DATE    |  |
| F 561   | Continued From pag  | ne 19   | F 5                 | 561                               |  |                              |                               |  |
|   | and extensive assist<br>dressing. Limited rar<br>both upper extremitie  |   |                     |                                   | Director of Nurses updated the resident shower task to Tuesday/Friday evening shift. A shower/shampoo was offered a refused on 3/4/2022 and 3/08/2022. Bed baths we  | ]<br>nd                      |                               |  |
|   | Resident #35's active care plan, last reviewed on 2/1/22, included a focus area for "Activities of Daily Living (ADL) deficit related to disease process". The interventions included to offer choices in daily care. |   |                     |                                   | provided by nursing staff. For resident # 1, on 03/03/2022 the Director of Nurses updated the resident shower task to Tuesday/Friday day shi shower/shampoo was offered on   | ft. A                        |                               |  |
|   | revealed she had so<br>and Friday evenings<br>Nursing progress no   | t #35's medical record heduled showers on Tuesday (3:00 PM to 11:00 PM shift). tes were reviewed from d did not reveal any refusals ng assistance.  |                     |                                   | <ul> <li>3/04/2022 and 3/08/2022 and refused the resident. Bed baths were provided staff.</li> <li>2. Corrective action for residents with the potential to be affected by the alleg deficient practice.</li> </ul>  | by<br>1                      |                               |  |
|   | bathing/shower docusheets from 9/25/21 #35 refused a shower on her scheduled shower friday on 10/15/21 adocumentation reveal  | t #35's Nursing Assistant (NA) umentation and facility shower to 2/15/22 indicated Resident er and requested a bed bath ower days of Tuesday and and 10/22/21. The NA aled she had received a n 10/19/21, 11/9/21, 11/30/21, 1.   |                     |                                   | All residents have the potential to be affected. On 02/24/2022 the Nurse Manager interviewed all current alert a oriented residents for their preference regarding shower days.  The Director of Nurses /MDS nurse will then task the requested shower schedule to PCC task to fire to the CNA's for documentation. This will be completed 03/04/2022.   | l<br>ule                     |                               |  |
|   | 2/14/22 at 9:40 AM, receive her schedule twice a week. Resid been "a while" since shower/shampoo, or instead. She stated swashing her lower le Resident #35 stated were Tuesday and F                                 | d with Resident #35 on who stated she would like to ed showers and shampoos lent #35 explained it had she had received a hly receiving a bed bath she required assistance with egs, back, shoulders and hair, her scheduled shower days riday in the evening and she em completed as scheduled. |                     |                                   | For current non-alert and oriented residents, the Certified Nursing Assista were educated by the nurse manager of the new facility shower schedule and the sche | on<br>nat<br>ers<br>e<br>wer |                               |  |

| OF DEFICIENCIES<br>F CORRECTION   | IDENTIFICATION NUMBER:   |   |   | (X3) DATE SURVEY<br>COMPLETED   |
|---|--|---|---|---|
|   | 345532   | B. WING   |   | C<br>02/17/2022   |
| PROVIDER OR SUPPLIER  | •  |   | STREET ADDRESS, CITY, STATE, ZIP CODE   | 1 02/11/2022  |
| LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY   |  |   | 310 COMMERCE DRIVE  |   |
|   |  |   | SANFORD, NC 27332   |   |
| (EACH DEFICIEN  | ICY MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | JLD BE COMPLETION   |
| Continued From page   | ge 20  | F 56  | 1   |   |
|   |  |   | schedule unless they refuse. If they  |   |
| up in a wheelchair in   | n the hallway and stated she   |   | bed bath will be provided by nursing and showers/shampoos will con to be offered following their prefere and  | ntinue  |
| AM. She was lying puzzle. She stated s shower/shampoo as received a bed bath  | in bed working on a word<br>she didn't receive her<br>s scheduled last night but<br>instead. Stated the NA had   |   | shower schedule> The responsible will be notified of refusa 3. Measures /Systemic changes prevent reoccurrence of alleged de practice: On 03/09/2022 Director of Nurses, Consultant and the Nurse Manager education to all full time, part time.  | to<br>rficient<br>Nurse<br>r began  |
| NA #4. She explain agency, had been a November 2021 and 3:00 PM and 3:00 P was familiar with Rebaths were provided showers. Stated she  | ed she worked with an ssisting the facility since d worked both the 7:00 AM to M to 11:00 PM shifts. NA #4 esident #35 and stated bed d to her since she refused her e would use a washcloth to  |   | and agency Nurses and CNA's on following:  New revised shower schedule Refusal documentation Documentation of completion i tasks. This information has been integrate the standard orientation training an required in-service refresher course all staff identified above and will be  | in PCC ed into id in the es for   |
| 3:55 PM. She worked shift and was familiar not assigned to care not recall Resident as showers and preferr was served. NA #3 was provided to Resident Aphone interview of 2/17/22 at 3:40 PM. | ed the 3:00 PM to 11:00 PM ar with Resident #35 but was a for her often. NA #3 could #35 refusing scheduled red to get them before dinner had documented a shower sident #35 on 12/31/21.  ccurred with NA #12 on She explained she worked   |   | process to verify that the change had been sustained. The facility specificin-service will be provided to all age Nurses and CNA's who give reside care in the facility. Any nursing states does not receive scheduled in-servitraining will not be allowed to work training has been completed by Ma 2022.  4. Monitoring Procedure to ensur   | as ic ency ents aff who rice until arch 28,   |
|   | COMMONS NSG AND F  SUMMARY S (EACH DEFICIEN REGULATORY OF SUMMARY S) (EACH DEFICIEN RE | ROVIDER OR SUPPLIER  COMMONS NSG AND REHAB CTR OF LEE COUNTY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 20 Resident #35's hair was unbrushed and had a greasy appearance.  On 2/15/22 at 3:43 PM, Resident #35 was sitting up in a wheelchair in the hallway and stated she was to get her shower this evening.  Resident #35 was interviewed on 2/16/22 at 8:29 AM. She was lying in bed working on a word puzzle. She stated she didn't receive her shower/shampoo as scheduled last night but received a bed bath instead. Stated the NA had no response when she asked why she couldn't get a shower.  On 2/16/22 at 2:00 PM an interview occurred with NA #4. She explained she worked with an agency, had been assisting the facility since November 2021 and worked both the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts. NA #4 was familiar with Resident #35 and stated bed baths were provided to her since she refused her showers. Stated she would use a washcloth to provide shampoos when bed baths were | ROVIDER OR SUPPLIER  COMMONS NSG AND REHAB CTR OF LEE COUNTY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 20  Resident #35's hair was unbrushed and had a greasy appearance.  On 2/15/22 at 3:43 PM, Resident #35 was sitting up in a wheelchair in the hallway and stated she was to get her shower this evening.  Resident #35 was interviewed on 2/16/22 at 8:29  AM. She was lying in bed working on a word puzzle. She stated she didn't receive her shower/shampoo as scheduled last night but received a bed bath instead. Stated the NA had no response when she asked why she couldn't get a shower.  On 2/16/22 at 2:00 PM an interview occurred with NA #4. She explained she worked with an agency, had been assisting the facility since November 2021 and worked both the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts. NA #4 was familiar with Resident #35 and stated bed baths were provided to her since she refused her showers. Stated she would use a washcloth to provide shampoos when bed baths were provided.  An interview occurred with NA #3 on 2/16/22 at 3:55 PM. She worked the 3:00 PM to 11:00 PM shift and was familiar with Resident #35 but was not assigned to care for her often. NA #3 could not recall Resident #35 refusing scheduled showers and preferred to get them before dinner was served. NA #3 had documented a shower was provided to Resident #35 on 12/31/21.  A phone interview occurred with NA #12 on 2/17/22 at 3:40 PM. She explained she worked | ROVIDER OR SUPPLIER  COMMONS NSG AND REHAB CTR OF LEE COUNTY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 20  Resident #35's hair was unbrushed and had a greasy appearance.  On 2/15/22 at 3:43 PM, Resident #35 was sitting upin a wheelchair in the hallway and stated she was to get her shower this evening.  Resident #35 was interviewed on 2/16/22 at 8:29 AM. She was lying in bed working on a word puzzle. She stated she didn't receive her shower/shampoo as scheduled last night but received a bed bath instead. Stated the NA had no response when she asked why she couldn't get a shower.  On 2/16/22 at 2:00 PM an interview occurred with NA #4. She explained she worked with an agency, had been assisting the facility since November 2021 and worked both the 7:00 AM to 3:00 PM to 11:00 PM shifts. NA #4 was familiar with Resident #35 and stated bed baths were provided to her since she refused her showers. Stated she would use a washcloth to provide shampoos when bed baths were provided.  An interview occurred with NA #3 on 2/16/22 at 3:55 PM. She worked the 3:00 PM to 11:00 PM shift and was familiar with Resident #35 but was not assigned to care for her often. NA #3 could not recall Resident #35 for 12/31/21.  A phone interview occurred with NA #3 to 2/31/21.  A phone interview occurred with NA #12 on 2/17/22 at 3:40 PM. She explained she worked |

| AND PLAN OF CORRECTION IDENTIFICATION   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ` ′   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|---|--|--|-------------------------------|--|
|   |  | 345532  | B. WING   |  |  | C<br><b>02/17/2022</b>        |  |
| NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY |  |   | STREET ADDRESS, CITY, STATE, ZIP COL<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332 | DE   | 02/11/2022   |                               |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)   | N SHOULD BE<br>E APPROPRIATE   | (X5)<br>COMPLETION<br>DATE    |  |
| F 561   | was familiar with Rewas most often assishe worked. NA #12 baths and not show kind of transfer assiresidents. NA #12 care by Resident #3 On 2/17/22 at 5:33 limits the Director of employed at the fact felt the lack of according for not providing schadded she expected provided/offered on and if a resident refidocumentation on big well as nursing programmed as nursing program | the facility for 2 months. She isident #35 and stated she gned to care for her when a stated she only provided bed it is stated she only provided bed it is stance was needed for the could not recall any refusals of it.  PM, an interview was held it is not interview was held it is not interview was held it is not interview. Was held it is not interview was held interview. She was held interview and be not blame interview in the DON interview in the DON interview interview in the DON interview in the NA documentation as it is originally admitted to the interview in the interview pulmonary into it is not interview in the | F 56  | and/or in compliance with regrequirements.  The Director of Nurses or demonitor compliance utilizing the Quality Assurance Tool week weeks then monthly x 3 monitor shower compliance.  Worker or designee will monitor satisfaction with showers were monthly x 3 or until resolved. The Nurses to ensure corrective a initiated as appropriate. Combe monitored and the ongoin program reviewed at the week Assurance Meeting or until dinecessary for compliance with The weekly QA Meeting is at Administrator, Director of Nur Coordinator, Therapy Manag Information Manager, and the Manager. | signee will the F677 ly for 2 ths or until rsing will The Social itor ekly x 2 and Reports will Quality Director of action is pliance will g auditing ekly Quality eemed not th ADL Care tended by the rsing, MDS er, Health |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` ′   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |                        |
|---|--|---|---|--|------------------------|
|   |  | 345532  | B. WING                                 |  | C<br><b>02/17/2022</b> |
|   | NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332                           | 1 VEHINEVEE            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION          |
| F 561   | related to general of interventions included the sensitive skin, passistance with ground offer choices in the revealed she had sand Friday evening Nursing progress in 10/1/21 to 2/15/22 for showers or bath. The Director of Nurfollowing Nursing A sheets for Residen showers for Tuesday time period of 10/1/2 - Friday 10/22/21- rindication of a bath - Tuesday 2/1/22- rindication of a bath - Tuesday 2/15/22- stated she does he indication of a bath The DON stated she documentation region bathing.  An interview occurr 2/14/22 at 11:15 Al "remember the last hair washed". She her hair felt greasy, she would "love to week if they couldned She was able to state and offer the sensitive she was able to state the sensi | deconditioning". The deconditioning". The deconditioning". The ded to avoid scrubbing and pat preference of showers, staff doming and personal hygiene in daily care.  Int #44's medical record decheduled showers on Tuesday is (3:00 PM to 11:00 PM shift), otes were reviewed from and did not reveal any refusals along assistance.  It will be a serious decided the decided as in the decided as serious did not reveal any refusals along assistant (NA) facility shower to the decided and the decided as refused with no provided.  In the decided as refused with no provided.  In the decided as refused bath and the rown. There was no | F 561                                   |  |                        |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION  | (X3) DATE SURVEY COMPLETED C |
|--------------------------|---|---|-----------------------------|---|------------------------------|
|                          |   | 345532  | B. WING                     |   | 02/17/2022                   |
|                          | ROVIDER OR SUPPLIER   | REHAB CTR OF LEE COUNTY   | ;                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br>B10 COMMERCE DRIVE<br>SANFORD, NC 27332                    | ,                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICS) | D BE COMPLETION              |
| F 561                    | Continued From pag  | ge 23   | F 561                       |   |                              |
|                          | how she kept herse  | retrieve her. When asked<br>If clean she stated, "I use<br>n my body and wipe my hair   |                             |   |                              |
|                          | 9:50 AM. She was s<br>a game on her phor<br>scheduled for a sho<br>but no one came to<br>one. Resident #44 a  | nterviewed again on 2/17/22 at<br>sitting on her bedside playing<br>ne. She explained she was<br>wer on Tuesday of this week,<br>ask her or retrieve her for<br>added she had not refused<br>ally wanted her hair washed  |                             |   |                              |
|                          | She worked the 7:00 was familiar with Revery independent. I #44 was scheduled   | AM, NA #2 was interviewed.  AM to 3:00 PM shift and esident #44, stating she was NA #2 was aware Resident for showers in the evening f any refusals for personal  |                             |   |                              |
|                          | 3:55 PM. She work<br>shift and was most of<br>Resident #44 when<br>Resident #44 "did h<br>recall her refusing s<br>facility shower shee<br>stated Resident #44<br>that evening but fail | ed with NA #7 on 2/17/22 at ed the 3:00 PM to 11:00 PM often assigned to care for she worked. NA #7 stated er own thing" but could not howers. When reviewing the t for 2/1/22 and 2/15/22 she must have refused a shower ed to document what type of She was unable to answer hair was washed. |                             |   |                              |
|                          | with the Director of employed at the factorial felt the lack of accordance.   | PM, an interview was held<br>Nursing (DON) who had been<br>ility since January 2022. She<br>untability could be to blame<br>owers and shampoos as   |                             |   |                              |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | (X2) MULTIPLI<br>A. BUILDING | E CONSTRUCTION  | (X3) DATE SURVEY COMPLETED |  |
|--|--|--|------------------------------|---|----------------------------|--|
|  |  | 345532   | B. WING                      |   | C<br>02/17/2022            |  |
|  | ROVIDER OR SUPPLIER  | REHAB CTR OF LEE COUNTY  | ;                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332                        | VEHINZUZZ                  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETION              |  |
| F 561  | showers and shampy the scheduled show 3. Resident #1 was 1/25/21 with multiple above the knee ame admission Minimum dated 2/1/21 indicated important for Reside bath, showers, bed quarterly MDS asset indicated that Reside and she did not have care.  Resident #1's care reviewed. The care activity of daily livin deficit related to act AKA. The approach choices in my daily Review of the facility revealed that Reside a shower twice a weard that the shown 4 months (October Resident #1 did not bath.  Resident #1 was im AM, She stated that since she was admit reported that the could not get in the legs. She added the | DN added she expected coos to be provided/offered on ver days.  admitted to the facility on e diagnoses including bilateral putation (AKA). The n Data Set (MDS) assessment ted that it was somewhat ent #1 to choose between tub bath or sponge bath. The essment dated 11/3/21 lent #1's cognition was intact, we behaviors of rejection of plan dated 11/3/21 was a plan problem was "I have an g (ADL) self-care performance civity intolerance and bilateral les included "to offer me care."  y's shower scheduled ent #1 was scheduled to have eek every Monday and | F 561                        |   |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     | (X3) DATE SURVEY COMPLETED   |                        |
|--|--|---|---------------------|--|------------------------|
|  |  | 345532  | B. WING             |  | C<br><b>02/17/2022</b> |
|  | ROVIDER OR SUPPLIER  | REHAB CTR OF LEE COUNTY   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332                           | , VETTIZEE             |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY) | D BE COMPLÉTION        |
| F 561  | her hair was only way was in the building a been coming due to Nurse Aide (NA) #1: was interviewed on stated that she was not work at the facilidid not know the sol Resident #1, but she beauty shop this moderate NA #1, assigned to on 2/17/22 at 9:30 A #1 had refused show she had documented. The Director of Nurse on 2/17/2 at 3:34 Pt started as DON of the She stated that she the shower as schere resident had refused due to the turn- over was no oversight or showers were proving the state of the shower were proving the state of the state of the shower were proving the state of the | y day. Resident #1 stated that ashed when the beautician and the beautician had not the COVID outbreak.  3, assigned to Resident #1, 2/16/22 at 1:40 PM. The NA an agency staff, and she did ty often. She added that she neduled shower days for e had her hair done in the brining.  Resident #1, was interviewed M. She stated that Resident wers, but she did not know if | F 56                | 1  |                        |
| F 565<br>SS=D  | them accountable. Resident/Family Gro CFR(s): 483.10(f)(5) §483.10(f)(5) The re and participate in re (i) The facility must group, if one exists, reasonable steps, w  | oup and Response  | F 56                | 5  | 3/29/22                |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION  G  | , ,  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|---------------------|--|--|-------------------------------|--|
|  |  | 345532   | B. WING _           |  |  | C<br>2/17/2022                |  |
|  | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY   |                     | STREET ADDRESS, CITY, STATE, ZIP COI<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332  |  | 2/11/2022                     |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | N SHOULD BE<br>E APPROPRIATE   | (X5)<br>COMPLETION<br>DATE    |  |
| F 565  | resident group or far the respective group (iii) The facility must person who is approgroup and the facility providing assistance requests that result f (iv) The facility must resident or family groups concerning is in the facility.  (A) The facility must response and rationa (B) This should not be facility must implement request of the resident of the resident of the resident of the facility must implement facility must implement for the facility must implement for the resident of the facility member (s) or representative (s) metallity member (s) or repres | in a timely manner.  other guests may attend nily group meetings only at 's invitation.  provide a designated staff ved by the resident or family and who is responsible for and responding to written from group meetings.  consider the views of a oup and act promptly upon ecommendations of such issues of resident care and life  be able to demonstrate their ale for such response. The construed to mean that the ent as recommended every and or family group.  In sident has a right to groups.  In sident has a right to have other resident teet in the facility with the epresentative(s) of other ty.  The is not met as evidenced  and staff interviews and cility failed to communicate to address group concerns and Council (RC) meetings to concerns for 2 of 2 months the eting minutes reviewed.  detically in the contents the concerns for 2 of 2 months the eting minutes reviewed.  detically in the contents the concerns for 2 of 2 months the eting minutes reviewed.  detically in the contents the concerns for 2 of 2 months th | F 5                 | The statements made on thi correction are not an admiss not constitute an agreement alleged deficiencies.  To remain in compliance with and state regulations the facior will take the actions set for plan of correction. The plan of constitutes the facility's allegations. | ion to and do with the n all federal ility has taken rth in this of correction |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | IDENTIFICATION NUMBER:  |                    | TIPLE CONSTRUCTION ING |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|---|--------------------|------------------------|---|-------------------------------|----------------------------|
|   |   | 345532  | B. WING            |                        |   | C<br><b>02/17/2022</b>        |                            |
| NAME OF D   | ROVIDER OR SUPPLIER                               | 0.70002   |                    | 6.                     | TREET ADDRESS, CITY, STATE, ZIP CODE  | 1 02/                         | 17/2022                    |
| NAME OF FI  | NOVIDER OR SUFFLIER                               |   |                    |                        |   |                               |                            |
| LIBERTY (   | COMMONS NSG AND I                                 | REHAB CTR OF LEE COUNTY   |                    |                        | 10 COMMERCE DRIVE   |                               |                            |
|   |   |   |                    | S                      | ANFORD, NC 27332  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEN                                    | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG |                        | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 565   | Continued From pa                                 | ge 27   | F t                | 565                    |   |                               |                            |
|   | 12/16/21 indicated s                              | several concerns related to   |                    |                        | compliance such that all alleged  |                               |                            |
|   | nursing. A RC comr                                | nunication form was   |                    |                        | deficiencies cited have been or will be   |                               |                            |
|   | _   | esident concerns and verbal   |                    |                        | corrected by the dates indicated.   |                               |                            |
|   |   | ded to each resident  |                    |                        | ,   |                               |                            |
|   |   | ommunication form dated   |                    |                        | F565 The facility failed to communicate   | )                             |                            |
|   | 12/16/21 included a                               | concern voiced by Resident  |                    |                        | the facility 's efforts to address group  |                               |                            |
|   | #3. Her quarterly M                               | inimum Data Set (MDS) dated   |                    |                        | concerns  |                               |                            |
|   | 11/6/21 indicated sh                              | ne was cognitively intact.  |                    |                        | voiced in the Resident Council (RC)   |                               |                            |
|   |   |   |                    |                        | meetings.   |                               |                            |
|   |   | neeting minutes dated 1/20/22   |                    |                        | Corrective action for resident(s)   |                               |                            |
|   | indicated several concerns related to nursing and |   |                    |                        | affected by the alleged deficient praction  |                               |                            |
|   |   | RC communication form was   |                    |                        | Resident Council meeting was held on  |                               |                            |
|   |   | nistration regarding no   |                    |                        | 2/24/2022. Minutes were taken by the  |                               |                            |
|   | •   | ncerns raised by the RC   |                    |                        | Activities Director. Concerns from the  |                               |                            |
|   |   | mmunication forms dated   |                    |                        | previous RC meeting on 1/20/22 were   |                               |                            |
|   |   | concerns voiced by Resident   |                    |                        | addressed and residents noted that the  |                               |                            |
|   |   | . His quarterly MDS dated   |                    |                        | had been improvements in response to  | 1                             |                            |
|   | 11/10/21 indicated f                              | ne was cognitively intact.  |                    |                        | their grievances/concerns.  |                               |                            |
|   | A DO ti   |   |                    |                        | 2. Corrective action for residents with   |                               |                            |
|   | _   | conducted on 2/15/22 at 9:30  |                    |                        | the potential to be affected by the alleg   | ea                            |                            |
|   |   | ellert and oriented participants,   |                    |                        | deficient practice.   |                               |                            |
|   |   | Resident #3) and another  |                    |                        | Beginning February 24, 2022 the prior   |                               |                            |
|   |   | #4) who routinely attended the dents voiced frustration with                                |                    |                        | month's grievances/concerns will be reviewed after review of resident rights                                |                               |                            |
|   | _   | dents voiced indication with  |                    |                        | information on how to make a  | ,                             |                            |
|   |   | e RC meetings. They stated  |                    |                        | grievance/concerns and survey   |                               |                            |
|   | _   | evelopment since the previous   |                    |                        | information, and ambassador informati   | on                            |                            |
|   |   | D) resigned in November   |                    |                        | Current grievances/concerns as well as  |                               |                            |
|   |   | the new AD started the first  |                    |                        | ongoing grievances/concerns from the  |                               |                            |
|   | part of December 2                                |   |                    |                        | previous month will be completed direct   |                               |                            |
|   | •   |   |                    |                        | after the meeting by the Activities Direc   | •                             |                            |
|   | An interview was co                               | onducted on 2/16/22 at 9:15   |                    |                        | ]   |                               |                            |
|   |   | e stated she started as the AD  |                    |                        | 3.Measures /Systemic changes to prev  | ent ent                       |                            |
|   |   | ther stated she did not review  |                    |                        | reoccurrence of alleged deficient practi  |                               |                            |
|   | the December 16, 2                                | 2021, RC meeting concerns   |                    |                        |   |                               |                            |
|   |   | RC meeting. She validated   |                    |                        | On 02/25/2022, the Administrator  |                               |                            |
|   |   | ed no improvements to the   |                    |                        | educated the facility department heads  | on                            |                            |
|   | concerns reported of                              | during the 1/20/22 meeting.   |                    |                        | the following:  |                               |                            |
|   |   |   |                    |                        | F565 requirements   |                               |                            |

| NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)  F 565  Continued From page 28  An interview was conducted on 2/17/22 at 10:35 AM with the Administrator. He stated he was planning to attend the February 2022 RC meeting once scheduled to discuss the groups ongoing concerns voiced during the 1/20/22 meeting. He stated a concern or grievance should be addressed promptly with follow up provided to the members of the RC committee.  F 565  Continued From page 28  An interview was conducted on 2/17/22 at 10:35 AM with the Administrator. He stated he was planning to attend the February 2022 RC meeting once scheduled to discuss the groups ongoing concerns voiced during the 1/20/22 meeting on 2/25/22 assigned responsibility for resolving grievances.  - Going forward, Administrator or DON (in his absence) will continue to assign responsibility for resolving grievances the morning after the RC meeting.  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 identified staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022.  3. 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.  | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |   | (X3) DATE SURVEY<br>COMPLETED   |            |
|--|---|---|---|---|---|---|---|------------|
| NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY    (X4)   (1)   (24)   (1)   (24)   (1)   (24)   ( |   |   | 345532  | B. WING                                 |   |   | l   |            |
| CALL      | NAME OF P   | ROVIDER OR SLIPPLIER  | 0.0002  |   | STREET ADDRESS CITY STATE 2   | ZIP CODE  | 02/1  | 17/2022    |
| CAJ   D   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY SINCE PREFIX TAG)   PROVIDER'S PLAN OF CORRECTION (PS)   CAN CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PREFIX TAG)   PROVIDER'S PLAN OF CORRECTION (PS)   COMPLETION (PREFIX TAG)   PREFIX TAG    F 565   Continued From page 28   An interview was conducted on 2/17/22 at 10:35   AM with the Administrator. He stated he was planning to attend the February 2022 RC meeting once scheduled to discuss the groups ongoing concerns voiced during the 1/20/22 meeting, He stated a concern or grievance should be addressed promptly with follow up provided to the members of the RC committee.   Going forward, Administrator or DON (in his absence) will continue to assign responsibility for resolving grievances.   Going forward, Administrator or DON (in his absence) will continue to assign responsibility for resolving grievances the morning after the RC meeting. 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 identified staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022.    3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory   | TO THE OT T   | NOVIDEN ON CONTINUE   |   |   |   | -11 0002  |   |            |
| F 565 Continued From page 28 An interview was conducted on 2/17/22 at 10:35 AM with the Administrator. He stated he was planning to attend the February 2022 RC meeting once scheduled to discuss the groups ongoing concerns voiced during the 1/20/22 meeting. He stated a concern or grievance should be addressed promptly with follow up provided to the members of the RC committee.  F 565 Going forward, Administrator or DON (in his absence) will continue to assign responsibility for resolving grievances the morning after the RC meeting. 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 identified staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022.  3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory  | LIBERTY   | COMMONS NSG AND R   | EHAB CTR OF LEE COUNTY  |   |   |   |   |            |
| An interview was conducted on 2/17/22 at 10:35 AM with the Administrator. He stated he was planning to attend the February 2022 RC meeting once scheduled to discuss the groups ongoing concerns voiced during the 1/20/22 meeting. He stated a concern or grievance should be addressed promptly with follow up provided to the members of the RC committee.  **The Administrator educated department heads on the grievance process and at the daily standup meeting on 2/25/22 assigned responsibility for resolving grievances.  **Going forward, Administrator or DON (in his absence) will continue to assign responsibility for resolving grievances the morning after the RC meeting. 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 identified staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022.  **3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory   | PRÉFIX  | (EACH DEFICIENC   | Y MUST BE PRECEDED BY FULL  | PREFIX                                  | (EACH CORRECTIVE CROSS-REFERENCED   | ACTION SHOULD BI  |   | COMPLETION |
| The Administrator will monitor compliance utilizing the F565 Quality Assurance Tool weekly for 4 weeks then monthly x 3 months or until resolved. The tool will monitor to ensure that grievances from resident council meetings are addressed following the grievance process and are in compliance. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate.  Compliance will be monitored and the ongoing auditing program reviewed at the   | F 565   | An interview was cor<br>AM with the Administ<br>planning to attend the<br>once scheduled to di<br>concerns voiced duri<br>stated a concern or g<br>addressed promptly | rator. He stated he was e February 2022 RC meeting scuss the groups ongoing ng the 1/20/22 meeting. He prievance should be with follow up provided to the | F 5                                     | The Administrator of department heads on the process and at the daily on 2/25/22 assigned recessolving grievances. Going forward, Administrator will concess on the standard orientation required in-service refres all staff identified above reviewed by the Quality process to verify that the been sustained. Any induces not receive sched training will not be allow training has been compact.  Monitoring Procedute plan of correction is specific deficiency cited and/or in compliance we requirements. The Administrator will not utilizing the F565 Quality weekly for 4 weeks the months or until resolved monitor to ensure that gresident council meeting following the grievance compliance. Reports with the weekly Quality Assuby the Administrator to action is initiated as applications. | ne grievance y standup meeti sponsibility for ministrator or Do ntinue to assign ing grievances to eeting. een integrated in training and in esher courses for e and will be y Assurance e change has lentified staff wholed in-service yed to work until eleted by March ure to ensure the effective and the fremains correct ith regulatory monitor compliant ty Assurance To monthly x 3 d. The tool will grievances from gs are addresse process and and ll be presented urance committe ensure corrective propriate. nitored and the | on on the or on one of the or |            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |                     | (X3) DATE SURVEY<br>COMPLETED  |                           |
|--|--|---|---------------------|--|---------------------------|
|  |  | 345532  | B. WING             |  | C<br>02/17/2022           |
|  | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332   | , OLITIZALE               |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)   | OULD BE COMPLETION        |
| F 565  | Continued From page  |   | F 565               | weekly Quality Assurance Meetin<br>weekly QA Meeting is attended by<br>Administrator, Director of Nursing<br>Coordinator, Therapy Manager, H<br>Information Manager, and the Die<br>Manager. | y the<br>g, MDS<br>Health |
| F 604<br>SS=D  | Right to be Free from CFR(s): 483.10(e)(1)<br>§483.10(e) Respect a   | , 483.12(a)(2)  | F 604               | 1  | 3/29/22                   |
|  | The resident has a rig<br>and dignity, including   | ght to be treated with respect<br>:   |                     |  |                           |
|  | physical or chemical purposes of discipline  | ght to be free from any restraints imposed for e or convenience, and not resident's medical symptoms, 12(a)(2).   |                     |  |                           |
|  | neglect, misappropria<br>and exploitation as d<br>includes but is not lin<br>corporal punishment,  | , involuntary seclusion and<br>nical restraint not required to  |                     |  |                           |
|  | §483.12(a) The facilit   | ty must-  |                     |  |                           |
|  | from physical or cher<br>purposes of discipline<br>are not required to tre<br>symptoms. When the<br>indicated, the facility<br>alternative for the lea | e that the resident is free mical restraints imposed for e or convenience and that eat the resident's medical e use of restraints is must use the least restrictive ast amount of time and e-evaluation of the need for |                     |  |                           |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING   | (X3) DATE SURVEY<br>COMPLETED                  |
|--|--|
| <b>345532</b> B. WING  | C  |
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP   | 02/17/2022                                     |
|  | SODE   |
| LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY  |  |
| SANFORD, NC 27332  |  |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO DEFICIEN   | TION SHOULD BE COMPLETION THE APPROPRIATE DATE |
| F 604 Continued From page 30 F 604   |  |
| restraints. This REQUIREMENT is not met as evidenced by:   |  |
| Based on observations, staff and Medical The statements made on  | this plan of                                   |
| Director (MD) interviews and record review, the correction are not an admi   | ssion to and do                                |
| facility failed to identify an abdominal binder (a not constitute an agreeme   | nt with the                                    |
| wide compression belt that encircles the alleged deficiencies.   |  |
| abdomen) as a physical restraint. This was for 1  To remain in compliance w  |  |
| (Resident #42) of 1 residents reviewed for and state regulations the f   | · .  |
| restraints. The findings included:  or will take the actions set   |  |
| Resident #42 was admitted on 11/25/15 with plan of correction. The plan of constitutes the facility's all  |  |
| anoxic brain damage and dysphagia. compliance such that all a  | -  |
| deficiencies cited have be   | •  |
| Review of Resident #42's quarterly Minimum corrected by the dates ind  |  |
| Data Set (MDS) dated 1/31/22 indicated severe  |  |
| cognitive impairment. The MDS was not coded F604 The facility failed to  | o identify an                                  |
| for the use of a restraint.  abdominal binder as a phy   |  |
| 1. Corrective action for r   |  |
| Review of Resident #42's comprehensive care affected by the alleged de   | ficient practice:                              |
| plan last revised on 7/27/21 did not include a care For resident #42, on 02/16   |  |
| plan for the use of his abdominal binder as a Director of Nurses conferr   |  |
| restraint. physician and the abdomin discontinued.   | nal binder was                                 |
| Review of a nursing note dated 10/28/21 at 4:52  |  |
| AM read in part as follows: Increased calling out 2. Corrective action for r   | esidents with                                  |
| with restlessness and pulling at bed clothes. the potential to be affected   | by the alleged                                 |
| Abdominal binder in place for feeding tube deficient practice.   |  |
| protection because he attempts to grab and pull  All residents have the potential and pull   | ential to be                                   |
| on his feeding tube. affected. On 03/04/2022 the   |  |
| Nurses and Nurse Manage  |  |
| Review of Resident #42's February 2022 current residents for the p   |  |
| Physician orders included an order dated 2/15/22 restraint devices with none   |  |
| for an abdominal binder over his feeding tube site  3. Measures /Systemic of the property and a second propert | -  |
| to prevent removal. prevent reoccurrence of all  | legea aeticient                                |
| practice:  On 03/00/2022 Director of   | Nurses Nurse                                   |
| Review of Resident #42's electronic medical  record (EMR) did not revealed documented  On 03/09/2022 Director of Consultant and the Nurse  |  |
| record (EMR) did not revealed documented Consultant and the Nurse evidence of a consent for the use of a restraint, education of all full time, p  |  |

PRINTED: 03/16/2022 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<br>COMPLETED |  |
|--|---------------------|--|---------------|---|--|--------------|-------------------------------|--|
|  |                     | 345532   | B. WING _     |   |  | 1            | C<br>/ <b>17/2022</b>         |  |
| NAME OF P  | ROVIDER OR SUPPLIER |  | 1             | STI                                     | REET ADDRESS, CITY, STATE, ZIP CODE  | 1 02/        | 1772022                       |  |
|  |                     |  |               |   | COMMERCE DRIVE   |              |                               |  |
| LIBERTY  | COMMONS NSG ANI     | REHAB CTR OF LEE COUNTY  |               |   | NFORD, NC 27332  |              |                               |  |
| (X4) ID  | SUMMAR              | Y STATEMENT OF DEFICIENCIES                                      | ID            |   | PROVIDER'S PLAN OF CORRECTION  |              | (X5)                          |  |
| PREFIX<br>TAG                                    | (EACH DEFICI        | ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION) | PREFI)<br>TAG | ×                                       | (EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)        |              | COMPLETION<br>DATE            |  |
| F 604  | Continued From p    | age 31   | F 6           | 504                                     |  |              |                               |  |
|  | restraint assessm   | ent or reassessments and no                                      |               |   | and agency Nurses and CNA's on the   |              |                               |  |
|  | evidence of an att  | empted restraint reduction or                                    |               |   | following:   |              |                               |  |
|  | elimination.        | ·  |               |   | <ul> <li>What is a physical restraint and ty</li> </ul>                                    | pes          |                               |  |
|  |                     |  |               |   | · Risks/Benefits of physical restrain  | ts           |                               |  |
|  | An interview was    | conducted on 2/16/22 at 8:30                                     |               |   | <ul> <li>Releasing restraints</li> </ul>   |              |                               |  |
|  |                     | . She stated Resident #42 had                                    |               |   | <ul> <li>Physical restraint process</li> </ul>   |              |                               |  |
|  |                     | der to prevent him for sucking                                   |               |   | <ul> <li>Restraint reduction process</li> </ul>  |              |                               |  |
|  |                     | e. She stated the binder had                                     |               |   | This information has been integrated in  |              |                               |  |
|  | been in use for at  | least a year or more.  |               |   | the standard orientation training and in   |              |                               |  |
|  | An interview was    | conducted on 2/16/22 at 9:40                                     |               |   | required in-service refresher courses for all staff identified above and will be           | or           |                               |  |
|  |                     | conducted on 2/16/22 at 8:40<br>Assistant (NA) #10. She stated   |               |   | reviewed by the Quality Assurance  |              |                               |  |
|  | _                   | served Resident #42 attempt to                                   |               |   | process to verify that the change has  |              |                               |  |
|  |                     | ninal binder and he probably                                     |               |   | been sustained. The facility specific  |              |                               |  |
|  |                     | to remove it. She stated she                                     |               |   | in-service will be provided to all agence  | V            |                               |  |
|  | only opened the b   | inder during his bath but all                                    |               |   | Nurses and CNA's who give residents  | •            |                               |  |
|  |                     | s secured in place with Velcro.                                  |               |   | care in the facility.  |              |                               |  |
|  |                     |  |               |   | Any nursing staff who does not receive   | <del>;</del> |                               |  |
|  | An interview was    | conducted on 2/16/22 at 8:45                                     |               |   | scheduled in-service training will not be  |              |                               |  |
|  | **                  | he stated she had never  |               |   | allowed to work until training has been  |              |                               |  |
|  |                     | it #42 attempt to remove the                                     |               |   | completed by March 28, 2022.   |              |                               |  |
|  | abdominal binder.   |  |               |   | 4 14 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  |              |                               |  |
|  | An interview was    | conducted on 2/16/22 at 10:22                                    |               |   | 4. Monitoring Procedure to ensure the  |              |                               |  |
|  |                     | conducted on 2/16/22 at 10:22<br>tor of Nursing (DON). She       |               |   | the plan of correction is effective and the specific deficiency cited remains corrections. |              |                               |  |
|  |                     | ded to do away with Resident                                     |               |   | and/or in compliance with regulatory   | Jieu         |                               |  |
|  |                     | nder and they were going to get                                  |               |   | requirements.  |              |                               |  |
|  |                     | pants. The DON confirmed   |               |   | The Director of Nurses or designee wil   | ı            |                               |  |
|  |                     | umentation of a restraint  |               |   | monitor compliance utilizing the F604  | •            |                               |  |
|  |                     | assessment or reassessment                                       |               |   | Quality Assurance Tool weekly for 2  |              |                               |  |
|  | · ·                 | ed attempts to try other less                                    |               |   | weeks then monthly x 3 months or until   | ı            |                               |  |
|  | restrictive devices | or an attempted elimination.                                     |               |   | resolved. The Director of Nursing will   |              |                               |  |
|  |                     |  |               |   | monitor restraints and the restraint   |              |                               |  |
|  |                     | conducted on 2/16/22 at 10:29                                    |               |   | process compliance. Reports will be  |              |                               |  |
|  |                     | e Consultant. She stated she                                     |               |   | presented to the weekly Quality  | ,            |                               |  |
|  |                     | ite the order yesterday for the                                  |               |   | Assurance committee by the Director of   | )Ť           |                               |  |
|  |                     | nal binder but now the facility                                  |               |   | Nurses to ensure corrective action is  | :11          |                               |  |
|  | opted to try high v | vasted pants to eliminate the                                    |               |   | initiated as appropriate. Compliance w   |              |                               |  |

Facility ID: 980156

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                | IPLE CONSTRUCTION NG   |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|--------------------|--|---|-------------------------------|--|
|   |  | 345532  | B. WING            |  |   | C<br>02/17/2022               |  |
| NAME OF P   | ROVIDER OR SUPPLIER  |   |                    | STREET ADDRESS, CIT  | TY, STATE, ZIP CODE   | 1 02/11/2022                  |  |
| LIDEDTV   | COMMONS NSC AND  | REHAB CTR OF LEE COUNTY   |                    | 310 COMMERCE DRI   | VE  |                               |  |
| LIBERTT   | COMMONS NSG AND  | REHAB CIR OF LEE COUNTY   |                    | SANFORD, NC 273  | 332   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE  | ' STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | (EACH CO   | IDER'S PLAN OF CORRECTION<br>ORRECTIVE ACTION SHOULD BE<br>FERENCED TO THE APPROPRIA<br>DEFICIENCY)   |                               |  |
| F 604   | An observation wan 11:10 AM with Nu #42's shirt. There abdominal binder included in width the abdomen and sec asked Resident #4 abdominal binder. attempt to remove evident that Resid commands and mustre binder. Nurse removed it before long ago. She stat binder every few han observation of on 2/17/22 at 10:2 his left side wearing not wearing any particularly abdominal binder. observed touching noted pulling at his Another review of orders on 2/17/22 2/15/22 for the use still an active order at 4:56 PM with the needed the abdom removing his feeding understood the intit felt like a "catch to utilize a restrain | as conducted on 2/16/22 at rse #3. She lifted Resident was observed a tan colored approximately 10-12 inches, hat extended around his ured with Velcro. Nurse #3 42 to attempt to remove the After several prompts to the abdominal binder, it was ent #42 could not follow ade no visible effort to touch #3 stated she thought he had but she was unable to say how ed she had not be releasing the rours.  Resident #42 was conducted 9 AM. He was lying in bed on ag a shirt and a brief. He was ants. He was not wearing his Resident #42 was not the feeding tube but was as brief.  Resident #42's Physician revealed the order dated as of the abdominal binder was | F                  | Assurance Me<br>necessary for<br>The weekly QA<br>Administrator,<br>Coordinator, T | wed at the weekly Quality seting or until deemed not compliance with ADL Carl A Meeting is attended by Director of Nursing, MDS Therapy Manager, Health anager, and the Dietary | t<br>re.<br>the<br>S          |  |

| STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|-----------------------------|---|-------------------------------|--|
|  |  | 345532   | B. WING                     |   | C<br><b>02/17/2022</b>        |  |
|  | ROVIDER OR SUPPLIER  | REHAB CTR OF LEE COUNTY  | ;                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332                                | ,                             |  |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETION               |  |
| F 604  | Continued From pa  | ge 33  | F 604                       | L   |                               |  |
| F 623<br>SS=B  | PM with the DON. Sabdominal binder was acknowledged it she since it restricts his he was unable to resolve the sable to resolve the sable to the sable that was a sable to the was unable to representative (s) of the reasons for the language and mannary facility must send a representative of the Long-Term Care Or (ii) Record the reasolve the r | ts Before Transfer/Discharge 3)-(6)(8)  e before transfer. asfers or discharges a must- at and the resident's the transfer or discharge and move in writing and in a aner they understand. The copy of the notice to a e Office of the State | F 623                       |   | 3/29/22                       |  |
|  | (c)(8) of this section<br>discharge required<br>made by the facility<br>resident is transferr<br>(ii) Notice must be r<br>before transfer or di<br>(A) The safety of inc   | ng of the notice. ed in paragraphs (c)(4)(ii) and in, the notice of transfer or under this section must be at least 30 days before the ed or discharged. made as soon as practicable   |                             |   |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | 1 ' '   | IPLE CONSTRUCTION  IG | (X3  | (X3) DATE SURVEY COMPLETED |                            |  |
|---|--|---|-----------------------|--|----------------------------|----------------------------|--|
|   |  | 345532  | B. WING _             |  |                            | C<br><b>02/17/2022</b>     |  |
|   | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY  |                       | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332                 |                            | OZ/11/ZOZZ                 |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE                   | (X5)<br>COMPLETION<br>DATE |  |
| F 623   | (B) The health of ind be endangered, under this section; (C) The resident's he allow a more immediunder paragraph (c)((D) An immediate trarequired by the residunder paragraph (c)((E) A resident has not days.  §483.15(c)(5) Content notice specified in paragraph (c)(i) The reason for trace (ii) The location to we transferred or dischala (iv) A statement of the including the name, and telephone number ceives such request to obtain an appeal of completing the form hearing request; (v) The name, addretelephone number of Long-Term Care Om (vi) For nursing facility and developmental content of the protection and accept the developmental disable C of the Developmental content of the protection and accept the developmental disable C of the Developmental content of the protection and accept the developmental disable C of the Developmental content of the protection and accept the developmental disable C of the Developmental content of the developmental disable C of the Developmental content of the developmental disable C of the Developmental disable C of the Developmental content of the developmental disable C of the Developmental disable C of the Developmental disable C of the Developmental content of the developmental disable C o | ividuals in the facility would be paragraph (c)(1)(i)(D) of sealth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; ansfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or of tresided in the facility for 30 on the soft the notice. The written aragraph (c)(3) of this section owing: ansfer or discharge; of transfer or discharge; thich the resident is reged; e resident's appeal rights, address (mailing and email), er of the entity which ests; and information on how orm and assistance in and submitting the appeal ses (mailing and email) and the Office of the State budsman; the office of the State budsman; the residents with intellectual disabilities or related and email address and the agency responsible for divocacy of individuals with illities established under Part and Disabilities Assistance of 2000 (Pub. L. 106-402, | F6                    |  |                            |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '               | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|---------------------|--|-------------------------------|--|
|  |  | 345532   | B. WING             |  | C<br>02/17/2022               |  |
| NAME OF P  | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | 02/1//2022                    |  |
| LIDEDTY  | COMMONO NOO AND DE   | THAD OTD OF LEE COUNTY   |                     | 310 COMMERCE DRIVE   |                               |  |
| LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY  |  | EHAB CIR OF LEE COUNTY   |                     | SANFORD, NC 27332  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                         | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  | BE COMPLÉTION                 |  |
| F 623  | Continued From page  | ∍ 35   | F 623               | 3  |                               |  |
|  | disorder or related dis<br>email address and tel<br>agency responsible for<br>advocacy of individua  | als with a mental disorder<br>Protection and Advocacy  |                     |  |                               |  |
|  | effecting the transfer must update the recip   | es to the notice. ne notice changes prior to or discharge, the facility pients of the notice as soon ne updated information  |                     |  |                               |  |
|  | In the case of facility the administrator of the written notification prior to the State Survey A State Long-Term Carathe facility, and the rewell as the plan for the relocation of the residues 483.70(I).  This REQUIREMENT by: | in advance of facility closure closure, the individual who is ne facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate lents, as required at § |                     |  |                               |  |
|  | responsible party (RF the facility failed to no reason for the discha sampled residents re (Residents #23, #5, 1 Findings included:  | iew and interview with the P), and or resident and staff, bitify the RP in writing of the rge to the hospital for 4 of 5 viewed for hospitalizations 7 & #206).  |                     | The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies.  To remain in compliance with all federand state regulations the facility has to a will take the actions set forth in this plan of correction. The plan of correctic constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. | al<br>aken<br>on              |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | IDENTIFICATION NUMBER:  |                     | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |     | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|---|---------------------|---|--|-----|-------------------------------|--|
|   |   | 345532  | B. WING             |   |  | (   |                               |  |
| NAME OF B   | 201/1050 00 01 1001 150                         | 343332  | B. WING_            | 0.7.0                                   | DEET ADDRESS SITY STATE ZID SODE   | 02/ | 17/2022                       |  |
| NAME OF PI  | ROVIDER OR SUPPLIER                             |   |                     |   | REET ADDRESS, CITY, STATE, ZIP CODE  |     |                               |  |
| LIBERTY (   | COMMONS NSG AND R                               | EHAB CTR OF LEE COUNTY  |                     |   | O COMMERCE DRIVE   |     |                               |  |
|   |   |   |                     | SA                                      | NFORD, NC 27332  |     |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | ×                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |     | (X5)<br>COMPLETION<br>DATE    |  |
| F 623   | Continued From pag                              | e 36  | F 6                 | 523                                     |  |     |                               |  |
|   | Review of the nurse'                            | s note dated 10/25/21 at  |                     |   |  |     |                               |  |
|   | 11:38 AM revealed the                           | nat the resident was  |                     |   | F623   |     |                               |  |
|   | discharged to the ho                            | spital after the resident was   |                     |   | The facility failed to notify the responsib  | ole |                               |  |
|   | noted to be difficult to                        | o arouse and was readmitted   |                     |   | party in writing of the reason for hospital  | al  |                               |  |
|   | back to the facility or                         | n 11/2/21.  |                     |   | discharge.   |     |                               |  |
|   |   |   |                     |   | <ol> <li>Corrective action for resident(s)</li> </ol>  |     |                               |  |
|   | The nurse's note dat                            | ed 11/11/21 at 12:02 AM   |                     |   | affected by the alleged deficient practic  | e:  |                               |  |
|   |   | nt #23 was observed with a  |                     |   |  |     |                               |  |
|   | •   | The physician was notified,   |                     |   | On 3/9/2022 the responsible parties of   | _   |                               |  |
|   |   | s sent to the hospital for  |                     |   | residents #23, 5, 17 and 206 were mail   |     |                               |  |
|   | evaluation. The resident was readmitted back to |   |                     |   | written notice of the reason for discharge   |     |                               |  |
|   | the facility on 11/15/2                         | 2.  |                     |   | to the hospital by the Director of Nurses  | 5.  |                               |  |
|   | The quarterly Minimu                            | um Data Set (MDS)   |                     |   | 2. Corrective action for residents with  | ı   |                               |  |
|   | assessment dated 1                              | 2/31/21 indicated that  |                     |   | the potential to be affected by the allege   | ed  |                               |  |
|   | Resident #23 had se                             | vere cognitive impairment.  |                     |   | deficient practice.  |     |                               |  |
|   |   |   |                     |   | Any resident who is transferred or   |     |                               |  |
|   |   | ewed on 2/16/22 at 2:48 PM.   |                     |   | discharged has the potential to be   |     |                               |  |
|   |   | at when a resident was  |                     |   | affected.  |     |                               |  |
|   | _   | ed to the hospital, the RP  |                     |   | On 3/09/2022 the Director of Nurses  |     |                               |  |
|   |   | ner/him that the resident was   |                     |   | audited all discharges for the last 7 day  |     |                               |  |
|   | discharged to the ho                            | spital.   |                     |   | to monitor that the responsible party ha   |     |                               |  |
|   | The Designation of Norma                        | on (DNI) Companies and one  |                     |   | been notified in writing of the reason for   | r   |                               |  |
|   | •   | se (RN) Supervisor was<br>22 at 2:49 PM.  The RN                                  |                     |   | discharge to the hospital with no other discharges to hospital found. The  |     |                               |  |
|   |   | at when a resident was  |                     |   | Business Office Manager or Admissions  | ۹ ا |                               |  |
|   |   | ed to the hospital, the RP  |                     |   | Coordinator will assure that written noti  |     |                               |  |
|   | •   | ner/him that the resident was   |                     |   | is sent to the responsible party beginning   |     |                               |  |
|   |   | spital. She added that she  |                     |   | on 3/16/2022.  | '9  |                               |  |
|   | •   | RP should be notified in  |                     |   | · · <del></del>  |     |                               |  |
|   | writing of the reason                           |   |                     |   | 3. Measures /Systemic changes to   |     |                               |  |
|   | <u> </u>  | -   |                     |   | prevent reoccurrence of alleged deficie  | nt  |                               |  |
|   | Resident #23's Resp                             | onsible Party (RP) was  |                     |   | practice:  |     |                               |  |
|   |   | 22 at 4;30 PM. The RP   |                     |   |  |     |                               |  |
|   |   | #23 was discharged and was  |                     |   | On 3/09/22, the Director of Nurses and   |     |                               |  |
|   |   | ital in October and November  |                     |   | Nurse Consultant began education of a  |     |                               |  |
|   |   | ated that he/she had not  |                     |   | full time, part time and as needed nurse   |     |                               |  |
|   |   | n the facility informing  |                     |   | social worker, administrator, admission  |     |                               |  |
|   | him/her of the reason                           | n the resident was  |                     |   | business and office manager on facility  |     |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|---|-----|--|-------------------------------|----------------------------|
|   |  | 345532   | B. WING _                               |     |  |                               | C<br>/ <b>17/2022</b>      |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  | 1 02/                         | 1172022                    |
|   |  |  |   |     | 10 COMMERCE DRIVE  |                               |                            |
| LIBERTY   | COMMONS NSG AND RI   | EHAB CTR OF LEE COUNTY   |   |     | SANFORD, NC 27332  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                                  | ID<br>PREFI)<br>TAG                     |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  |                               | (X5)<br>COMPLETION<br>DATE |
| F 623   | Continued From page  | e 37   | F 6                                     | 323 |  |                               |                            |
|   | discharged to the hos  | •  |   |     | policy on notifying the responsible part<br>writing of the reason for a resident's<br>discharge to the hospital. Education wi  |                               |                            |
|   | The Director of Nursing (DON) was interviewed on 2/17/22 at 3:34 PM. The DON stated that she didn't know the regulation to notify the RP in writing the reason for hospitalization. She reported that the nurse notified the RP by calling her/him.  2. Resident #5 was admitted to the facility on 5/12/21. |  |   |     | be completed by 3/28/22 at which time of the above must be in-serviced prior   | all                           |                            |
|   |  |  |   |     | working.  4. Monitoring Procedure to ensure the  |                               |                            |
|   |  |  |   |     | the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements.   | cted                          |                            |
|   | PM revealed that the the hospital due to co  | note dated 9/16/21 at 3:15<br>resident was discharged to<br>emplaint of severe pain and<br>to the facility on 9/17/21. |   |     | The Director of Nurses or Designee wi<br>monitor compliance utilizing the Writtel<br>Notification of RP Hospital Discharge<br>Quality Assurance Tool weekly x 2 wee<br>then monthly x 3 months. The Director | eks<br>of                     |                            |
|   | The quarterly Minimu<br>assessment dated 11<br>Resident #5's cognition   | /8/21 indicated that   |   |     | Nursing will monitor for compliance wit written notification of reason for a resident's discharge to the hospital.  Reports will be presented to the week!  Quality Assurance committee by the               |                               |                            |
|   | Nurse #3 was interviewed on 2/16/22 at 2:48 PM. The Nurse stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital.  |  |   |     | Director of Nurses to ensure corrective action is initiated as appropriate.  Compliance will be monitored and the ongoing auditing program reviewed at weekly Quality Assurance Meeting. Th                  | the                           |                            |
|   | interviewed on 2/16/2<br>Supervisor stated that<br>transferred/discharge<br>was called to notify his<br>discharged to the hos<br>didn't know that the Fill<br>writing of the reason  | -  |   |     | weekly QA Meeting is attended by the Administrator, Director of Nursing, MD Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.   |                               |                            |
|   |  | rviewed on 2/16/22 at 3:10 rified that she was admitted  |   |     |  |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |         |   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|---|---|--|---|---------|---|-------------------------------|----------------------------|--|
|   |   | 345532   | B. WING                                 |         |   | C<br>02/17/2022               |                            |  |
|   | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY   |   | 310 COM | DDRESS, CITY, STATE, ZIP CODE MERCE DRIVE RD, NC 27332  | 021                           | 1112022                    |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                      | ×       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE |  |
| F 623   | the exact date) and seletter from the facility. The Director of Nursi on 2/17/22 at 3:34 Pt didn't know the regular writing the reason for reported that the nursher/him.  3) Resident #17 was facility on 3/1/21.  The quarterly Minimulassessment dated 12 #17 was cognitively in Resident #17's medic transferred to the hose readmitted to the facino documentation the hospital transfer was and/or responsible particles and the Bed Hold pol transferred to the hospital transferred. The Registered Nursinterviewed on 2/16/2 | s ago (unable to remember he had not received any about that discharge.  Ing (DON) was interviewed where the DON stated that she ation to notify the RP in thospitalization. She are notified the RP by calling originally admitted to the notified the RP by calling and a Set (MDS) (2/11/21, indicated Resident intact.  In Data Set (MDS) (2/11/21, indicated Resident intact. | F                                       | 523     |   |                               |                            |  |
|   | reason of the hospita of anything sent in wi  | I transfer but was unaware riting.   |   |         |   |                               |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | ` ′   | PLE CONSTRUCTION    | (X3) DATE SURVEY<br>COMPLETED   |                 |                           |
|--|---|---|---------------------|---|-----------------|---------------------------|
|  |   | 345532  | B. WING             |   | C<br>02/17/2022 |                           |
|  | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332                  | 02/11/2         | .022                      |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF | D BE CO         | (X5)<br>DMPLETION<br>DATE |
| F 623  | Continued From page   | e 39  | F 62                | 23  |                 |                           |
|  | #17's RP on 2/16/22 facility called when the but she had not received. The Administrator was 10:01 AM and verified regulation regarding for hospital transfer to and/or RP but it was He was unable to offer 4. Resident #206 was Resident #206's quark dated 10/29/21 indications impairment.  Review of a nursing repulse PM read Resident #2 for an evaluation. The party (RP) was notified the received and communication of the party (RP) was not document. |   |                     |   |                 |                           |
|  | PM with Nurse #3. SI<br>the face sheet, any D<br>information if present<br>medication and treatr<br>and the Bed Hold pol<br>transferred to the hos  | ducted on 2/16/22 at 2:48 ne stated she sent a copy of to Not Resuscitate (DNR) , physician orders, ment administration records icy when a resident was spital. She called the RP by of the change and reason |                     |   |                 |                           |
|  | PM with the Register  | ducted on 2/16/22 at 2:49<br>red Nurse (RN) Supervisor.<br>g staff would call the RP in   |                     |   |                 |                           |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | L IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|---|---|--|---------------------|---|-------------------------------|
|   |   | 345532   | B. WING             |   | C<br><b>02/17/2022</b>        |
|   | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332  | 02/11/2022                    |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)  | BE COMPLETION                 |
| F 623   | was unaware of anythe A telephone call was to Resident #206's R but a message was learn surveyor's call 2/17/22 there was no An interview was con Administrator on 2/17 he was aware of the need for written reasonsent to the resident a   | of the hospital transfer but hing sent in writing.  made on 2/16/22 at 4:15 PM P. The cell mailbox was full left at home phone number to At the time of exit on return call from the RP. | F 62                | 23  |                               |
| F 637<br>SS=D                                       | CFR(s): 483.20(b)(2) §483.20(b)(2)(ii) With determines, or should there has been a sign resident's physical or purpose of this sectio means a major declir resident's status that itself without further in implementing standal interventions, that ha one area of the reside requires interdisciplin care plan, or both.) This REQUIREMENT by: Based on record rev facility failed to comp Change in Status Ass | nin 14 days after the facility<br>I have determined, that  | F 63                | The statements made on this Plan or Correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in |                               |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                    | ` ′     | ) MULTIPLE CONSTRUCTION BUILDING  |   |            | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|---|---------|---|---|------------|-------------------------------|--|
|                          |   | 345532  | B. WING |   |   | 1          | C<br><b>17/2022</b>           |  |
| NAME OF P                | ROVIDER OR SUPPLIER                           |   |         | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  | 1 02/      | 1772022                       |  |
|                          |   |   |         |   | 10 COMMERCE DRIVE   |            |                               |  |
| LIBERTY (                | COMMONS NSG AND RE                            | EHAB CTR OF LEE COUNTY  |         |   | SANFORD, NC 27332   |            |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                               | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) |         | ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APF DEFICIENCY) |   |            | (X5)<br>COMPLETION<br>DATE    |  |
| F 637                    | Continued From page                           | e 41  | F       | 637   |   |            |                               |  |
|                          | resident reviewed for                         | hospice (Resident #23).   |         |   | compliance with all Federal and State<br>Regulations the facility has taken or wi | II         |                               |  |
|                          | Findings included:                            |   |         |   | take the actions set forth in this Plan of Correction. The Plan of Correction     |            |                               |  |
|                          | Resident #23 was ad                           | mitted to the facility on   |         |   | constitutes the facility's allegation of  |            |                               |  |
|                          |   | es that included vascular   |         |   | compliance such that all alleged  |            |                               |  |
|                          | dementia and delusion                         | nal disorder.   |         |   | deficiencies cited have been or will be   |            |                               |  |
|                          |   |   |         |   | corrected by the date or dates indicate   | d.         |                               |  |
|                          |   | ated 11/23/21 indicated a   |         |   | 5 007 00MPD5M5N0N/5   |            |                               |  |
|                          | hospice evaluation was requested for Resident |   |         |   | F 637 COMPREHENSIVE   |            |                               |  |
|                          | #23.  |   |         |   | ASSESSMENT AFTER SIGNIFICANT CHANGE   |            |                               |  |
|                          | A review of hospice documentation indicated   |   |         |   | Corrective Action:  |            |                               |  |
|                          |   | mitted to hospice care on   |         |   | Resident #23 Resident elected Hospi   | ce         |                               |  |
|                          | 11/24/21.                                     | •   |         |   | benefits on 11/24/2021 and revoked  |            |                               |  |
|                          |   |   |         |   | hospice benefits on 2/12/2022   |            |                               |  |
|                          | A review of Resident                          | #23's Minimum Data Set  |         |   | Identification of other residents who ma  | ау         |                               |  |
|                          | , ,   | indicated a SCSA had not  |         |   | be involved with this practice:   |            |                               |  |
|                          |   | n 14 days of her admission  |         |   | All current residents who have elected  | or         |                               |  |
|                          | to hospice care (12/7)                        | /21).   |         |   | revoked Hospice Benefits have the   |            |                               |  |
|                          | The MDC Numer was                             | interviewed on 2/17/22 at   |         |   | potential to be affected by the alleged   | ,          |                               |  |
|                          |   | Nurse stated that she started   |         |   | practice. On 3/3/2022 through 3/4/2022 an audit was completed by the MDS          | 2          |                               |  |
|                          |   | onths ago. She confirmed  |         |   | Nurse consultant to ensure that the fac   | ility      |                               |  |
|                          |   | s admitted to hospice   |         |   | had completed Significant Change in   | anty       |                               |  |
|                          |   | She reported that she was   |         |   | Status Comprehensive Minimum Data   | Set        |                               |  |
|                          |   | me, and she did not know  |         |   | (MDS) assessments within 14days after   |            |                               |  |
|                          | that a SCSA was req                           |   |         |   | the Assessment Reference Date (ARD  |            |                               |  |
|                          |   |   |         |   | for residents who had elected or revok  | ed         |                               |  |
|                          |   | ducted with the Director of   |         |   | hospice benefits. Out of the 55 current   |            |                               |  |
|                          | •   | t 3:34 PM. She indicated  |         |   | residents, 0 number of residents did no   | ot         |                               |  |
|                          | she expected the MD                           |   |         |   | have their significant comprehensive  |            |                               |  |
|                          | accurately and as rec                         | quirea.   |         |   | assessments completed within 14   |            |                               |  |
|                          |   |   |         |   | calendar days of electing or revoking hospice benefits. 4 current residents w     | ith        |                               |  |
|                          |   |   |         |   | hospice benefits have significant change  |            |                               |  |
|                          |   |   |         |   | assessments completed and 1 current   | <b>J</b> C |                               |  |
|                          |   |   |         |   | resident has revoked hospice benefits   | and        |                               |  |
|                          |   |   |         |   | has a significant change assessment   |            |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                     | ` ′   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |                                       | (X3) DATE SURVEY<br>COMPLETED  |   |                            |
|---|---------------------|---|---|---------------------------------------|--|---|----------------------------|
|   |                     | 345532  | B. WING                                 |                                       |  | l   | C 47/2022                  |
| NAME OF P   | ROVIDER OR SUPPLIER | 34332   | B. Wo                                   | ST                                    | REET ADDRESS, CITY, STATE, ZIP CODE  | 02/   | 17/2022                    |
|   |                     |   |   | 310 COMMERCE DRIVE                    |  |   |                            |
| LIBERTY   | COMMONS NSG AND R   | EHAB CTR OF LEE COUNTY  |   |                                       | ANFORD, NC 27332   |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC     | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG                      | FIX (EACH CORRECTIVE ACTION SHOULD BE |  |   | (X5)<br>COMPLETION<br>DATE |
| F 637   | Continued From pag  | e 42  | F                                       | 537                                   | completed. This audits were completed 3/4/2022.  Systemic Changes: On 3/4/2022 The Registered Nurse (RI Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Supponurses any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse Consultar The education focused on: The educat focused on: The facility must; Within 1 days after the facility determines, or should have determined, that there has been a significant change in the reside physical or mental condition. (For purpof this section, a "significant change "means a major decline or improvement the resident's status that will not normal resolve itself without further intervention by staff or by implementing standard disease-related clinical that has an impon more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)  If a resident elects the hospice benefit the facility is required to complete an M Significant Change in Status Assessme (SCSA). The facility is required to complete an SCSA when they resident comes off the hospice benefit (revoke).  The facility must conduct initially and periodically a comprehensive, accurate standardized reproducible assessment each resident's functional capacity.  OBRA-required comprehensive assessments include the completion of | nt. ion 4 snt's ose at in ally n eact s e , IDS ent |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      | ,  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |  | (X3) DATE SURVEY<br>COMPLETED                 |    |
|---|----------------------|--|---|---|--|---|----|
|   |                      | 345532   | B. WING                                 |   |  | C<br><b>02/17/2022</b>                        |    |
| NAME OF P   | ROVIDER OR SUPPLIER  |  | <u> </u>                                | STREET ADDRESS, CITY, STATE, ZIP CO   | DF   | 02/11/2022                                    | -  |
| TVAIVIL OF T  | TOVIDER OR GOLT EIER |  |   |   |  |   |    |
| LIBERTY   | COMMONS NSG AND RE   | HAB CTR OF LEE COUNTY  |   | 310 COMMERCE DRIVE  |  |   |    |
|   |                      |  |   | SANFORD, NC 27332   |  |   |    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC      | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF C<br>( (EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY  | ON SHOULD BI<br>HE APPROPRIA   | DATE  | ON |
| F 637   | Continued From page  | e 43   | F6                                      | both the MDS and the CAA well as care planning. Compassessments are completed admission, annually, and whisignificant change in a resid has occurred or a significant a prior comprehensive asses required. They consist of: An Assessment, Annual Assess Significant Change in Status (SCSA) and Significant Corrocomprehensive Assessment acomprehensive assessment resident and, under some cita returning resident that must completed by the end of day the date of admission to the as day 1 if: this is the reside in this facility, OR the reside admitted to this facility and which arged return not anticipate and was discharged return and did not return within 30 discharge. The Annual assessment that must be completed on a basis (at least every 366 day SCSA or a SCPA has been since the most recent compassessment was completed completion dates (MDS/CAM depend on the most recent compassessment Instrument. A famake a comprehensive assessment instrument. | orehensive I upon hen a ent's status t correction ssment is dmission sment, and a Assessment of t (SCPA). The for a new reumstance of the transport of transport of the transport of the transport of the transport of transport of the transport of the transport of the transport of transport of the transport of the transport of the transport of transport of the transport of the transport of the transport of transport of the transport of the transport of the transport of transport of the transport of the transport of the transport of transport of the transport of the transport of the transport of transport of the transport of the transport of the transport of transport of the transport of the transport of the transport of transport of the transport of the transport of the transport of transport of the transport of the transport of the transport of t | ent ior The es, ng me ne the tty a ent a ann) |    |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                     | 1 ' '  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED  |   |  |
|---|---------------------|--|---|--|--|---|--|
|   |                     | 345532   | B. WING                                 |  |  | C   |  |
|   | ROVIDER OR SUPPLIER | EHAB CTR OF LEE COUNTY   |   | STREET ADDRESS, CITY 310 COMMERCE DRIVI SANFORD, NC 2733   | E  | 02/17/2022  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC     | SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG |   | PROVID   |  | N   |  |
| F 637   | Continued From pag  | e 44   | F                                       | history and pref resident assess specified by CN include at least Identification an information(ii) C Cognitive patter Vision. (vi) Mood (vii) Psychologic Physical functio problems. (ix) C diagnosis and hand nutritional s (xiii) Activity pur Special treatme Discharge plant of summary informational assessment. The must include direct communication as communication as communicational communicational ilicensed direct coshifts.  This in service training work until training information has standard orientarequired in-servall employees a Quality Assurant | ferences, using the sment instrument (RAI) //S. The assessment muthe following:(i) and demographic customary routine.(iii) rns.(iv) Communication. d and behavior patterns cal well-being.(viii) oning and structural ontinence.(x) Disease nealth conditions.(xi) Destatus.(xii) Skin Conditions. (xii) Medications. ents and procedures.(xvning.(xvii) Documentation regarding the ssment performed on the pered by the completion ata Set (MDS).(xviii) of participation in the assessment process rect observation and with the resident, as we ion with licensed and no care staff members on a swas completed by MDS nurse (full time, participation in the vicent and member of the vicent and will be reviewed by the process to verify that is been sustained. | ental ons.  i) on lee of lell on lall lert live of lee or the letter or |  |

|                          | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | l ` ′               | IPLE CONSTRUCTION NG   | (X3) DATE SURVEY<br>COMPLETED  |  |                            |
|--------------------------|-------------------------------|--|---------------------|--|--|--|----------------------------|
|                          |                               | 345532   | B. WING _           |  |  | C<br>02/17/2022  |                            |
|                          | ROVIDER OR SUPPLIER           | REHAB CTR OF LEE COUNTY  |                     | STREET ADDRESS, CITY, STATE, ZIP COI<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332  | DE   |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)  | N SHOULD BE<br>E APPROPRIA   |  | (X5)<br>COMPLETION<br>DATE |
| F 637                    | Continued From page           |  | F6                  | Monitoring: To ensure compliance, The D Nursing and/or Mini Data Set Coordinators will review wee residents electronic records welected or revoked hospice b with either two or more areas two or more areas of improve may include two changes wit particular domain (e.g., two a decline or improvement) in a condition from his/her baselir occurred as indicated by com the resident's current status to recent comprehensive asses any subsequent Quarterly as and The resident's condition expected to return to baseline weeks to ensure that a Signifi in Status Assessment are con timely. This will be done on we include the weekend for 4 we monthly for 3 months. Report presented to the weekly QA of the Director of Nursing and/o Set (MDS) Coordinators to encorrective action initiated as a Any immediate concerns will the Director of Nursing or Adi for appropriate action. Comp monitored and ongoing audit reviewed at the Weekly Qual Meeting. Weekly QA Commit is attended by Administrator, Nursing, MDS Coordinator, U Support Nurse, Therapy, HIM Manager, Wound Nurse. | t (MDS) kly, 5 who have benefits or s of decline ement ;this thin a areas of AE resident's ne has nparison of to the most is not e within twe ficant Char mpleted reekly basis eeks then ts will be Committee or Mini Data nsure appropriate be brough ministrator diance will le cing progran lity of Life ttee meetin Director or Jnit Manag | of t t t to the total tota |                            |
| F 641                    | Accuracy of Assess            | ments  | F6                  | 341  |  |  | 3/9/22                     |

| ` '                      |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|--|---|-----|--|-------------------------------|----------------------------|
|                          |  | 345532   | B. WING                                 |     |  |                               | C<br><b>17/2022</b>        |
| NAME OF P                | ROVIDER OR SUPPLIER  | 2.5552   | <u> </u>                                | ST  | REET ADDRESS, CITY, STATE, ZIP CODE  | 02/                           | 1772022                    |
|                          | 101.52.1.01.100.1.2.2.1  |  |   |     | 0 COMMERCE DRIVE   |                               |                            |
| LIBERTY                  | COMMONS NSG AND RE   | EHAB CTR OF LEE COUNTY   |   |     | ANFORD, NC 27332   |                               |                            |
|                          | OLIMANA DV OT  | ATEMENT OF REFIGIENCIES  |   |     | <u> </u>   |                               | 0.47)                      |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | (   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |                               | (X5)<br>COMPLETION<br>DATE |
| F 641                    | Continued From page  | e 46   | F6                                      | 641 |  |                               |                            |
|                          | CFR(s): 483.20(g)  |  |   |     |  |                               |                            |
|                          | resident's status. This REQUIREMENT by: Based on record revinterviews, the facility Data Set (MDS) asseareas of nutrition (Rerestraints (Resident ##42), accidents (Residents #14, #23 accidents #14, #24, #24, #24, #24, #24, #24, #24, #2 | is accurately reflect the is not met as evidenced siews, observations, and staff a failed to code the Minimum assment accurately in the sidents #12 and #52), the sident status (Resident dent #16), pressure ulcers and #46) and pain |   |     | The statements made on this Plan of Correction are not an admission to and 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                                  | I                             |                            |
|                          | management (Reside   | ent #46). This was for 7 of  |   |     | Correction. The Plan of Correction constitutes the facility's allegation of  |                               |                            |
|                          | 22 residents reviewed  | J.   |   |     | compliance such that all alleged   |                               |                            |
|                          | The findings included  |  |   |     | deficiencies cited have been or will be corrected by the date or dates indicated   | d.                            |                            |
|                          | 1) Resident #12 was admitted to the facility on 1/11/13 with diagnoses that included congestive heart failure (CHF), diabetes type 2 and morbid obesity.   |  |   |     | F641 Accuracy of Assessments Corrective Action: Resident # 12: Resident Minimum Data Set (MDS) assessment (Quarterly   | a                             |                            |
|                          | weights during the Mi<br>period of July 2021 to<br>showed a 2.01% weig<br>24.19% weight loss in<br>1/17/22- 159.6 pound<br>12/22/21- 162.8 lbs.<br>7/7/21- 198.2 lbs.<br>A quarterly MDS asse  |  |   |     | Assessment,) with Assessment /Reference Date (ARD) [1/28/2022] wa modified. Resident #52: Resident Minimum Data Set (MDS) assessments (Annual Assessment,) with Assessment /Reference Date (ARD) [1/13/2021 and Resident Minimum Data Set (MDS) assessment (5 day PPS Assessment,) with Assessment /Reference Date (ARI [1/25/2022] were modified. | ı                             |                            |
|                          | She was coded with i   | no weight loss or gains of<br>t month or 10% or more in  |   |     | Resident #42: Resident Minimum Data<br>Set (MDS) assessment (Quarterly<br>Assessment,) with Assessment<br>/Reference Date (ARD) [1/31/2022] wa   |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |   |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|---|--------------------|--|---|--|-------------------------------|--|
|  |  |   |                    |  |   |  | С                             |  |
|  |  | 345532  | B. WING _          |  |   | 0  | 2/17/2022                     |  |
| NAME OF P  | ROVIDER OR SUPPLIER  |   |                    | STREET AD  | DDRESS, CITY, STATE, ZIP CODE   |  |                               |  |
|  |  |   |                    | 310 COMM   | MERCE DRIVE   |  |                               |  |
| LIBERTY  | COMMONS NSG AND  | REHAB CTR OF LEE COUNTY   |                    | SANFOR   | RD, NC 27332  |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICI   | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)   | OULD BE  | (X5)<br>COMPLETION<br>DATE    |  |
| F 641  | Continued From p   | age 47  | F                  | 641  |   |  |                               |  |
| F 641  | On 2/17/22 at 2:53 interviewed and consection on the MD the MDS assessment weight data for Manager stated showing the weights in the Elecompleting the MI view the weight data the 1/28/22 MDS and Manager indicated been coded for we oversight.  During an intervie on 2/17/22 at 5:33 expectation for the accurately.  2a. Resident # 52 cumulative diagnor. Alzheimer's Disease Review of Resider 7/7/21 she weight weight loss over the section of t | or PM, the Dietary Manager was confirmed she coded the nutrition as assessments. She reviewed then the dated 1/28/22 as well as a resident #12. The Dietary the reviewed Resident #12's actronic Medical Record prior to DS assessment and was able to dated 1/17/22 when she coded assessment. The Dietary of the assessment should have eight loss and stated it was a was with the Director of Nursing as PM, she indicated it was here a MDS assessment to be coded assessment and was admitted on 1/6/21 with the ses of breast cancer and see.  Int #52's weights revealed on the date 183.6 pounds, and on the date 183.6 pounds with a 11.76% | F                  | modification of the control of the c | dent #14: Resident Minimum MDS) assessment (Quarterly essment,) with Assessment erence Date (ARD) [12/6/202 fied. dent #23: Resident Minimum MDS) assessment (Quarterly essment,) with Assessment erence Date (ARD) [12/31/20 fied. dent #46: Resident Minimum MDS) assessment (Admission essment,) with Assessment erence Date (ARD) [1/17/202 | Data Set  [1] was  Data [1] was  Data [21] was  Data [21] was  ho may  eight onth or oths from ho have |                               |  |
|  | Resident #52's annual Minimum Data Set (MDS) dated 1/13/22 indicated she was not coded for any weight loss.  |   |                    | equip<br>reside<br>remo  | ical or mechanical device, man<br>coment attached or adjacent to<br>lent's body that the individual<br>ove easily which restricts free<br>ement or normal access to or  | o the<br>cannot<br>dom of  |                               |  |
|  | PM with the Dieta stated she did no  | conducted on 2/15/22 at 12:20<br>ry Manager (DM). The DM<br>t code the annual MDS dated<br>for Resident #52's documented  |                    | body)<br>day lo<br>date(<br>medio  | o) during the Mini Data Set (Mook back for assessment refe(s); who received scheduled pication regimen At any time do Data Set (MDS) 5 day look f   | IDS) 7<br>erence<br>pain<br>luring the   |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBER:   |         | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |  |         | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------|---|--|---------|-------------------------------|--|
|   |  | 345532   | B. WING |   |  |         | C<br>47/2022                  |  |
| NAME OF P   | ROVIDER OR SUPPLIER  | 0.0001   |         | STREET ADDRESS, CITY, STATE, ZIP CO   |  | 02/     | 17/2022                       |  |
| NAME OF T   | NOVIDER ON SOLT LIER   |  |         |   | 110 COMMERCE DRIVE   |         |                               |  |
| LIBERTY   | COMMONS NSG AND RE   | EHAB CTR OF LEE COUNTY   |         |   | SANFORD, NC 27332  |         |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |  | I       | ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY) |  |         | (X5)<br>COMPLETION<br>DATE    |  |
| F 641   | Continued From page  | e 48<br>ducted on 2/17/22 at 6:00  | F       | 641   | assessment reference date (s); Who have had a fall (s) since admission or  |         |                               |  |
|   | PM with the Director   | of Nursing (DON). She<br>s MDS dated 1/13/22 should<br>curately to reflect her                             |         |   | prior assessment with no injury, with ir<br>and with major injury from assessment<br>reference date(s); Who has one or mo<br>unhealed pressure ulcers/injuries in the<br>7-day look back period of the Mini Data<br>Set (MDS) for assessment reference d                   | re<br>e |                               |  |
|   |  | s admitted on 1/6/21 with<br>s of breast cancer and  |         |   | (s); who has surgical wound in the 7-c look back period of the Mini Data Set (MDS) for assessment reference date have the potential to be affected by the  |         |                               |  |
|   | 7/7/21 she weighed 1   | 163 pounds with a weight   |         |   | alleged practice. On 3/4/2022 through 3/7/2022 an audi was completed by the MDS Nurse Consultant to review all Minimum Data Set (MDS) assessments in the last 3 months to ensure that all current reside   |         |                               |  |
|   | -  | Minimum Data Set (MDS) ed she was not coded for  |         |   | who have had weight loss of 5% or moin the last month or loss of 10% or moin last 6 months from assessment   | e       |                               |  |
|   | PM with the Dietary N stated she did not co  | ducted on 2/15/22 at 12:20<br>Manager (DM). The DM<br>Ide the 5-day MDS dated<br>Resident #52's documented |         |   | reference date(s) were coded accurately. 8 out of 54 residents were noted to have had weight loss of 5% or more in the last month or loss of 10% or more in last 6 months from assessment reference date(s). 4 Resident Mini Date Set assessments were modified and 4 Mini |         |                               |  |
|   | PM with the Director   | •  |         |   | Data Set assessments were already coded accurately. On 3/4/2022 through 3/7/2022 an audi was completed by the MDS Nurse Consultant to review Minimum Data Se (MDS) assessments to ensure that all current residents who have Physical                                      | t       |                               |  |
|   | 3. Resident #42 was anoxic brain damage  | admitted on 11/25/15 with and dysphagia  |         |   | restraints (any manual method or phys<br>or mechanical device, material or<br>equipment attached or adjacent to the  | ical    |                               |  |
|   | Review of Resident #   | 42's quarterly Minimum   |         |   | resident's body that the individual canr   | ot      |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:            | ` '          | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |     | (X3) DATE SURVEY<br>COMPLETED |  |
|---|-------------------------|---|--------------|---|--|-----|-------------------------------|--|
|   |                         |   |              | _                                       |  | (   |                               |  |
|   |                         | 345532  | B. WING      |   |  | 02/ | 17/2022                       |  |
| NAME OF P   | ROVIDER OR SUPPLIER     | •   | ,            | S                                       | TREET ADDRESS, CITY, STATE, ZIP CODE   | -   |                               |  |
| LIDEDTY   | COMMONG NGC AND E       | DELLAR CTR OF LEE COUNTY                                      |              | 3′                                      | 10 COMMERCE DRIVE  |     |                               |  |
| LIBERTY   | COMMONS NSG AND R       | REHAB CTR OF LEE COUNTY                                       |              | S                                       | ANFORD, NC 27332   |     |                               |  |
| (X4) ID   | SUMMARY S               | TATEMENT OF DEFICIENCIES                                      | ID           |   | PROVIDER'S PLAN OF CORRECTION  |     | (X5)                          |  |
| PRÉFIX<br>TAG                                       |                         | CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION) | PREFI<br>TAG | X                                       | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY) |     | COMPLETION<br>DATE            |  |
| F 641   | Continued From pag      | ge 49   | F            | 641                                     |  |     |                               |  |
|   | Data Set (MDS) date     | ed 1/31/22 indicated severe                                   |              |   | remove easily which restricts freedom  | of  |                               |  |
|   | cognitive impairmen     | t. The MDS was not coded                                      |              |   | movement or normal access to one's   |     |                               |  |
|   | for the use of a restr  | aint.   |              |   | body) during the Mini Data Set (MDS)   | 7   |                               |  |
|   |                         |   |              |   | day look back for assessment referenc  | e   |                               |  |
|   | An interview was co     | nducted on 2/16/22 at 8:30                                    |              |   | date(s) is coded accurately. All   |     |                               |  |
|   |                         | She stated Resident #42 had                                   |              |   | assessments coded accurately for   |     |                               |  |
|   |                         | r to prevent him for sucking                                  |              |   | physical restraints. Out of the 54 currer                                      |     |                               |  |
|   |                         | She stated the binder had                                     |              |   | residents in the facility, 0 have physical                                     | .   |                               |  |
|   | been in use for at lea  | ast a year or more.   |              |   | restraints.  |     |                               |  |
|   | A :                     |   |              |   | On 3/4/2022 through 3/7/2022 an audit  |     |                               |  |
|   |                         | nducted on 2/16/22 at 8:40                                    |              |   | was completed by the MDS Nurse Consultant to review Minimum Data Se            |     |                               |  |
|   | _                       | sistant (NA) #10. She stated rved Resident #42 attempt to     |              |   | (MDS) assessments to ensure that all   | ١   |                               |  |
|   |                         | nal binder and he probably                                    |              |   | current residents who received schedu  | led |                               |  |
|   |                         | remove it. She stated she                                     |              |   | pain medication regimen At any time  | Cu  |                               |  |
|   |                         | der during his bath but all                                   |              |   | during the Mini Data Set ( MDS) 5 day  |     |                               |  |
|   | other times, it was s   |   |              |   | look for assessment reference date (s)   | is  |                               |  |
|   | ,                       |   |              |   | coded accurately. All assessments cod  |     |                               |  |
|   | An observation of Re    | esident #42 was conducted                                     |              |   | accurately for scheduled pain  |     |                               |  |
|   | on 2/16/22 at 11:10     | AM with Nurse #3. The nurse                                   |              |   | management.  |     |                               |  |
|   | lifted his shirt, and a | tan colored abdominal binder                                  |              |   | On 3/4/2022 through 3/7/2022 an audi   | t   |                               |  |
|   | was observed exten      | ding around his abdomen                                       |              |   | was completed by the MDS Nurse to  |     |                               |  |
|   |                         | elcro. Nurse #3 asked   |              |   | review Minimum Data Set (MDS)  |     |                               |  |
|   |                         | mpt to remove the abdominal                                   |              |   | assessments to ensure that all current   |     |                               |  |
|   |                         | prompts, it was evident that                                  |              |   | residents who have had a fall (s) since  |     |                               |  |
|   |                         | not follow commands and                                       |              |   | admission or prior assessment with no  |     |                               |  |
|   | made no visible effo    | rt to touch the binder.                                       |              |   | injury, with injury and with major injury                                      |     |                               |  |
|   | An interview was as     | ndusted on 2/16/22 at 2:20                                    |              |   | from assessment reference date(s) is   | 24  |                               |  |
|   |                         | nducted on 2/16/22 at 2:30<br>m Data Set (MDS) Nurse.         |              |   | coded accurately. All assessments cod accurately for falls.                    | eu  |                               |  |
|   |                         | not code Resident #42'  |              |   | On 3/4/2022 through 3/7/2022 an audit  |     |                               |  |
|   |                         | s a restraint. She stated the                                 |              |   | was completed by the MDS Nurse   |     |                               |  |
|   |                         | as used to prevent Resident                                   |              |   | Consultant to review Minimum Data Se   | t   |                               |  |
|   |                         | his feeding tube. The MDS                                     |              |   | (MDS) assessments to ensure that all   |     |                               |  |
|   | Nurse stated she wa     | <del>-</del>  |              |   | current residents who have surgical  |     |                               |  |
|   |                         | as a physical restraint if                                    |              |   | wounds and/or unhealed pressure ulce   | ers |                               |  |
|   | Resident #42 could      | . ,   |              |   | in the 7 day look back of the Mini Data  |     |                               |  |
|   |                         |   |              |   | is coded accurately All assessments  |     |                               |  |
|   | An interview was co     | nducted on 2/17/22 at 6:00                                    |              |   | coded accurately. All assessments code   | bet |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         | ` ′           | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|---------------|---|--|--|-------------------------------|--|
|   |   |  | 7. BOILDII    |   |  | ، ا  | c                             |  |
|   |   | 345532   | B. WING _     |   |  |  | 17/2022                       |  |
| NAME OF P   | ROVIDER OR SUPPLIER                     |  |               | ST                                      | TREET ADDRESS, CITY, STATE, ZIP CODE   | <u>,                                      </u> |                               |  |
|   |   |  |               | 31                                      | 10 COMMERCE DRIVE  |  |                               |  |
| LIBERTY   | COMMONS NSG AND R                       | EHAB CTR OF LEE COUNTY                                     |               | S                                       | ANFORD, NC 27332   |  |                               |  |
| (X4) ID   | SUMMARY ST                              | TATEMENT OF DEFICIENCIES                                   | ID            |   | PROVIDER'S PLAN OF CORRECTION  |  | (X5)                          |  |
| PREFIX<br>TAG                                       |   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFI)<br>TAG | X                                       | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |  | COMPLETION<br>DATE            |  |
| F 641   | Continued From page                     | e 50   | F 6           | 641                                     |  |  |                               |  |
|   | PM with the Director                    | of Nursing (DON). She                                      |               |   | accurately for surgical wounds and/or  |  |                               |  |
|   |   | not consider the abdominal                                 |               |   | unhealed pressure ulcers.  |  |                               |  |
|   | 1                                       | restraint, but she expected it                             |               |   | This was completed on 3/7/2022.  |  |                               |  |
|   | to be coded accurate                    | ly since he was unable to                                  |               |   |  |  |                               |  |
|   | remove it.                              |  |               |   | Systemic Changes:  |  |                               |  |
|   | 4 a. Resident #46 wa                    | as admitted to the facility on                             |               |   | On 3/8/2022 The Registered Nurse (RI   | ۷)   |                               |  |
|   | 1/10/22.                                |  |               |   | Minimum Data Set (MDS) Coordinator   |  |                               |  |
|   |   |  |               |   | and MDS Support nurse and any other  |  |                               |  |
|   |   | pressure ulcer review form                                 |               |   | Interdisciplinary team member that   |  |                               |  |
|   |   | eviewed. The form revealed                                 |               |   | participates in the MDS assessment   |  |                               |  |
|   |   | d 1 unstageable pressure                                   |               |   | process was in serviced /educated by t   | he   |                               |  |
|   | ulcer on her right iliad                |  |               |   | MDS Nurse consultant.  |  |                               |  |
|   | centimeter (cm) by 2                    | cm.  |               |   | The education focused on: The facility   |  |                               |  |
|   | The admission Minim                     | num Data Sat (MDS)   |               |   | must ensure that each assessment   |  |                               |  |
|   | The admission Minim assessment dated 1/ | , ,  |               |   | accurately reflects the resident's status<br>Section K0300. Weight loss: Loss of 5   |  |                               |  |
|   | · ·                                     | unstageable pressure ulcer                                 |               |   | or more in the last month or loss of 109   |  |                               |  |
|   | that was present on a                   | -  |               |   | or more in last 6 months. This item do   |  |                               |  |
|   | linat was present on t                  | dumission.   |               |   | not consider weight fluctuation outside  |  |                               |  |
|   | Review of the care a                    | rea assessment (CAAs) and                                  |               |   | these two time points, although the  | •  |                               |  |
|   | the care plan dated 1                   | , ,  |               |   | resident's weight should be monitored  | on   |                               |  |
|   |   | pressure ulcer, unstageable                                |               |   | a continual basis and weight loss  |  |                               |  |
|   | to the right lower bac                  |  |               |   | assessed and addressed on the care p   | lan  |                               |  |
|   |   |  |               |   | as necessary. Code 0, no or unknown:   | if   |                               |  |
|   | Review of the Wound                     | d Physician note dated                                     |               |   | the resident has not experienced weigh   | nt   |                               |  |
|   | 1/18/22 revealed a po                   | ost-surgical wound on the                                  |               |   | loss of 5% or more in the past 30 days   | or   |                               |  |
|   | right lower back. The                   | e note indicated that                                      |               |   | 10% or more in the last 180 days or if   |  |                               |  |
|   |   | dergone T11 (thoracic                                      |               |   | information about prior weight is not  |  |                               |  |
|   | , ,                                     | r spine) spinal fusion and L4                              |               |   | available. Code 1, yes on  |  |                               |  |
|   | vertebroplasty (a pro                   |  |               |   | physician-prescribed weight-loss regim   |  |                               |  |
|   |   | es of the spine). "Today on                                |               |   | if the resident has experienced a weigh  |  |                               |  |
|   | 1                                       | n wound was overlying part                                 |               |   | loss of 5% or more in the past 30 days   |  |                               |  |
|   | of her incision".                       |  |               |   | 10% or more in the last 180 days, and  |  |                               |  |
|   | The Means of Marine                     | interviewed av 0/45/00 -1                                  |               |   | weight loss was planned and pursuant   | to   |                               |  |
|   |   | as interviewed on 2/15/22 at                               |               |   | a physician's order. In cases where a  |  |                               |  |
|   |   | I that she started as Wound                                |               |   | resident has a weight loss of 5% or mo   |  |                               |  |
|   |   | 21. She made rounds with                                   |               |   | in 30 days or 10% or more in 180 days  |  |                               |  |
|   | _                                       | weekly and transcribed the commended. She reviewed         |               |   | a result of any physician ordered diet p<br>or expected weight loss due to loss of   | ıan  |                               |  |
|   | r neannean bian as fe¢                  | JULIUELIUEU, SHE LEVIEWED                                  | 1             | - 1                                     | ⊢ OF EXDECTED WEIGHT IOSS QUE TO IOSS OF   |  | 1                             |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:          | ` ′          | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |                        | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---------------------|---|--------------|--|---|------------------------|-------------------------------|--|
|   |                     | 345532  | B. WING      |  |   | C<br><b>02/17/2022</b> |                               |  |
| NAME OF PE  | ROVIDER OR SUPPLIER | <b>L</b>  |              | S                                      | TREET ADDRESS, CITY, STATE, ZIP CODE  | 1 02/                  | 1772022                       |  |
|   |                     |   |              |  | 10 COMMERCE DRIVE   |                        |                               |  |
| LIBERTY (   | COMMONS NSG AND     | REHAB CTR OF LEE COUNTY                                     |              | SANFORD, NC 27332                      |   |                        |                               |  |
| (V4) ID   | SLIMMARY            | STATEMENT OF DEFICIENCIES                                   | ID           |  | PROVIDER'S PLAN OF CORRECTION   |                        | (X5)                          |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE       | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | PREFI<br>TAG |  | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                        | COMPLETION<br>DATE            |  |
| F 641   | Continued From pa   | age 51  | F            | 641                                    |   |                        |                               |  |
|   | the Wound Physici   | an note dated 1/18/22 and                                   |              |  | fluid with physician orders for diuretics   | ,                      |                               |  |
|   |                     | und on the right lower back                                 |              |  | K0300 can be coded as 1 Code 2, yes   |                        |                               |  |
|   | was a surgical wou  | ind and not a pressure ulcer.                               |              |  | not on physician-prescribed weight-los  | s                      |                               |  |
|   |                     |   |              |  | regimen: if the resident has experience   | ed a                   |                               |  |
|   | The MDS Nurse wa    | as interviewed on 2/17/22 at                                |              |  | weight loss of 5% or more in the past 3   |                        |                               |  |
|   | -                   | S Nurse stated that she started                             |              |  | days or 10% or more in the last 180 da  | •                      |                               |  |
|   |                     | months ago. She reported                                    |              |  | and the weight loss was not planned a   | nd                     |                               |  |
|   |                     | ormation from the Wound                                     |              |  | prescribed by a physician. Section  |                        |                               |  |
|   |                     | and documentation in  |              |  | J0100A. Received scheduled pain   |                        |                               |  |
|   |                     | S assessments for pressure                                  |              |  | medication regimen. Determine all   |                        |                               |  |
|   |                     | . She stated that the Wound ed the wound on Resident #46 '  |              |  | interventions for pain provided to the  |                        |                               |  |
|   |                     |   |              |  | resident during the 5-day look-back   |                        |                               |  |
|   |                     | as a pressure ulcer. She<br>nd Physician note dated         |              |  | period. Answer these items even if the resident currently denies pain Code 0,       |                        |                               |  |
|   |                     | d that the wound was a                                      |              |  | if the medical record does not contain  | 110.                   |                               |  |
|   |                     | d not a pressure ulcer. She                                 |              |  | documentation that a scheduled pain   |                        |                               |  |
|   | -                   | nission MDS dated 1/17/22 was                               |              |  | medication was received. Code 1, yes  | : if                   |                               |  |
|   |                     | area of pressure ulcer. The                                 |              |  | the medical record contains   |                        |                               |  |
|   |                     | jical wound and not a pressure                              |              |  | documentation that a scheduled pain   |                        |                               |  |
|   | ulcer wound.        | •   |              |  | medication was received. Section J190   | 00.                    |                               |  |
|   |                     |   |              |  | Number of Falls since Admission/Entry   | or /                   |                               |  |
|   | The Director of Nur | rsing (DON) was interviewed                                 |              |  | Reentry or Prior Assessment (OBRA o   | r                      |                               |  |
|   | on 2/17/2 at 3:34 P | M. She reported that she just                               |              |  | Scheduled PPS). Coding Instructions f   | or                     |                               |  |
|   | started as DON of   | the facility in January 2022.                               |              |  | J1900A, No Injury Code 0, none: if the  |                        |                               |  |
|   |                     | MDS Nurse and the Wound                                     |              |  | resident had no injurious fall since the  |                        |                               |  |
|   |                     | their position but that was not                             |              |  | admission/entry or reentry or prior   |                        |                               |  |
|   |                     | these errors. They were                                     |              |  | assessment (OBRA or Scheduled   |                        |                               |  |
|   | expected to be res  | ponsible and accountable.                                   |              |  | PPS).Code 1, one: if the resident had   |                        |                               |  |
|   |                     |   |              |  | non-injurious fall since admission/entry  |                        |                               |  |
|   | 1 b Dooid # 40 :    | upp admitted to the feetility are                           |              |  | reentry or prior assessment (OBRA or  |                        |                               |  |
|   |                     | was admitted to the facility on                             |              |  | Scheduled PPS).Code 2, two or more:   |                        |                               |  |
|   | 1/10/22.            |   |              |  | the resident had two or more non-injur falls since admission/entry or reentry or    |                        |                               |  |
|   | The admission Min   | imum Data Set (MDS)   |              |  | prior assessment (OBRA or Scheduled   |                        |                               |  |
|   |                     | 1/17/22 indicated that                                      |              |  | PPS).Coding Instructions for J1900B,  | 4                      |                               |  |
|   |                     | not on a scheduled pain                                     |              |  | Injury (Except Major) Code 0, none: if  | the                    |                               |  |
|   | medication.         | not on a contodulou pulli                                   |              |  | resident had no injurious fall (except  |                        |                               |  |
|   |                     |   |              |  | major) since admission/entry or reentry   | v or                   |                               |  |
|   | Resident #46 had a  | a doctor's order dated 1/10/22                              |              |  | prior assessment (OBRA or Scheduled   | •                      |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | IPLE CONSTRUCTION  | , ,  | E SURVEY<br>MPLETED        |
|---|---|--|---------------------|--|--|----------------------------|
|   |   | 345532   | B. WING             |  |  | C<br><b>2/17/2022</b>      |
| NAME OF P   | ROVIDER OR SUPPLIER   | 0.0002   | 1                   | STREET ADDRESS, CITY, STATE, ZIP COI   | •  | 2/1//2022                  |
| TO UNE OF T   | NOVIDEN ON COLL FEET  |  |                     | 310 COMMERCE DRIVE   |  |                            |
| LIBERTY   | COMMONS NSG ANI   | REHAB CTR OF LEE COUNTY  |                     | SANFORD, NC 27332  |  |                            |
|   | I   |  |                     |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICI  | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CO<br>( (EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY)  | N SHOULD BE<br>E APPROPRIATE   | (X5)<br>COMPLETION<br>DATE |
| F 641   | Continued From p  | page 52  | F6                  | 641  |  |                            |
|   | of nerve pain) - appain.  | th 5% (used to treat symptoms oply in AM and remove at HS for  |                     | PPS).Code 1, one: if the resi<br>injurious fall (except major) s<br>admission/entry or reentry or<br>assessment (OBRA or Schee   | since<br><sup>-</sup> prior<br>duled PPS).   |                            |
|   | Administration Re   | nuary 2022 Medication<br>cords (MARs) revealed that<br>received Lidoderm patch daily<br>ment period.   |                     | Code 2, two or more: if the re<br>two or more injurious falls (e.<br>since admission/entry or reel<br>assessment (OBRA or Sche   | xcept major)<br>ntry or prior<br>duled   |                            |
|   | 2:15 PM. The ME as MDS Nurse 4-the doctor's order that the admission 1/17/22 was code management. She   | The MDS Nurse was interviewed on 2/17/22 at 1:15 PM. The MDS Nurse stated that she started is MDS Nurse 4-5 months ago. She reviewed the doctor's orders and MARs, and she verified that the admission MDS assessment dated 1/17/22 was coded wrong in the area of pain than agement. She reported that the resident was in scheduled pain medication.  The Director of Nursing (DON) was interviewed in 2/17/2 at 3:34 PM. She reported that she just that the as DON of the facility in January 2022. She stated that the MDS Nurse was new to her resident was not an excuse to make these errors. The DON stated that she expected the MDS assessments to be coded accurately. |                     | PPS).Coding Instructions for J1900C, Major Injury Code 0, none: if the resident had no major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).Code 1, one: if the resident had one major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS). Code 2, two or more: if |  |                            |
|   | on 2/17/2 at 3:34<br>started as DON o<br>She stated that th<br>position but that v<br>these errors. The |  |                     | the resident had two or more injurious falls since admissio reentry or prior assessment (Scheduled PPS).Coding Tip: injury directly related to a fall during the look-back period i after the ARD and is at a diffilevel than what was originally assessment that was submit   | n/entry or (OBRA or If the level of that occurred s identified erent injury y coded on an ted to the |                            |
|   | 5. Resident #16 w<br>6/2/21   | as admitted to the facility on   |                     | Quality Improvement and Ev<br>System (QIES) Assessment<br>and Processing (ASAP) syst<br>assessment must be modifie   | Submission<br>em, the<br>ed to update  |                            |
|   | assessment dated<br>Resident #16 had<br>since admission,<br>The incident repo                           | imum Data Set (MDS) d 12/9/21 indicated that 2 or more falls with no injury reentry, or prior assessment. rts for Resident #16 were  |                     | the level of injury that occurre<br>fall. Section M0210 Unhealer<br>Ulcers/Injuries. Code based<br>presence of any pressure ulc<br>(regardless of stage) in the p<br>Code 0, no: if the resident die   | d Pressure<br>on the<br>cer/injury<br>past 7 days.<br>d not have a                                   |                            |
|   | the resident had a  | port dated 9/9/21 revealed that<br>a fall and the x-ray report dated<br>acute, non-displaced fracture at   |                     | pressure ulcer/injury in the 7-<br>look-back period. Then skip to<br>Number of Venous and Arter  | to M1030,  |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                |     | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|----------------------|---|--------------------|-----|---|-------------------------------|----------------------------|
|   |                      | 345532  | B. WING            |     |   | 1                             | C<br>/ <b>17/2022</b>      |
| NAME OF P   | ROVIDER OR SUPPLIER  | 0.0002  |                    | ST  | FREET ADDRESS, CITY, STATE, ZIP CODE  | 1 02/                         | 11//2022                   |
| NAME OF T   | NOVIDEN ON OUT FIEN  |   |                    |     | 0 COMMERCE DRIVE  |                               |                            |
| LIBERTY   | COMMONS NSG ANI      | D REHAB CTR OF LEE COUNTY   |                    |     | ANFORD, NC 27332  |                               |                            |
|   | I                    |   |                    | 3/  | <u> </u>  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICI         | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE |
| F 641   | Continued From p     | page 53   | F                  | 641 |   |                               |                            |
|   | base of first distal | phalanx and mild subluxation at   |                    |     | Code 1, yes: if the resident had any  |                               |                            |
|   | first metacarpoph    |   |                    |     | pressure ulcer/injury (Stage 1, 2, 3, 4,  | or                            |                            |
|   | '                    | 3 ,   |                    |     | unstageable) in the 7-day look-back   |                               |                            |
|   | The report dated     | 9/15/21 at 6:59 AM revealed   |                    |     | period. Proceed to M0300, Current   |                               |                            |
|   |                      | was observed sitting on the   |                    |     | Number of Unhealed Pressure   |                               |                            |
|   | floor at the doorw   | ay of room. Resident was  |                    |     | Ulcers/Injuries at Each Stage. Section  | M:                            |                            |
|   | assessed for injur   | y. Range of motion to all   |                    |     | Other Ulcers, Wounds and Skin   |                               |                            |
|   | extremities with n   | o change in limitations noted.  |                    |     | Problems. Review the medical record   |                               |                            |
|   |                      |   |                    |     | including skin care flow sheets or other  |                               |                            |
|   |                      | dated 9/15/21 at 9:41 AM  |                    |     | skin tracking forms. Speak with direct  |                               |                            |
|   |                      | ident #16 noted to be in pain   |                    |     | care staff and the treatment nurse to   |                               |                            |
|   |                      | nd up. When asked, she stated   |                    |     | confirm conclusions from the medical  |                               |                            |
|   |                      | The resident was medicated narcotic used to treat pain).                                  |                    |     | record review. Examine the resident a determine whether any ulcers, wound   |                               |                            |
|   | with framador (a     | narcolic used to freat pairi).  |                    |     | skin problems are present. Key areas  |                               |                            |
|   | The nurse's note     | dated 9/23/21 revealed that   |                    |     | diabetic foot ulcers include the plantar  |                               |                            |
|   | Resident #16 con     | tinued not to bear weight on her  |                    |     | (bottom) surface of the foot, especially  | / the                         |                            |
|   |                      | nity, the physician was notified  |                    |     | metatarsal heads (the ball of the foot)   |                               |                            |
|   |                      | I tomography CT) scan of the  |                    |     | there is no evidence of such problems   |                               |                            |
|   | pelvis was ordere    | d.  |                    |     | the last 7 days, check none of the abo  | ve.                           |                            |
|   |                      |   |                    |     | Surgical wounds Any healing and   |                               |                            |
|   |                      | ort dated 9/24/21 revealed  |                    |     | non-healing, open or closed surgical  |                               |                            |
|   |                      | nuted right superior pubic ramus  |                    |     | incisions, skin grafts or drainage sites  |                               |                            |
|   | ramus fracture.      | isplaced left inferior pubis  |                    |     | Section P0100. Physical Restraints.   |                               |                            |
|   | ramus fracture.      |   |                    |     | Physical restraints are any manual method or physical or mechanical dev   | vice                          |                            |
|   | The MDS Nurse v      | vas interviewed on 2/17/22 at   |                    |     | material or equipment attached or   | ice,                          |                            |
|   |                      | OS Nurse stated that she started  |                    |     | adjacent to the resident's body that the  | <b>e</b>                      |                            |
|   | _                    | 5 months ago. The MDS Nurse   |                    |     | individual cannot remove easily which   |                               |                            |
|   |                      | only reviewed the incident  |                    |     | restricts freedom of movement or norr   |                               |                            |
|   |                      | e nurse's notes when  |                    |     | access to one's body. Exclude from th   | iis                           |                            |
|   | completing the MI    | DS assessments for falls. She   |                    |     | section items that are typically used in  |                               |                            |
|   |                      | e's notes and the x-ray/CT  |                    |     | provision of medical care, such as  |                               |                            |
|   |                      | ed that the quarterly MDS   |                    |     | catheters, drainage tubes, casts, tract   |                               |                            |
|   |                      | d 12/9/21 was coded wrong in  |                    |     | leg, arm, neck, or back braces, abdon   |                               |                            |
|   |                      | Resident #16 had falls with   |                    |     | binders, and bandages that are serving  | g in                          |                            |
|   | major injury.        |   |                    |     | their usual capacity to meet medical  |                               |                            |
|   |                      |   |                    |     | need(s).  |                               |                            |
|   | The Director of No   | ursing (DON) was interviewed  |                    |     | This in service was completed by  |                               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | 2) MULTIPLE CONSTRUCTION BUILDING  |   |                         | (X3) DATE SURVEY<br>COMPLETED |  |
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|   |  | 345532  | B. WING             |  |   | C                       | 00                            |  |
| NAME OF D   | DOVIDED OD CLIDDLIED   | 343332  | 1 5:                | STREET ADDRESS, CIT  |   | 02/17/20                | 22                            |  |
| NAME OF PI  | ROVIDER OR SUPPLIER  |   |                     | •  | ,   |                         |                               |  |
| LIBERTY   | COMMONS NSG AND RE   | HAB CTR OF LEE COUNTY   |                     | 310 COMMERCE DRIV  |   |                         |                               |  |
|   |  |   |                     | SANFORD, NC 273  | 332   |                         |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD BE   |   | E COME                  | (X5)<br>PLETION<br>DATE       |  |
| F 641   | Continued From page  | e 54  | F 6                 | 41   |   |                         |                               |  |
|   | started as DON of the<br>She stated that the M<br>position but that was<br>these errors. The DO<br>the MDS assessment  | She reported that she just a facility in January 2022. IDS Nurse was new to her not an excuse to make N stated that she expected to be coded accurately.  |                     | (RN) and or Lic<br>(LPN) Support<br>Coordinators a<br>Interdisciplinar<br>participates in<br>process who d<br>training will no                         | The Registered Nurse censed Practical Nurse is Minimum Data Set (MD and any other by team member that the MDS assessment lid not receive in-service to be allowed to work untilityleted. This information   |                         |                               |  |
|   | 9/4/17.  The quarterly Minimu assessment dated 12  | m Data Set (MDS)<br>2/6/21 indicated that<br>tage 4 pressure ulcer that   |                     | has been integ<br>orientation trai<br>in-service refre<br>employees and<br>Quality Assura  | grated into the standard ning and in the required esher courses for all d will be reviewed by the ince Process to verify that s been sustained.   |                         |                               |  |
|   | 11/30/21 revealed that 4 pressure ulcer on the pressure ulcer on the Review of the Decem Administration Record Resident #14 had record to the pressure ulcer on the pressure ulc | bber 2021 Treatment<br>ds (TARs) revealed that<br>eived treatment to his sacral<br>ssure ulcers during the  |                     | To ensure com Nursing and/or resident electro Minimum Data this could be e assessments A Quarterly Asses section K0300 or more in the or more in last  | npliance, The Director of r Administrator will review onic medical records a Set (MDS) assessment either one of the following Admission, Annual or essment to ensure that . Weight loss: Loss of 5% last month or loss of 10% 6 months; Section J010 eduled pain medication   | 6<br>6                  |                               |  |
|   | 2:15 PM. The MDS Nas MDS Nurse 4-5 m the Wound Physician verified that the quart 12/6/21 was coded wulcers. Resident #14 pressure ulcers.  The Director of Nursinon 2/17/2 at 3:34 PM  | interviewed on 2/17/22 at Nurse stated that she started onths ago. She reviewed notes and the TARs and erly MDS assessment dated rong in the area of pressure had stage 3 and stage 4 ang (DON) was interviewed. She reported that she just a facility in January 2022. |                     | since Admission Assessment (Control Mo210 Ulcers/Injuries Wounds and Some Po100. Physic accurately. This basis for 4 weed months. The regreewed at the | ion J1900. Number of Fa<br>on/Entry or Reentry or Pr<br>OBRA or Scheduled PPS<br>O Unhealed Pressure<br>; Section M: Other Ulcers<br>Skin Problems; Section<br>cal Restraints are coded<br>is will be done on weekly<br>eks then monthly for 3<br>esults of this audit will be<br>be weekly QA Team Meetic<br>presented to the weekly | ior<br>i);<br>s,<br>ng. |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | IDENTIFICATION NUMBER:   |                     |  | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
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|  |   | 345532   | B. WING _           |  |  | 03                            | C<br>2/17/2022             |
|  | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332 |  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                         | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | ×  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   |                               | (X5)<br>COMPLETION<br>DATE |
| F 641  | position but that was these errors. The DO the MDS assessment 7. Resident #23 was 7/13/17.  The quarterly Minimulassessment dated 12 Resident #23 did not The Wound Physicial indicated that Reside pressure ulcer on help treatment plan was Cabsorbent that promode absorbent that promode Review of the Decem Administration Recorn Resident #23's left but treated with calcium assessment period.  The MDS Nurse was 2:15 PM. The MDS I as MDS Nurse 4-5 m the Wound Physician verified that the quart 12/31/21 was coded pressure ulcers. Resipressure ulcer during The Director of Nursi | IDS Nurse was new to her not an excuse to make N stated that she expected is to be coded accurately.  admitted to the facility on  IDDE MIDS Set (MDS)  IDDE | F                   | 641  | QA Committee by the Director of Nursiand/or Mini Data Set (MDS) Coordinate to ensure corrective action initiated as appropriate. Any immediate concerns be brought to the Director of Nursing of Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MD Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Would Nurse. | ors will r the y S            |                            |
|  | just started as DON o   | of the facility in January<br>It the MDS Nurse was new   |                     |  |  |                               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | I DENTIFICATION NUMBER:   |                    | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED   |               |
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|   |   | 345532  | B. WING            |                    |   | C             |
| NAME OF P   | ROVIDER OR SUPPLIER   | 040002  |                    | STREET ADDRESS, CI | ITY, STATE, ZIP CODE  | 02/17/2022    |
|   |   |   | 310 COMMERCE DRIVE |                    |   |               |
| LIBERTY   | COMMONS NSG AND RE  | HAB CTR OF LEE COUNTY   | SANFORD, NC 27332  |                    | 332   |               |
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| F 641   | Continued From page   | e 56  | F                  | 641                |   |               |
|   | make these errors. The expected the MDS as accurately.  | at was not an excuse to<br>the DON stated that she<br>disessments to be coded   |                    |                    |   |               |
| F 656<br>SS=D                                       |   | comprehensive Care Plan   | F                  | 556                |   | 3/9/22        |
|   | implement a compreh care plan for each res resident rights set for §483.10(c)(3), that incobjectives and timefra medical, nursing, and needs that are identificassessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (iii) Any services that under §483.24, §483. provided due to the reunder §483.10, includit reatment under §483. (iii) Any specialized simplement in the reside sprovide as a result of recommendations. If findings of the PASAF rationale in the reside (iv)In consultation wit resident's representation. The resident's good desired outcomes. | cility must develop and bensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ided in the comprehensive inprehensive care plan must grant to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse \$1.10(c)(6).  Betwices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)- |                    |                    |   |               |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | I DENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION   |  | (X3) DATE SURVEY<br>COMPLETED |  |
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|   |   | 345532   | B. WING             |  |  | C<br><b>2/17/2022</b>         |  |
| NAME OF P   | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |  | 2/11/2022                     |  |
|   |   |  |                     | 310 COMMERCE DRIVE   |  |                               |  |
| LIBERTY   | COMMONS NSG AND R   | EHAB CTR OF LEE COUNTY   |                     | SANFORD, NC 27332  |  |                               |  |
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| F 656   | Continued From pag  | e 57   | F 65                | 56   |  |                               |  |
| F 656   | future discharge. Face whether the resident community was assel local contact agencie entities, for this purp (C) Discharge plans plan, as appropriate, requirements set for section.  This REQUIREMENT by:  Based on record revinterviews, the facility planned intervention for 1 of 22 residents.  The findings included Resident #40 was as 6/7/15 with diagnose history of falling.  A review of the active an order dated 3/26/help define borders.  Review of Resident included a nursing policy was as 10 cm and 10 cm. | cilities must document 's desire to return to the essed and any referrals to es and/or other appropriate ose. in the comprehensive care in accordance with the th in paragraph (c) of this  T is not met as evidenced view, observations and staff y failed to implement care is after a fall (Resident #40) reviewed.  d: dmitted to the facility on is that include dementia and e physician orders revealed 20 for a scoop mattress to  #40's medical record rogress note, written by she was found on the floor 1/26/21 at 4:54 PM. Resident | F 65                | The statements made on this F Correction are not an admission not constitute an agreement wit alleged deficiencies. To remain compliance with all Federal and Regulations the facility has take take the actions set forth in this Correction. The Plan of Corrections to the facility's allegatic compliance such that all alleged deficiencies cited have been or corrected by the date or dates in F656 Develop/Implement Compliance Plan Corrective Action:  Resident #40: Care plan review revised on 2/16/2022 by interdisteam. Scoop mattress resolved has new implementation to have at beside while in bed (both side | n to and do th the in I State en or will Plan of tion on of d will be indicated. orehensive  yed and sciplinary resident e fall mat es of bed) |                               |  |
|   | 12/2/21, included a f<br>risk for further falls.<br>scoop mattress to he<br>An Interdisciplinary [  | e care plan, last reviewed ocus area for actual fall with The interventions included alp define bed boundaries.  Departmental Team (IDT) 12/14/21 to review the fall   |                     | Identification of other residents be involved with this practice: All current residents with care p interventions after a fall have th to be affected by the alleged pro 3/8/2022 through 3/9/2022 an a completed by the Director of NuMDS Coordinators, to ensure the   | olan<br>le potential<br>actice. On<br>ludit was<br>ursing and  |                               |  |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1                  | ) MULTIPLE CONSTRUCTION BUILDING |  |                               | (X3) DATE SURVEY COMPLETED |  |
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|                          |   | 345532  | B. WING            |                                  |  |                               | C<br><b>17/2022</b>        |  |
| NAME OF P                | ROVIDER OR SUPPLIER   |   | '                  | S                                | TREET ADDRESS, CITY, STATE, ZIP CODE   | , 02.                         |                            |  |
| LIDEDTY                  |   | DELLAR OTR OF LEE COUNTY  | 310 COMMERCE D     |                                  | 10 COMMERCE DRIVE  |                               |                            |  |
| LIBERTY                  | COMMONS NSG AND F   | REHAB CTR OF LEE COUNTY   |                    | S                                | ANFORD, NC 27332   |                               |                            |  |
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| F 656                    | Continued From pag  | ge 58   | F                  | 656                              |  |                               |                            |  |
| F 030                    | that occurred on 11/foam floor mats wer safety. The note increviewed. The root of determined to be concerned and the bed at 12:11 PM.  An IDT meeting was fall that occurred on unable to explain with the fall. An interven of bed upon waking suggested.  A quarterly Minimum assessment dated 1 #40 had severe cog one fall with no injur.  On 2/14/22 at 11:30 observed lying in be was no scoop mattre to either side of the bathroom in Reside foam fall mat leaning. | 26/21. Nurse #1 indicated e on each side of the bed for dicated the care plan was cause of the fall was infusion.  Inote, dated 1/17/22, written ed Resident #40 was the floor on her back beside l.  Is held on 1/18/22 to review the 1/17/22. Resident #40 was that happened at the time of tion of offering assistance out in the morning was  In Data Set (MDS)  I/28/22 indicated Resident initive impairment and had by.  AM, Resident #40 was d with her eyes closed. There ess present, or foam fall mats bed. Observation of the int #40's room revealed a g against the wall. |                    | 056                              | plan was implemented for current residents with careplan interventions at a fall to ensure that the interventions wimplemented as indicated on the plan ocare. All current residents with a care printervention after a fall, have intervention implemented as indicated on the plan ocare. This was completed on 3/9/2022. Systemic Changes:  On 3/9/2022 The Registered Nurse (Riminimum 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 consultar. The education focused on: The facility must develop and implement a comprehensive person-centered care process resident, consistent with the resident rights set forth and that include measurable objectives and timeframes meet a resident's medical, nursing and mental psychosocial needs that are identified in the comprehensive care plan must describe the following: the services that are to be furnished to atta or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing; and any services that would otherwise be required but the care in the resident of the process in the plan in the | ere of olan ons of  N) s  at. |                            |  |
|                          | AM lying in bed with<br>mats to either side of<br>was observed again<br>Resident #40's roon   |   |                    |                                  | that would otherwise be required but an 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                            |                            |  |
|                          | observed lying in be  | PM, Resident #40 was d with her eyes closed. There ess or fall mats present to  |                    |                                  | a result of PASARR recommendations,<br>and after consultation with the resident<br>and the resident's representative's on t  |                               |                            |  |

|                          | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                      | ` ′                 |     | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|-------------------------------|---|---------------------|-----|--|-------------------------------|----------------------------|
|                          |                               | 245520  | B WING              |     |  | 1                             | c                          |
|                          |                               | 345532  | B. WING _           |     |  | 02/                           | 17/2022                    |
| NAME OF PR               | ROVIDER OR SUPPLIER           |   |                     |     | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                            |
| LIBERTY                  | COMMONS NSG AND R             | EHAB CTR OF LEE COUNTY  |                     | 31  | 10 COMMERCE DRIVE  |                               |                            |
| LIDEIXIII                | SOMMONO NOO AND IX            | LIAB OIN OF ELE GOON I  |                     | S   | ANFORD, NC 27332   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC               | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | <   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 656                    | Continued From pag            | e 59  | Fe                  | 656 |  |                               |                            |
| . 555                    | either side of the bed        |   |                     | ,50 | regidents and for admission and desi   | - a d                         |                            |
|                          | either side of the bed        | 1.  |                     |     | residents goals for admission and design outcomes, the resident's preference an  |                               |                            |
|                          | An interview occurre          | d with Nurse Aide (NA) #7 on  |                     |     | potential for future discharge, and  | u                             |                            |
|                          |                               | who was familiar with   |                     |     | discharge plans. A comprehensive per   | con                           |                            |
|                          |                               | vas unaware a scoop   |                     |     | centered care plan must be reviewed a  |                               |                            |
|                          |                               | n place or fall mats. Stated  |                     |     | implemented for all residents after a fal  |                               |                            |
|                          | she monitored Resid           |   |                     |     | This in service was completed by   |                               |                            |
|                          | checking on her frequency     |   |                     |     | 3/9/2022. Any MDS nurse (full time, pa   | art                           |                            |
|                          | 555g 5554                     |   |                     |     | time, and PRN) and member of the   |                               |                            |
|                          | Resident #40 was ob           | oserved on 2/16/22 at 10:22   |                     |     | interdisciplinary team who did not recei   | ve                            |                            |
|                          | AM, lying in bed with         | her eyes closed. A scoop  |                     |     | in-service training will not be allowed to   |                               |                            |
|                          | mattress was not in p         | place nor fall mats to any  |                     |     | work until training is completed. This   |                               |                            |
|                          | side of the bed. A fal        | l mat was observed against  |                     |     | information has been integrated into the   | е                             |                            |
|                          | the wall of Resident          | #40's bathroom.   |                     |     | standard orientation training and in the   |                               |                            |
|                          |                               |   |                     |     | required in-service refresher courses for  |                               |                            |
|                          |                               | ed on 2/16/22 at 2:00 PM  |                     |     | all employees and will be reviewed by  |                               |                            |
|                          |                               | peen assisting the facility   |                     |     | Quality Assurance Process to verify that   | at                            |                            |
|                          |                               | 1 and worked both the first   |                     |     | the change has been sustained.   |                               |                            |
|                          |                               | ) and second (3:00 PM to  |                     |     | Monitoring:  |                               |                            |
|                          |                               | e was familiar with Resident  |                     |     | To ensure compliance, The Director of  |                               |                            |
|                          |                               | re a scoop mattress was to  |                     |     | Nursing and/or Assistant Director of   |                               |                            |
|                          | be in place or fall ma        | ts utilized to the side of her  |                     |     | Nursing will observe 5 resident's with a   |                               |                            |
|                          | pea.                          |   |                     |     | interventions for a falls careplan to ens that care plan is implemented. This will                                     |                               |                            |
|                          | On 2/16/22 at 3:29 P          | M, Nurse #1 was interviewed   |                     |     | done on weekly basis for 4 weeks then  |                               |                            |
|                          |                               | reviewed Resident #40's fall  |                     |     | monthly for 3 months. The results of the   |                               |                            |
|                          |                               | 26/21. She was unable to  |                     |     | audit will be reviewed at the weekly QA  |                               |                            |
|                          |                               | mats were an intervention   |                     |     | Team Meeting. Reports will be presented  |                               |                            |
|                          |                               | fall or was already in place.   |                     |     | to the weekly QA Committee by the  |                               |                            |
|                          | •                             | #1 was unable to explain why  |                     |     | Director of Nursing and/or Mini Data Se  | et                            |                            |
|                          |                               | have fall foam mats in place  |                     |     | (MDS) Coordinators to ensure corrective  |                               |                            |
|                          |                               | s. She indicated Resident   |                     |     | action initiated as appropriate. Any   |                               |                            |
|                          |                               | om change (1/25/22 to 2/9/22)   |                     |     | immediate concerns will be brought to  | the                           |                            |
|                          |                               | nt not have moved with her.   |                     |     | Director of Nursing or Administrator for   |                               |                            |
|                          | _                             |   |                     |     | appropriate action. Compliance will be   |                               |                            |
|                          | The Registered Nurs           | e (RN) supervisor was   |                     |     | monitored and ongoing auditing progra  | m                             |                            |
|                          |                               | 22 at 3:45 PM. She reviewed   |                     |     | reviewed at the Weekly Quality of Life   |                               |                            |
|                          | •                             | tive physician orders which   |                     |     | Meeting. Weekly QA Committee meeting   |                               |                            |
|                          | stated a scoop mattre         | ess was present and the fall  |                     |     | is attended by Administrator, Director of  | f                             |                            |

| STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION |   | IDENTIFICATION NUMBER   |                     | PLE CONSTRUCTION  G  | (XX       | (X3) DATE SURVEY COMPLETED |  |
|--|---|---|---------------------|--|-----------|----------------------------|--|
|  |   | 345532  | B. WING _           |  |           | C<br><b>02/17/2022</b>     |  |
|  | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332   |           | OLI III/2022               |  |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)                        | SHOULD BE | (X5)<br>COMPLETION<br>DATE |  |
| F 656<br>F 657<br>SS=B                               | investigation dated 12 mats were to present RN supervisor indica the bathroom of Resi explain why the device. The Director of Nursi 2/17/22 at 5:33 PM, i employment at the fastated it was her explainterventions to be ut nursing staff as well a ensure they were in particular CFR(s): 483.21(b)(2) §483.21(b) Compreh §483.21(b)(2) A comple- (i) Developed within a the comprehensive a | 2/14/21 indicating foam fall to each side of the bed. The ted a fall mat was found in dent #40 but was unable to ses were not in place.  Ing was interviewed on indicating she had just stated cility in January 2022. She estation for the safety ilized and expected the as the nursing supervisor to place.  If Revision (i)-(iii)  In the safety ilized and expected the as the nursing supervisor to place.  If Revision (i)-(iii)  In the safety ilized and expected the as the nursing supervisor to place.  If Revision (i)-(iii) | F 6                 | Nursing, MDS Coordinator, Ur<br>Support Nurse, Therapy, HIM<br>Information Management), Die<br>Manager, Wound Nurse. | (Health   | 3/9/22                     |  |
|  | includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the explanation must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate  | responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident participation of the resident participation of the resident participation of the resident presentative is determined  |                     |  |           |                            |  |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | PLE CONSTRUCTION  IG  | (2  | (X3) DATE SURVEY<br>COMPLETED |     |
|--------------------------|--|--|---------------------|---|---|-------------------------------|-----|
|                          |  | 345532   | B. WING _           |   |   | C<br><b>02/17/2022</b>        |     |
| NAME OF P                | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |   | 02/11/2022                    |     |
|                          |  |  |                     | 310 COMMERCE DRIVE  |   |                               |     |
| LIBERTY                  | COMMONS NSG AND RI   | EHAB CTR OF LEE COUNTY   |                     | SANFORD, NC 27332   |   |                               |     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY)  | HOULD BE  | (X5)<br>COMPLETI<br>DATE      | ION |
| F 657                    | Continued From page  | e 61   | F 6                 | 57  |   |                               |     |
|                          | team after each assecomprehensive and cassessments. This REQUIREMENT by: Based on record revinterviews, the facility the care plan in the a #17) and pressure ulwas for 2 of 22 reside The findings included  1) Resident #17 was facility on 3/1/21 and | ised by the interdisciplinary ssment, including both the quarterly review  is not met as evidenced liews, observations, and staff failed to review and revise reas of medication (Resident cer (Resident #14). This ents reviewed.                 |                     | The statements made on this P Correction are not an admission not constitute an agreement with alleged deficiencies. To remain i compliance with all Federal and Regulations the facility has take take the actions set forth in this Correction. The Plan of Correct constitutes the facility's allegatio compliance such that all alleged deficiencies cited have been or corrected by the date or dates in   | to and on the in State n or will Plan of ion on of will be  |                               |     |
|                          | used as a hormonal of (mg) by mouth once a women after menopa 7/27/21.  Resident #17's active 11/22/21, included a hormonal chemothers breast cancer."  A review of the Janua Administration Recor #17 did not receive a chemotherapy medic              | ed Anastrozole (a medication chemotherapy) 1 milligram a day for breast cancer in use was discontinued on e care plan, last reviewed focus area "I am on apy related to previous ary 2022 Medication d (MAR) revealed Resident my type of hormonal |                     | Corrective Action: Resident #17: Care plan for antimedication resolved on 2/17/202 MDS nurse. Resident #14: Care plan for preducers revised and updated on 3 by MDS nurse. Identification of other residents who be involved with this practice: All current residents receiving antineoplastic medication; all curresidents with pressure ulcers he potential to be affected by the all practice. On 3/7/2022 through 3 an audit was completed by the MData Set (MDS) Nurse Consulta | neoplast<br>22 by<br>ssure<br>8/9/2022<br>who may<br>rrent<br>ave the<br>lleged<br>/8/2022<br>Minimum |                               |     |
|                          |  | After reviewing Resident   |                     | ensure that a care plan was imp   |   | d                             |     |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | IDENTIFICATION NUMBER:  |                     |     | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|---|---|---|---------------------|-----|--|-------------------------------|----------------------------|--|
|   |   | 245520  | D WING              |     |  | 1                             |                            |  |
|   |   | 345532  | B. WING _           |     |  | 02/                           | 17/2022                    |  |
| NAME OF P   | ROVIDER OR SUPPLIER   |   |                     | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                            |  |
| LIBERTY   | COMMONS NSG AND R   | EHAB CTR OF LEE COUNTY  |                     | 31  | 10 COMMERCE DRIVE  |                               |                            |  |
| LIDLIKIT  | Commono NOC AND IN  | EIAB OTK OF ELE GOOK!   |                     | S   | ANFORD, NC 27332   |                               |                            |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |                               | (X5)<br>COMPLETION<br>DATE |  |
| F 657   | should have been re when it was reviewed.  The Director of Nursi 2/17/22 at 5:33 PM a expectation for the carepresentation of the 2. Resident #14 was   | medical record she nal chemotherapy ontinued on 7/27/21 and solved from the care plan d on 11/22/21.  ng was interviewed on and indicated it was her are plan to be an accurate resident. admitted to the facility on   | F                   | 957 | for current residents on antineoplastic medication and on residents with pressulcers. 1 current resident is on antineoplastic medication and care plan updated, and all current residents with pressure ulcers have updated care plan This was completed on 3/8/2022. Systemic Changes:  On 3/9/2022 The Registered Nurse (RI Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS   | n is<br>ns.<br>N)             |                            |  |
|   | developmental disord communication and I Minimum Data Set (I 12/6/21 indicated that moderate cognitive is pressure ulcer.  Resident #14's care that the resident had sacrum, right and lef was not revised as o                     | /4/17 with multiple diagnoses including evelopmental disorder that affects ommunication and behavior. The quarterly finimum Data Set (MDS) assessment dated 2/6/21 indicated that Resident #14 had noderate cognitive impairment and had 1 stage 4 ressure ulcer.  Resident #14's care plan dated 12/6/21 indicated nat the resident had pressure ulcers to his acrum, right and left buttocks. The care plan was not revised as of 2/17/22 to address the ressure ulcers to the right thigh and the left heel. |                     |     | assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on: The facility must develop, implement, review and revise 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  |                               |                            |  |
|   | indicated that Reside pressure ulcers on hand Left heel (unstage Treatment Administrative revealed that the ulceprep and covered with The Wound Physicial revealed that Reside pressure ulcers to his and to his left heel (stage). | n note dated 12/10/21 ent #14 had developed is right thigh (unstageable) geable). The December 2021 ation Records (TARs) ers were treated with skin th foam dressing daily.  n note dated 1/11/22 nt #14 continued to have s right thigh (unstageable) tage 3). The January 2022 he right thigh was treated ing agent), and the left heel   |                     |     | plan must describe the following: the services that are to be furnished to atta or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing; and any service that would otherwise be required but an 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 a result of PASARR recommendations, and after consultation with the resident and the resident's representative's on tresidents goals for admission and desire | es<br>re<br>as                |                            |  |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  |  |  |   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|--|--|---|-------------------------------|--|
|                          |  | 345532  | B. WING _  |  |   | C<br>2/ <b>17/2022</b>        |  |
|                          | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY  | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332 |  |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                               | ID<br>PREFIX<br>TAG  | •  | OULD BE   | (X5)<br>COMPLETION<br>DATE    |  |
| F 657                    | that resident #14 con ulcers to his right thig left heel (stage 3). The revealed that both ulcalcium alginate daily. The MDS Nurse was 2:15 PM. The MDS Nas MDS Nurse 4-5 m the Wound Physician verified that Resident the right thigh and left added them on the care plan to address and left heel.  The Director of Nursi on 2/17/2 at 3:34 PM started as DON of the She stated that the M position but that was these errors. The DO | n note dated 2/8/22 revealed tinued to have pressure th (unstageable) and to his ne February 2022 TARs treated with | F  | outcomes, the resident's preferer potential for future discharge, and discharge plans. A comprehensive centered care plan must develop implemented, reviewed and revis admission, readmission and with change in condition.  This in service was completed by 3/9/2022. Any MDS nurse (full titime, and PRN) and member of the interdisciplinary team who did not inservice training will not be allow work until training is completed. In information has been integrated instandard orientation training and required inservice refresher court all employees and will be reviewed Quality Assurance Process to verthe change has been sustained. Monitoring:  To ensure compliance, The Direct Nursing and/or Assistant Director Nursing will observe 5 residents are receiving antineoplastic medication ensure that care plan is reviewed. The Director of Nursing will observe 5 resident's with pressure ulcers to that care plan is reviewed /revise will be done on weekly basis for a then monthly for 3 months. The resident's with pressure dat the QA Team Meeting. Reports will be presented to the weekly QA Comthe Director of Nursing and/or Mi Set (MDS) Coordinators to ensur corrective action initiated as approach and interest of the precent of Nursing or Adminitiated as approach in the Director of Nursing or Adminitiated as approach in the Director of Nursing or Adminitiated or Adminitiated as approach in the Director of Nursing or Adminitiated or Adminitiated as approach in the Director of Nursing or Adminitiated as approach in the Director of Nursing or Adminitiated or Adminitiated as approach in the Director of Nursing or Adminitiated or Adminitiated as approach in the Director of Nursing or Adminitiated as approach in the Director of Nursing or Adminitiated as approach in the Director of Nursing or Adminitiated as approach in the Director of Nursing or Adminitiated as approach in the Director of Nursing or Adminitiated as approach in the Director of Nursing or Adminitiated as approach in the Director of Nursing or Adminitiated in the Director of | d /e person ed, sed upon any / me, part he t receive wed to This into the in the reses for ed by the rifty that etor of for of who are on to d /revised. essistant of ensure d. This 4 weeks esults of weekly e mittee by ni Data re ropriate. prought to |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDII |     | LE CONSTRUCTION   |                                     | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|-------------------------|-----|---|-------------------------------------|-------------------------------|--|
|   |  |  |                         | _   |   |                                     | С                             |  |
|   |  | 345532   | B. WING _               |     |   | 02/                                 | 17/2022                       |  |
| NAME OF PR  | ROVIDER OR SUPPLIER  |  |                         | S1  | TREET ADDRESS, CITY, STATE, ZIP CODE  |                                     |                               |  |
| LIBERTY (   | COMMONS NSG AND RE   | HAB CTR OF LEE COUNTY  | 310 COMMERCE DRIVE      |     |   |                                     |                               |  |
|   |  |  |                         | S   | ANFORD, NC 27332  |                                     |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG      | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |                                     | (X5)<br>COMPLETION<br>DATE    |  |
| F 658<br>SS=D                                       | CFR(s): 483.21(b)(3) §483.21(b)(3) Comproduced Services provided as outlined by the commustical Meet professional at This REQUIREMENT by: Based on record revisiterviews, the facility shampoo as ordered sampled residents reviews. The findings included Resident #40 was additional and the services of the | eet Professional Standards (i)  ehensive Care Plans d or arranged by the facility, mprehensive care plan,  standards of quality.  is not met as evidenced iew, observation and staff failed to provide medicated (Resident #40) for 1 of 22 viewed.  : mitted to the facility on |                         | 657 | for appropriate action. Compliance will monitored and ongoing auditing progra reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meetir is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manag Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse.  The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has tall or will take the actions set forth in this plan of correction. The plan of corrections | ng<br>of<br>ger,<br>do<br>al<br>ken | 3/29/22                       |  |
|   | osteoarthritis.  The quarterly Minimu assessment dated 1/2 #40 had severe cogni required extensive as hygiene and bathing.  A review of Resident   | 28/22 indicated Resident itive impairment. She sistance with personal #40's February 2022  |                         |     | constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658  The facility failed to provide medicated shampoo to a resident as ordered.  1. Corrective action for resident(s) affected by the alleged deficient practic On 2/ 18/2022 the RN Supervisor verifithat the medicated shampoo had been  | ce:<br>ied                          |                               |  |
|   | A review of Resident physician orders reve   |  |                         |     | On 2/ 18/2022 the RN Supervisor verifithat the medicated shampoo had been   |                                     |                               |  |

|               | OF DEFICIENCIES<br>CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         | ` ′           | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---------------|-------------------------------|--|---------------|--|---|--|-------------------------------|--|
|               |                               |  | A. BOILDII    |  |   | ، ا  | С                             |  |
|               |                               | 345532   | B. WING _     |  |   |  | /17/2022                      |  |
| NAME OF PI    | ROVIDER OR SUPPLIER           |  |               | ST                                     | REET ADDRESS, CITY, STATE, ZIP CODE   | <u>,                                      </u> | -                             |  |
|               |                               |  |               | 31                                     | 0 COMMERCE DRIVE  |  |                               |  |
| LIBERTY       | COMMONS NSG AND RI            | EHAB CTR OF LEE COUNTY                                     |               | SA                                     | ANFORD, NC 27332  |  |                               |  |
| (X4) ID       | SUMMARY ST                    | ATEMENT OF DEFICIENCIES                                    | ID            |  | PROVIDER'S PLAN OF CORRECTION   |  | (X5)                          |  |
| PREFIX<br>TAG |                               | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFI)<br>TAG | X                                      | (EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |  | COMPLETION<br>DATE            |  |
| F 658         | Continued From page           | e 65   | F 6           | 558                                    |   |  |                               |  |
|               | Ketoconazole Shamp            | ooo (an antifungal shampoo)                                |               |  | administered to resident # 40 as ordered  | ed   |                               |  |
|               |                               | he scalp topically every                                   |               |  | by direct observation. On 3/11/2022 the   | 9  |                               |  |
|               | evening shift on Mon-         | day and Thursday for tinea                                 |               |  | medicated shampoo administration wa   | s  |                               |  |
|               | versicolor (a commor          | n fungus). Use on the scalp                                |               |  | reviewed by the nurse manager and is  |  |                               |  |
|               | and hair and rinse we         | ell on shower days. This                                   |               |  | aligned to be administered on schedule  | ∌d   |                               |  |
|               | order was initiated or        | n 5/20/20.   |               |  | shower days.  |  |                               |  |
|               |                               |  |               |  | 2. Corrective action for residents with   |  |                               |  |
|               |                               | history was reviewed and                                   |               |  | the potential to be affected by the alleg   | ed   |                               |  |
|               |                               | en in the same room since                                  |               |  | deficient practice.   |  |                               |  |
|               |                               | led shower/shampoo on                                      |               |  | On 3/08/2022 the Director of Nurses ar  |  |                               |  |
|               |                               | during the day shift (7:00 AM                              |               |  | RN Supervisor audited all residents wit   | n  |                               |  |
|               |                               | d a short stay in a different                              |               |  | orders for medicated shampoo and  |  |                               |  |
|               | with the shower/shan          | allway from 1/25/22 to 2/9/22                              |               |  | monitored to assure the resident was  |  |                               |  |
|               |                               | urday during the day shift.                                |               |  | receiving the medicated shampoo as ordered. Results: 2 of 2 residents were            | a in   |                               |  |
|               | Wednesday and Salt            | arday during the day siliit.                               |               |  | compliance as of 3/08/2022. On  | <i>7</i> 11 1                                  |                               |  |
|               | A review of the Febru         | uary 2022 Medication                                       |               |  | 3/11/2022 the nurse manager audited a   | all  |                               |  |
|               |                               | d (MAR) revealed the                                       |               |  | other residents who receive medicate  | ***  |                               |  |
|               |                               | oo was signed as provided                                  |               |  | shampoo to assure administration is   |  |                               |  |
|               |                               | Monday and Thursdays as                                    |               |  | aligned with their shower schedule.   |  |                               |  |
|               | ordered (2/3/22, 2/7/2        |  |               |  | 3. Measures /Systemic changes to  |  |                               |  |
|               | ,                             | ,  |               |  | prevent reoccurrence of alleged deficie   | nt   |                               |  |
|               | Nurse #1 was intervie         | ewed on 2/15/22 at 3:54 PM,                                |               |  | practice:   |  |                               |  |
|               | who had signed the F          | February 2022 MAR, that                                    |               |  |   |  |                               |  |
|               | Resident #40 receive          | d Ketoconazole shampoo on                                  |               |  | Beginning on 3/09/2022 the Director of  |  |                               |  |
|               |                               | stated she had assumed it                                  |               |  | Nurses, Nurse Consultant and RN   |  |                               |  |
|               | was done by the Nur           | se Aide (NA) because they                                  |               |  | Supervisor began in-service education   |  |                               |  |
|               |                               | t done. Nurse #1 added she                                 |               |  | all full time, part time, and as needed a   | nd   |                               |  |
|               |                               | hampoo had been provided                                   |               |  | agency nurses Topics included:  |  |                               |  |
|               | as ordered.                   |  |               |  | <ul> <li>Following physician orders for</li> </ul>                                    |  |                               |  |
|               | 0 0/40/00 1000                |  |               |  | treatments orders.  |  |                               |  |
|               |                               | M, an interview occurred                                   |               |  | Confirming that treatment orders s  | ucn  |                               |  |
|               | with Nurse #3. She h          | <del>-</del>   |               |  | as for medicated shampoo are being  |  |                               |  |
|               | -                             | that Resident #40 received                                 |               |  | provided as ordered before signing the  |  |                               |  |
|               |                               | oo on 2/3/22 and 2/7/22.<br>didn't verify with the NA that |               |  | treatment out as completed.   | ıto.   |                               |  |
|               |                               | curred but had assumed it                                  |               |  | This information has been integrated in the standard orientation training and in      |  |                               |  |
|               |                               | d not told her otherwise.                                  |               |  | required in-service refresher courses for   |  |                               |  |
|               | Had since the IVA Had         | a not told her otherwise.                                  |               |  | all staff identified above and will be  | "  |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                 | ` '  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |             | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--------------------------|--|--|---|-------------|-------------------------------|--|
|  |                          | 345532   | B. WING  |   |             | C<br><b>2/17/2022</b>         |  |
| NAME OF P  | ROVIDER OR SUPPLIER      | 0.0002   | <del>-   -   -   -   -   -   -   -   -   -  </del> | STREET ADDRESS, CITY, STATE, ZIP CODE   |             | 12/11/12022                   |  |
| NAME OF T  | TOVIDER OR GOLF EIER     |  |  |   | =           |                               |  |
| LIBERTY  | COMMONS NSG AND R        | EHAB CTR OF LEE COUNTY   |  | 310 COMMERCE DRIVE<br>SANFORD, NC 27332   |             |                               |  |
|  |                          |  |  | ·   |             |                               |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC          | TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY) | SHOULD BE   | (X5)<br>COMPLETION<br>DATE    |  |
| F 658  | Continued From pag       | e 66   | F 65   | 88  |             |                               |  |
|  | NA #4 was interviewe     | ed on 2/16/22 at 2:00 PM   |  | reviewed by the Quality Assura  | ance        |                               |  |
|  | and stated she worke     | ed with an agency, had been  |  | process to verify that the chan   |             |                               |  |
|  | assisting the facility s | since November 2021 and  |  | been sustained. Any of the ide  |             |                               |  |
|  | worked both the 7:00     | AM to 3:00 PM (first) and  |  | nursing staff who does not rec  | eive        |                               |  |
|  | 3:00 PM to 11:00 PM      | l (second) shifts. NA #4 was   |  | scheduled in-service training v   | vill not be |                               |  |
|  | familiar with Residen    |  |  | allowed to work until training h  |             |                               |  |
|  | _                        | her when she worked. NA #4   |  | completed by March 28, 2022.  |             |                               |  |
|  |                          | ent #40 required to be   |  |   |             |                               |  |
| shampooed with Ketoconazole.   |                          | oconazole.   |  | 4. Monitoring Procedure to e  |             |                               |  |
|  | 0 0/47/00 1005 4         | NA NIA //4   |  | the plan of correction is effecti   |             |                               |  |
| On 2/17/22 at 9:35 AM, NA #1 was interviewed and stated she worked both the first and second |                          |  |  | specific deficiency cited remain  |             |                               |  |
|  |                          |  |  | and/or in compliance with regu  | liatory     |                               |  |
|  |                          | assigned to Resident #40<br>A #1 was unaware Resident                              |  | requirements. The Director of Nursin  | g and/or    |                               |  |
|  | #40 required Ketocol     |  |  | designee will utilize the QA too  |             |                               |  |
|  | ,, 10 10quilou 11010001  | iazoio champoo.  |  | to monitor compliance with ad   |             |                               |  |
|  | A phone interview oc     | curred with NA #12 on  |  | of treatment orders. The Direct   |             |                               |  |
|  |                          | She indicated she worked   |  | Nurses and/or designee will m   | onitor 2    |                               |  |
|  | with an agency, had      | been assisting the facility  |  | residents with orders for medic   |             |                               |  |
|  | since December 202       | 1 and worked both first and  |  | shampoo weekly for 2 weeks,   | then        |                               |  |
|  |                          | 2 was assigned to Resident   |  | monthly for 3 months for comp   |             |                               |  |
|  |                          | nd shift. She stated Resident  |  | the ordered treatment. This wi  |             |                               |  |
|  |                          | or showers/shampoos on the   |  | direct observation of 2 residen   |             |                               |  |
|  |                          | not provided one to her on   |  | scheduled days for administra   |             |                               |  |
|  |                          | ded she was unaware  |  | medicate shampoo. (On variou  | -           |                               |  |
|  | Resident #40 was to      | be snampooed with  |  | evening shifts and days of the  |             |                               |  |
|  | Ketoconazole.            |  |  | include weekends if applicable will be completed as stated ab                                 | •           |                               |  |
|  | The Director of Nursi    | ing (DON) was interviewed  |  | such time that the QA Commit  |             |                               |  |
|  |                          | M, indicating she had been   |  | determines the need to change   |             |                               |  |
|  |                          | ity since January 2022. The  |  | frequency of the audit (when it   |             |                               |  |
|  |                          | follow through to ensure   |  | determined that sustained con   |             |                               |  |
|  |                          | ed her medicated shampoo   |  | been achieved). Identified are  | •           |                               |  |
|  |                          | bility and expected all orders   |  | concern are to be immediately   |             |                               |  |
|  | to be followed.          |  |  | The DON will present the resu   | Its to the  |                               |  |
|  |                          |  |  | QA Committee. The monthly   | QA Meeting  |                               |  |
|  |                          |  |  | is attended by the Administrate   |             |                               |  |
|  |                          |  |  | of Nursing, Minimum Data Set  |             |                               |  |
|  |                          |  |  | Coordinator, Therapy Manage   | r, Health   |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1 ` '               | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED     |  |
|--|--|--|---------------------|---|-----------------------------------|--|
|  |  | 345532   | B. WING             |   | C<br><b>02/17/2022</b>            |  |
| NAME OF P  | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                                   |  |
|  |  |  |                     | 310 COMMERCE DRIVE  |                                   |  |
| LIBERTY (  | COMMONS NSG AND RE   | HAB CTR OF LEE COUNTY  |                     | SANFORD, NC 27332   |                                   |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)   |                                   |  |
| F 658  | Continued From page  |  | F 658               | Information Manager, Dietary Manage<br>Maintenance Director, Medical Director   | r.                                |  |
| F 677<br>SS=E                                    | ADL Care Provided for CFR(s): 483.24(a)(2)   | or Dependent Residents   | F 67                | 7   | 3/29/22                           |  |
|  | out activities of daily I services to maintain of personal and oral hydrogen and oral hydrogen and oral hydrogen and oral hydrogen and record provide nail care (Res Resident #52, Resident or residents dependent activities of daily living reviewed for ADLs. The sident #29 was adiagnoses of Cerebra and right sided hemipersonal hydrogen and hyd | ns, staff and resident review, the facility failed to sident #29, Resident #31, and #54 and Resident #40) at on staff assistance with g (ADLs). This was for 5 of 8 are findings included: admitted on 7/6/17 with I Vascular Accident (CVA) alegia.  If Minimum Data Set dated and moderate cognitive no behaviors and was assistance with his  29's ADL Care Area ated 1/5/22 read in part as had a history of a CVA and as the was alert, oriented and dis known most of the time. It is sident to said the said assistance with assistance developed the said assistance with the company of the time. |                     | The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies.  To remain in compliance with all federand state regulations the facility has to or will take the actions set forth in this plan of correction. The plan of correctic constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.  F677 The facility failed to provide nail care.  1. Corrective action for resident(s) affected by the alleged deficient practic For resident #29, on 03/03/2022 nail of was provided and documented by the nurse.  For resident #31, on 03/03/2022 nail of was provided and documented by the nurse.  For resident #52, on 03/03/2022 nail of was provided and documented by the nurse. | al alken on ce: are hall are hall |  |
|  | with the completion of Review of Resident #  | 29's comprehensive care  |                     | was provided and documented by the nurse. For resident # 40, on 03/03/2022 nail of  |                                   |  |

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| ,                        |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|--|---|-----|--|-------------------------------|----------------------------|
|                          |  | 345532   | B. WING                                 |     |  |                               | C<br><b>17/2022</b>        |
| NAME OF P                | ROVIDER OR SUPPLIER  | 1 0.0002   |   |     | TREET ADDRESS, CITY, STATE, ZIP CODE   | 02/                           | 1772022                    |
| TO WILL OF T             | NOVIDER OR COLL FIER   |  |   |     | 10 COMMERCE DRIVE  |                               |                            |
| LIBERTY                  | COMMONS NSG AND R  | EHAB CTR OF LEE COUNTY   |   |     | ANFORD, NC 27332   |                               |                            |
|                          | I  |  |   |     | T  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | X   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  |                               | (X5)<br>COMPLETION<br>DATE |
| F 677                    | Continued From pag   | e 68   | F 6                                     | 377 |  |                               |                            |
|                          | self-care deficit due t<br>He was care planned   | 1/21/22 read he had a ADL<br>to his right sided hemiplegia.<br>If to specific behaviors but<br>the of a care plan for ADL  |   |     | was provided and documented by the nurse. For resident 54, on 3/03/2022 nail care was provided and documented by the nurse.  | <b>:</b>                      |                            |
|                          | 11:06 AM. Resident a hands extended past nails, it appeared bla cleaning. Resident assisted him with his stated it was his prefibut only bed baths.  An observation was appearance of his fin An interview was cor AM with Nurse #3. S | gernails.  Inducted on 2/16/22 at 8:30 he stated the aides provide diabetic residents and the  |   |     | 2. Corrective action for residents with the potential to be affected by the alleg deficient practice.  All residents have the potential to be affected. Beginning on 03/03/2022, the nurse manager began auditing all curreresidents for the need of nail care. This audit will be completed by 03/04/2022. Nail care was provided to those reside identified in need of nail care.  The Minimum Data Set Nurse then task the requested shower sched to Point Click Care tasks to fire to the certified nursing assistant's for documentation. This will be completed 03/08/2022  3. Measures /Systemic changes to prevent reoccurrence of alleged deficients. | e ent s mts will ule by       |                            |
|                          | AM with Nursing Ass she was an agency at the facility very long. instructed that the aid any resident who was were to provide nail or residents.  An interview was cor AM with NA #1. She working at the facility                      | des could provide nail care to s not a diabetic. The nurses care to all the diabetic nducted on 2/16/22 at 8:45 stated she had only been of for a month. She stated she mails and she only cleaned |   |     | practice: Beginning on 3/09/2022, the Director of Nurses, Nurse Consultant and RN Nur Manager began education of all full time part time, and PRN Nurses and CNA's the following:  Nail care should be performed dail with baths/showers and documented by the CNA in tasks in PCC.  Refusal documentation for CNA's/Nurses.  Diabetic nail care schedule and documentation by nurses.   | of<br>se<br>ne,<br>on         |                            |

Facility ID: 980156

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |  | (X3) DATE SURVEY<br>COMPLETED                         |         |
|--------------------------|--|---|---|---|--|---|---------|
|                          |  | 345532  | B. WING                                 |   |  | C<br><b>02/17/2022</b>                                |         |
| NAME OF D                | ROVIDER OR SUPPLIER  | 0.0002  |   |   | TREET ADDRESS, CITY, STATE, ZIP CODE   | 02/   | 17/2022 |
| NAME OF T                | TOVIDER OR SOLT EIER   |   |   |   |  |   |         |
| LIBERTY (                | COMMONS NSG AND RE   | EHAB CTR OF LEE COUNTY  |   |   | 10 COMMERCE DRIVE  |   |         |
|                          |  |   |   |   | ANFORD, NC 27332   |   |         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | REFIX (EACH CORRECTIVE ACTION SHOULD BE |  | (X5)<br>COMPLETION<br>DATE                            |         |
| F 677                    | Continued From page  | e 69  | F 6                                     | 677                                     |  |   |         |
|                          | AM. There was no chis fingernails.  An interview was con PM with NA #5. She stacility for a year and were allowed to trim tresidents. NA #5 stat refuse any of his ADL showers, his nail care stated she would probefore leaving for the An interview was con PM with the Director stated she started as The DON stated she problems with staff no and the facility had stand performance impathe problem. She started | conducted on 2/16/22 at 9:30 range in the appearance of ducted on 2/17/22 at 12:20 stated she had worked at the a half. She stated the aides fingernails of any nondiabetic ed Resident #29 did not as but since he did not take was likely forgotten. She wide Resident #29 nail care aday.  ducted on 2/17/22 at 6:00 of Nursing (DON). She the DON in January 2022. was aware there were of performing needed ADLs carted a quality assurance provement (QAPI) to address the did not appear to the performing needed ADLs carted a quality assurance provement (QAPI) to address the did not take and the performing needed ADLs carted a quality assurance provement (QAPI) to address the did not take and take the performing needed ADLs carted a quality assurance provement (QAPI) to address the did not take and take the performing needed ADLs carted a quality assurance provement (QAPI) to address the did not take and take the performing needed ADLs carted a quality assurance provement (QAPI) to address the performance that the |   |   | This information has been integrated in the standard orientation training and in 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. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff w does not receive scheduled in-service training will not be allowed to work untitraining has been completed by March 2022.  4. Monitoring Procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements.  The Director of Nurses or designee will monitor compliance utilizing the F677 Quality Assurance Tool weekly for 2 | the<br>or<br>/<br>ho<br>I<br>28,<br>at<br>nat<br>cted |         |
|                          | cumulative diagnoses<br>Vascular Accident (C'hemiplegia.<br>Resident #31's quarte<br>(MDS) dated 1/30/22   | admitted on 1/27/16 with s of Diabetes, Cerebral  |   |   | weeks then monthly x 3 months or unti resolved. Auditing will include various shifts and days of the week to include weekends. The Director of Nursing will monitor nail care compliance. Reports 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   | will<br>f   |         |
|                          | limited staff assistand  | e with his personal hygiene. 31's comprehensive care /24/22 read he had a ADL   |   |   | Assurance Meeting or until deemed no necessary for compliance with ADL Ca The weekly QA Meeting is attended by Administrator, Director of Nursing, MDS   | t<br>re.<br>the                                       |         |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | l ` '               | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |       | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|---------------------|---|---|-------|-------------------------------|--|
|   |   | 345532   | B. WING _           |   |   |       | C<br><b>17/2022</b>           |  |
| NAME OF PI  | ROVIDER OR SUPPLIER   | 1.000  | <u> </u>            | S                                       | TREET ADDRESS, CITY, STATE, ZIP CODE  | 1 02/ | 1112022                       |  |
|   |   |  |                     | 3.                                      | 10 COMMERCE DRIVE   |       |                               |  |
| LIBERTY   | COMMONS NSG AND RI  | EHAB CTR OF LEE COUNTY   |                     | S                                       | ANFORD, NC 27332  |       |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | <                                       | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) |       | (X5)<br>COMPLETION<br>DATE    |  |
| F 677   | Continued From page   | ∍ 70   | F 6                 | 677                                     |   |       |                               |  |
|   | Interventions included personal hygiene. He   | o his left sided hemiplegia.<br>d staff assistance with his<br>was care planned for<br>care plan for ADL refusals.   |                     |   | Coordinator, Therapy Manager, Health<br>Information Manager, and the Dietary<br>Manager.                    |       |                               |  |
|   | 11:55 AM of Residen hands extended past nails, it appeared blaceleaning. Resident # assisted him with his               | tonducted on 2/14/22 at at the #31. His fingernails on both fingertips and under her ck to suggest a lack of 31 stated the staff has not nail care in a long time. He erence not to take showers |                     |   |   |       |                               |  |
|   |   | conducted on 2/15/22 at 9:30 ange in the appearance of   |                     |   |   |       |                               |  |
|   | AM with Nurse #3. St<br>nail care for the nond<br>nurses did the fingerr<br>residents. She stated<br>was scheduled week | ducted on 2/16/22 at 8:30 ne stated the aides provide iabetic residents and the nails of the diabetic for the diabetic residents, it ly and appeared on their tion Record (TAR) to initial       |                     |   |   |       |                               |  |
|   | AM with Nursing Assishe was an agency a the facility very long. instructed that the aid                                 | les could provide nail care to<br>s not a diabetic. The nurses   |                     |   |   |       |                               |  |
|   |   | conducted on 2/16/22 at 9:10 ange in the appearance of   |                     |   |   |       |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED  |                            |  |
|---|--|---|---------------------|--|--------------------------------|----------------------------|--|
|   |  | 345532  | B. WING_            |  |                                | C<br>02/17/2022            |  |
|   | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CO  | •                              | 52/1//2022                 |  |
| LIBERTY   | COMMONS NSG AN   | D REHAB CTR OF LEE COUNTY   |                     | SANFORD, NC 27332  |                                |                            |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFIC  | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)                                 | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIVE<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |  |
| F 677   | 2022 indicated Nu #31's nail care on An observation w PM. There was no his fingernails.  An interview was PM with Nurse #3 on Resident #31's Nurse #3 stated she had performe to do it when she back to do it. She nail care prior to had interview was PM with the Direct stated she started The DON stated she problems ADLs and quality assurance (QAPI) to address the new outbreak and agency staff, the QAPI.  3. Resident # 52 views. | ent #31's TAR for February<br>urse #3 performed Resident  | F                   |  |                                |                            |  |
|   | revised on 5/6/21 performance defice   | nt #52's ADL care plan last<br>for an ADL self-care<br>cit due to her activity intolerance<br>ere was no intervention listed to |                     |  |                                |                            |  |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | PLE CONSTRUCTION  G   | , ,       | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|---------------------|---|-----------|-------------------------------|--|
|                          |  | 345532  | B. WING _           |   |           | C<br>2/17/2022                |  |
|                          | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332                    |           | 2/1//2022                     |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 677                    | dated 1/25/22 indical impairment, no beha assistance with pers. An observation was 12:30 PM. Resident hands extended pas nails, it appeared blacleaning.  An observation was 12:10 PM. There was appearance of her fill. An interview was con AM with Nurse #3. So nail care for the none nurses did the finger residents. She stated was scheduled week Treatment Administry off when completed. A review of Resident 2022 did not include to be initialed off when An interview was con AM with Nursing Assishe was an agency at the facility very long, instructed that the ail any resident who was an agent was an agency at the facility very long, instructed that the ail any resident who was as a service was an agency at the facility very long, instructed that the ail any resident who was an agency was an agency at the facility very long, instructed that the ail any resident who was an agency was an agency at the facility very long, instructed that the ail any resident who was a service with the side of the control of | Minimum Data Set (MDS) ted severe cognitive viors and coded for limited onal hygiene.  conducted on 2/14/22 at #52's's fingernails on both tringertips and under her tok to suggest a lack of conducted on 2/15/22 at sono change in the ingernails.  Inducted on 2/16/22 at 8:30 he stated the aides provide diabetic residents and the mails of the diabetic difference on their ation Record (TAR) to initial at #52's TAR for February enail care scheduled weekly en completed.  Inducted on 2/16/22 at 8:40 distant (NA) #10. She stated aide and had not worked at | F 6                 | 77  |           |                               |  |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                 | PLE CONSTRUCTION  G   |                              | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|---------------------|---|------------------------------|-------------------------------|--|
|                          |   | 345532   | B. WING             | ·····   |                              | C<br><b>)2/17/2022</b>        |  |
|                          | ROVIDER OR SUPPLIER   | REHAB CTR OF LEE COUNTY  |                     | STREET ADDRESS, CITY, STATE, ZIP COI<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332           | •                            |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 677                    | 12:25 PM. There wa appearance of her finder | conducted on 2/16/22 at as no change in the ingernails.  conducted on 2/17/22 at 4:02 shange in the appearance of anducted on 2/17/22 at 4:10 She stated her nail care did AR so she figured Resident c. Nurse #3 was reminded active insulin prior to her ad it was an oversight and she nail care prior to her leaving anducted on 2/17/22 at 6:00 or of Nursing (DON). She is the DON in January 2022. It was aware there were the facility had started a and performance improvement the problem. She stated with COVID, staff out with COVID had been difficult complete as admitted to the facility on the state included dementia, on, and osteoarthritis.  The care plan, last reviewed on the following focus areas:  Living (ADL) self-performance tions included staff assistance | F 67                |   |                              |                               |  |

|                          | OF DEFICIENCIES<br>F CORRECTION                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDI |       | NSTRUCTION   | (X3) DATE<br>COMF | SURVEY                     |
|--------------------------|---|---|------------------------|-------|--|-------------------|----------------------------|
|                          |   | 345532  | B. WING _              |       |  | 1                 | C<br><b>17/2022</b>        |
|                          | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY  |                        | 310 C | ET ADDRESS, CITY, STATE, ZIP CODE<br>COMMERCE DRIVE<br>FORD, NC 27332  | 1 02/             | 11/2022                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG     | ×     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | 3E                | (X5)<br>COMPLETION<br>DATE |
| F 677                    | Continued From pag  |   | F                      | 677   |  |                   |                            |
|                          | #40 had severe cogr   | 28/22 indicated Resident litive impairment and ssistance with personal  |                        |       |  |                   |                            |
|                          |   | ng progress notes from<br>ealed no refusals specific to<br>d.   |                        |       |  |                   |                            |
|                          | 2/14/22 at 11:30 AM with hands laying on                          | made of Resident #40 on while she was lying in bed top of the covers. She was substance under the third to the right hand.                    |                        |       |  |                   |                            |
|                          | observed sitting up ir  | PM, Resident #40 was<br>n bed eating lunch with her<br>bstance to the third and<br>ernails remained.  |                        |       |  |                   |                            |
|                          | member of Resident<br>who explained Resid<br>smearing feces on he | as completed with a family<br>#40 on 2/14/22 at 2:31 PM,<br>lent #40 had a history of<br>erself and the bed and<br>having nail care completed |                        |       |  |                   |                            |
|                          | AM sitting up in her b  | oserved on 2/15/22 at 10:42<br>oed. A dark substance<br>and fourth fingernails of the   |                        |       |  |                   |                            |
|                          |   | PM, Resident #40 was<br>g lunch using her right-hand  |                        |       |  |                   |                            |
|                          |   | of Resident #40 occurred on<br>where the dark substance   |                        |       |  |                   |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDIN | FIPLE CONSTRUCTION  NG  | 0                                 | (3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|---|-------------------------|---|-----------------------------------|------------------------------|
|                          |   | 345532  | B. WING _               |   |                                   | C<br><b>02/17/2022</b>       |
|                          | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY  |                         | STREET ADDRESS, CITY, STATE, ZIP C<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332 | CODE                              | <u> </u>                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     |   | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE   |
| F 677                    | Continued From pag  | e 75  | F 6                     | 677   |                                   |                              |
|                          | was still visible under hand fingernails.   | the third and fourth right  |                         |   |                                   |                              |
|                          | I .   | ewed on 2/15/22 at 3:54 PM<br>are was completed by the<br>uring personal care.  |                         |   |                                   |                              |
|                          | and explained the on<br>was with the nail brus<br>personal care. She c  | M, NA #1 was interviewed<br>ly nail care she completed<br>sh when needed during<br>ould neither confirm nor<br>t nail care to Resident #40.   |                         |   |                                   |                              |
|                          | and explained NAs p<br>personal care ensuring<br>free of jagged edges<br>Resident #40's nails<br>substance was visible<br>right hand nails. Nurst<br>occur more frequently<br>history of using her fi | and confirmed a dark e under the third and fourth se #2 added nail care should y to Resident #40 due to the ngers to eat, as well as erself and the bed. Nurse #2                             |                         |   |                                   |                              |
|                          | NA #4 was interviewed<br>and stated she worked<br>been assisting the fall<br>She explained nail car   | PM, Resident #40 was fingernails to both hands.  ed on 2/16/22 at 2:00 PM ed with an agency and had cility since November 2021.  are was completed during needed but was unaware d nail care. |                         |   |                                   |                              |
|                          | on 2/17/22 at 5:33 PI   | ng (DON) was interviewed<br>M, indicating she had been<br>ity since January 2022. She   |                         |   |                                   |                              |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDI |        | ISTRUCTION  | (X3) DATE | SURVEY                     |
|--------------------------|---|--|------------------------|--------|---|-----------|----------------------------|
|                          |   | 345532   | B. WING _              |        |   | 1         | C<br>/ <b>17/2022</b>      |
|                          | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY   |                        | 310 CC | TADDRESS, CITY, STATE, ZIP CODE  DMMERCE DRIVE  CORD, NC 27332  | 1 02      | 1112022                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG     | x      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE        | (X5)<br>COMPLETION<br>DATE |
| F 677                    | Continued From pag  |  | F                      | 677    |   |           |                            |
|                          | provided during pers<br>was not able to comp<br>expect the nurse to b<br>DON was unable to<br>occurred for Resider                  | ectation for nail care to be onal care tasks and if a NA olete the task she would be notified of the need. The explain why nail care had not at #40 as there was no ow this had or had not been ted. |                        |        |   |           |                            |
|                          |   | s admitted to the facility on<br>s that included dementia and  |                        |        |   |           |                            |
|                          | 12/2/21, included a f<br>Daily Living (ADL) se  | e care plan, last reviewed on<br>ocus area for Activities of<br>elf-performance deficit. The<br>d staff assistance with<br>nal hygiene.  |                        |        |   |           |                            |
|                          | #40 had severe cogr   | 28/22 indicated Resident nitive impairment. She sistance with personal   |                        |        |   |           |                            |
|                          | physician orders revolved to be applied to the evening shift on More versicolor (a commo and hair and rinse worder was initiated or | poo (an antifungal shampoo)<br>he scalp topically every<br>day and Thursday for tinea<br>in fungus). Use on the scalp<br>ell on shower days. This  |                        |        |   |           |                            |
|                          | indicated she had be 7/2/21 with a schedu   | en in the same room since<br>led shower/shampoo on<br>during the day shift (7:00 AM  |                        |        |   |           |                            |

|   | PROVIDER/SUPPLIER/CLIA<br>DENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDII |        | STRUCTION   |  | (X3) DATE<br>COMP | SURVEY<br>LETED            |
|---|--|-------------------------|--------|---|--|-------------------|----------------------------|
|   | 345532   | B. WING _               |        |   |  | 02/               | 0<br>17/2022               |
| NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS NSG AND REHAB   | CTR OF LEE COUNTY  | •                       | 310 CC | TADDRESS, CITY, STATE, ZIP CODE  DIMMERCE DRIVE  ORD, NC 27332  |  | <u> </u>          |                            |
| PREFIX (EACH DEFICIENCY MUS   | NT OF DEFICIENCIES<br>T BE PRECEDED BY FULL<br>ENTIFYING INFORMATION)  | ID<br>PREFII<br>TAG     | ×      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  |                   | (X5)<br>COMPLETION<br>DATE |
| F 677 Continued From page 77 to 3:00 PM). She had a sh room on the same hallway with the shower/shampoo Wednesday and Saturday  A review of the February 2 Administration Record (MA Ketoconazole shampoo wato Resident #40 on Monda ordered (2/3/22, 2/7/22 and On 2/14/22 at 12:35 PM, Fobserved sitting up in bed was noted to be greasy in the back of her head and a visible to the lower left back. A phone interview was commember of Resident #40 owho stated she wondered shampoos as scheduled a be unbrushed and greasy occurred.  Resident #40 was observed AM sitting up in her bed. Hunbrushed and matted in the braid to the lower left back undisturbed.  Nurse #1 was interviewed who had signed the Febru Resident #40 received Ket 2/14/22. The nurse stated was done by the Nurse Aid didn't tell her it wasn't done had not verified the shamp as ordered. | from 1/25/22 to 2/9/22 scheduled on during the day shift.  022 Medication AR) revealed the as signed as provided by and Thursdays as d 2/14/22).  Resident #40 was eating lunch. Her hair appearance, matted to a small braid was ekside of her hair.  Inpleted with a family on 2/14/22 at 2:31 PM, if she was getting her is her hair appeared to when a recent visit.  Ind on 2/15/22 at 10:42 ler hair was noted to be he back and the small side of her hair was  On 2/15/22 at 3:54 PM, ary 2022 MAR, that occonazole shampoo on she had assumed it de (NA) because they e. Nurse #1 added she | F                       | 577    |   |  |                   |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION  NG  | (.                          | X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|-------------------------|--|-----------------------------|------------------------------|
|                          |   | 345532   | B. WING _               |  |                             | C<br><b>02/17/2022</b>       |
|                          | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY   |                         | STREET ADDRESS, CITY, STATE, ZIP COD<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332            | )E                          | <b>322022</b>                |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIAT | (X5)<br>COMPLETION<br>DATE   |
| F 677                    | with Nurse #3. She February 2022 MAR Ketoconazole shamp Nurse #3 stated she the shampoo had ochad since the NA ha NA #4 was interview and stated she work assisting the facility worked both the 7:00 3:00 PM to 11:00 PM familiar with Resider assigned to care for was unaware Reside shampooed with Ket On 2/17/22 at 9:35 A and stated she work shifts and was often when she worked. N #40 required Ketoco A phone interview of 2/17/22 at 3:40 PM. with an agency, had since December 202 second shifts. NA #1 #40 on 2/14/22 seco #40 was scheduled first shift, so she had 2/14/22. NA #12 add Resident #40 was to Ketoconazole.  The Director of Nurs on 2/17/22 at 5:33 P | M, an interview occurred had signed off on the that Resident #40 received oo on 2/3/22 and 2/7/22. didn't verify with the NA that curred but had assumed it d not told her otherwise.  ed on 2/16/22 at 2:00 PM ed with an agency, had been since November 2021 and 0 AM to 3:00 PM (first) and 1 (second) shifts. NA #4 was at #40 and was often her when she worked. NA #4 ent #40 required to be occonazole.  MM, NA #1 was interviewed ed both the first and second assigned to Resident #40 A #1 was unaware Resident nazole shampoo.  Courred with NA #12 on She indicated she worked been assisting the facility end and worked both first and 2 was assigned to Resident not shift. She stated Resident for showers/shampoos on the linot provided one to her on ded she was unaware | F                       | 377  |                             |                              |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ' '                 | PLE CONSTRUCTION  G   |           | COMPLETED                  |
|--------------------------|---|--|---------------------|---|-----------|----------------------------|
|                          |   | 345532   | B. WING _           |   |           | C<br><b>02/17/2022</b>     |
|                          | ROVIDER OR SUPPLIER   | REHAB CTR OF LEE COUNTY  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332                      |           | OLI III ZOLL               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 677                    | Resident #40 receiv   | ge 79<br>follow through to ensure<br>ed her medicated shampoo<br>ability and expected all orders   | F 6                 | 77  |           |                            |
|                          | 9/1/17 with diagnose<br>stroke, diabetes type<br>A review of the phys   | s admitted to the facility on<br>es that included history of a<br>e 2 and osteoarthritis.  |                     |   |           |                            |
|                          |   | for weekly diabetic nail care ed if needed) to be completed e on Thursdays.  |                     |   |           |                            |
|                          | 12/6/21, included the - Activities of Daily L deficit Actual impairment | re care plan, last reviewed on<br>e following focus areas:<br>Living (ADL) self-performance<br>to skin integrity. The<br>ed to keep fingernails short. |                     |   |           |                            |
|                          |   | /28/22 indicated Resident<br>rintact and required extensive  |                     |   |           |                            |
|                          | Record (TAR) indica   | Treatment Administration<br>sted Resident #54 received<br>2/3/22 but was not initialed<br>/22.   |                     |   |           |                            |
|                          | I .   | ing progress notes from<br>vealed no refusals of nail care   |                     |   |           |                            |
|                          |   | servation was made of<br>4/22 at 9:30 AM while he was  |                     |   |           |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------------------|---|-------------------------------|--|
|   |  | 345532   | B. WING             |   | C<br><b>02/17/2022</b>        |  |
|   | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332                                      | 02/11/2022                    |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE COMPLETION               |  |
| F 677   | Continued From page  | e 80   | F 67                | 7   |                               |  |
|   | fingers to the left han  | nb and first and second<br>d. Resident #54<br>would like to have nice,   |                     |   |                               |  |
|   | and explained Reside<br>completed by the nur<br>status. She was assig<br>2/10/22 and after revi<br>stated she must not h<br>his nail care. Nurse # | ewed on 2/15/22 at 3:54 PM<br>ent #54's nail care was<br>sing staff due to his diabetic<br>gned to Resident #54 on<br>ewing the February TAR,<br>have had time to complete<br>1 added she had no difficulty<br>re to Resident #54 in the |                     |   |                               |  |
|   | and explained the on<br>was with the nail brus<br>personal care. Reside  | M, NA #1 was interviewed<br>ly nail care she completed<br>sh when needed during<br>ent #54 required nursing<br>hils as he was a diabetic.  |                     |   |                               |  |
|   | PM with long fingerna and second fingers.  | served on 2/16/22 at 3:37<br>hils to the left thumb, first<br>He repeated he would prefer<br>ed nails short and equal in   |                     |   |                               |  |
|   | (RN) Supervisor obse<br>hand with long nails t   | vas unable to state why nail   |                     |   |                               |  |
|   | 2/17/22 at 3:20 PM a<br>been completed for R<br>Nurse #3 stated she  | ducted with Nurse #3 on<br>nd had initialed nail care had<br>desident #54 on 2/3/22.<br>has had no difficulty in<br>Resident #54 but added   |                     |   |                               |  |

|   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   |   | (X3) DATE SURVEY<br>COMPLETED  | Y                    |
|---|--|---|---|--|----------------------|
|   | 345532   | B. WING   |   | C<br>02/17/202   | 2                    |
|   | EHAB CTR OF LEE COUNTY   |   | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332  | 02/11/202  | <b>.</b>             |
| (EACH DEFICIENC   | Y MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG   | (EACH CORRECTIVE ACTION SHOU  | D BE COMPL   | (5)<br>LETION<br>ATE |
| often times she would prior to rendering and pulled away to do sor made it to Resident # care.  The Director of Nursi on 2/17/22 at 5:33 PN employed at the facilistated it was her experienced as ordered factivities Meet Intere CFR(s): 483.24(c)(1)  §483.24(c) Activities. §483.24(c)(1) The fact the comprehensive a and the preferences or program to support reactivities, both facility individual activities are designed to meet the physical, mental, and each resident, encourand interaction in the This REQUIREMENT by:  Based on observation record review, the fact one-to-one (1:1) visits a resident who require to his severe cognitive (Resident #42) of 1 reactivities. The finding | d sign off for the nail care d a lot of the time would get mething else before she districted in the side in the s |   | The statements made on this plan correction are not an admission to a not constitute an agreement with the alleged deficiencies.  To remain in compliance with all fee and state regulations the facility has or will take the actions set forth in the plan of correction. The plan of correction.   | end do e leral s taken nis   | 22                   |
| anoxic brain damage   | and dysphagia.   |   | compliance such that all alleged deficiencies cited have been or will   | be   |                      |
|   | SUMMARY ST (EACH DEFICIENC REGULATORY OR I  Continued From page often times she would prior to rendering and pulled away to do sor made it to Resident # care.  The Director of Nursin on 2/17/22 at 5:33 PN employed at the facilit stated it was her expe provided as ordered if Activities Meet Interec CFR(s): 483.24(c)(1)  §483.24(c) Activities. §483.24(c)(1) The fact the comprehensive at and the preferences of program to support re activities, both facility individual activities ar designed to meet the physical, mental, and each resident, encou and interaction in the This REQUIREMENT by: Based on observation record review, the fact one-to-one (1:1) visits a resident #42) of 1 re activities. The finding  Resident #42 was ad  | COMMONS NSG AND REHAB CTR OF LEE COUNTY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 81 often times she would sign off for the nail care prior to rendering and a lot of the time would get pulled away to do something else before she made it to Resident #54's room to render the nail care.  The Director of Nursing (DON) was interviewed on 2/17/22 at 5:33 PM, indicating she had been employed at the facility since January 2022. She stated it was her expectation for nail care to be provided as ordered for diabetic residents.  Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)  §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.  This REQUIREMENT is not met as evidenced | A BUILDIN  345532  ROVIDER OR SUPPLIER  COMMONS NSG AND REHAB CTR OF LEE COUNTY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 81  often times she would sign off for the nail care prior to rendering and a lot of the time would get pulled away to do something else before she made it to Resident #54's room to render the nail care.  The Director of Nursing (DON) was interviewed on 2/17/22 at 5:33 PM, indicating she had been employed at the facility since January 2022. She stated it was her expectation for nail care to be provided as ordered for diabetic residents. Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)  §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide one-to-one (1:1) visits and sensory stimulation for a resident who required specialized activities due to his severe cognitive impairment. This was for 1 (Resident #42) of 1 resident reviewed for activities. The findings included:  Resident #42 was admitted on 11/25/15 with | A BUILDING  345532  ROVIDER OR SUPPLIER  COMMONS NSG AND REHAB CTR OF LEE COUNTY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 81  Often times she would sign off for the nail care prior to rendering and a lot of the time would get pulled away to do something else before she made it to Resident #54's room to render the nail care.  The Director of Nursing (DON) was interviewed on 2/17/22 at 5:33 PM, indicating she had been employed at the facility since January 2022. She stated it was her expectation for nail care to be provided as ordered for diabetic residents. Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:  Based on observations, staff interviews and record review, the facility failed to provide one-to-one (1:1) visits and sensory stimulation for a resident who required specialized activities due to his severe cognitive impairment. This was for 1 (Resident #42) of 1 resident reviewed for activities. The findings included:  Resident #42 was admitted on 11/25/15 with anoxic brain damage and dysphagia. | A BUILDING           |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |                         | IDENTIFICATION NUMBER:  |                     |     | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|-------------------------|---|---------------------|-----|--|-------------------------------|----------------------------|
|  |                         | 345532  | B. WING             |     |  |                               | C<br><b>17/2022</b>        |
| NAME OF P  | ROVIDER OR SUPPLIER     |   | <del></del>         | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   | 1 02/                         | 1772022                    |
| TVAINE OF T                                      | TOVIDER OR GOLT EIER    |   |                     |     |  |                               |                            |
| LIBERTY (  | COMMONS NSG AND RE      | EHAB CTR OF LEE COUNTY  |                     |     | 10 COMMERCE DRIVE  |                               |                            |
|  |                         |   |                     |     | ANFORD, NC 27332   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC         | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | (   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 679  | Continued From page     | e 82  | F 6                 | 379 |  |                               |                            |
|  |                         | erly Minimum Data Set<br>indicated severe cognitive                             |                     |     | corrected by the dates indicated.  |                               |                            |
|  | , ,                     | chibited no behaviors.  |                     |     | F679 The facility failed to provide on   | e to                          |                            |
|  |                         |   |                     |     | one visits and sensory stimulation for a   | l                             |                            |
|  |                         | y care plan last revised  |                     |     | resident who required specialized  |                               |                            |
|  |                         | ly participated in individual   |                     |     | activities due to sever cognitive  |                               |                            |
|  | activities and required | techniques. He enjoyed  |                     |     | impairment.  1. Corrective action for resident(s)  |                               |                            |
|  |                         | tation to people watch and  |                     |     | affected by the alleged deficient practic  | .e.                           |                            |
|  | being up out of bed m   |   |                     |     | For resident's #42 the activity director   |                               |                            |
|  |                         | d assisting Resident #42 to   |                     |     | provided 1:1 visits and sensory stimula  | tion                          |                            |
|  |                         | d provide 1:1 activities  |                     |     | beginning on 3/2/2022.   |                               |                            |
|  | throughout the week.    |   |                     |     | <ol><li>Corrective action for residents with</li></ol>   |                               |                            |
|  |                         |   |                     |     | the potential to be affected by the alleg  | ed                            |                            |
|  |                         | onic medical record did not   |                     |     | deficient practice.  |                               |                            |
|  | -                       | sessment or provision of 1:1  |                     |     | On 3/09/2022 the Activity Director and MDS coordinator audited all other   | the                           |                            |
|  | activities.             |   |                     |     | residents for the need for the provision   | of                            |                            |
|  | An observation was o    | conducted on 2/14/22 at   |                     |     | one to one visits and sensory stimulation  |                               |                            |
|  |                         | t #42. He was lying in bed  |                     |     | Results: 4 additional residents were   |                               |                            |
|  |                         | s while his roommate was  |                     |     | identified with a need for one to one  |                               |                            |
|  |                         | unch. Resident #42 had an   |                     |     | activities. No additional residents were   |                               |                            |
|  | ,                       | nouth and received all of his   |                     |     | identified needing sensory stimulation.  |                               |                            |
|  | _                       | eding tube. He did not have   |                     |     | 3. Measures /Systemic changes to   |                               |                            |
|  | any sensory objects v   |   |                     |     | prevent reoccurrence of alleged deficient practice:  | ent                           |                            |
|  | An interview was con    |   |                     |     |  |                               |                            |
|  |                         | //22 at 2:40 PM. He stated  |                     |     | On 03/14/2022, the Administrator   | _                             |                            |
|  | _                       | ctor (AD) started in early  |                     |     | educated the Activity Coordinator on the   | е                             |                            |
|  | 2/9/22 until 2/16/22.   | she was on vacation from  |                     |     | following:   |                               |                            |
|  |                         | ne stated the facility posed to proving activities                              |                     |     | F679 regulation for the provision c  | .f                            |                            |
|  |                         | ne but she called out so  |                     |     | activities that meet the needs of reside   |                               |                            |
|  |                         | A) #13 had been helping. He   |                     |     | such as one to one activities and sense  |                               |                            |
|  |                         | and NA #13 were expected  |                     |     | stimulation.   | ,                             |                            |
|  | to provide any 1:1 vis  | •   |                     |     |  |                               |                            |
|  | -                       |   |                     |     | This information has been integrated ir  | ito                           |                            |
|  |                         | was conducted on 2/14/22 at<br>#42. He was lying in bed                         |                     |     | the standard orientation training and in required in-service refresher courses for                                   |                               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|---------------------|--|---|-------------------------------|----------------------------|
|   |  | 345532   | B. WING _           |  |   |                               | C<br>/ <b>17/2022</b>      |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |                     | STR  | EET ADDRESS, CITY, STATE, ZIP CODE  | 1 02                          | 111/2022                   |
|   |  |  |                     |  | COMMERCE DRIVE  |                               |                            |
| LIBERTY   | COMMONS NSG AND  | REHAB CTR OF LEE COUNTY  |                     | SAI  | NFORD, NC 27332   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEI   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | <  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  |                               | (X5)<br>COMPLETION<br>DATE |
| F 679   |  | ge 83<br>ess. He did not have any<br>hin his reach. He had not   | F 6                 |  | all staff identified above and will be reviewed by the Quality Assurance  |                               |                            |
|   | been up out of the PM on 2/14/22.  | bed from 9:00 AM until 5:00  |                     |  | process to verify that the change has<br>been sustained. Any identified staff wl<br>does not receive scheduled in-service   |                               |                            |
|   | An observation was<br>AM of Resident #42<br>appeared restless.<br>objects within his re  |  |                     | training will not be allowed to work untitraining has been completed by March 2022.  4. Monitoring Procedure to ensure the | 28,   |                               |                            |
|   | AM with NA #13. S<br>understanding that<br>be completed. She   | onducted on 2/15/22 at 10:49<br>the stated it was her<br>only group activities were to<br>stated, "I'm not good at   |                     |  | the plan of correction is effective and the<br>specific deficiency cited remains correct<br>and/or in compliance with regulatory<br>requirements.   | nat<br>cted                   |                            |
|   | activities so I only do pretty nails and crafts.  An interview was conducted on 2/15/22 at 9:53 AM with Nursing Assistant (NA) #10. She stated she was an agency aide and had not worked with Resident #42 very long. She stated he was in |  |                     |  | The Administrator will monitor compliand utilizing the F679 Quality Assurance Toweekly for 2 weeks then monthly x 3 months or until resolved. The tool will monitor to ensure that residents who require 1:1 activities or supervision are  | ool<br>: in                   |                            |
|   | had not gotten him<br>because she was o<br>of the wheelchair d<br>movements. A Bro   | uile in bed. NA #10 stated she up to his Broda wheelchair oncerned that he could fall out ue to his continuous da wheelchair was designed of tilt-in-space and comfort ents. |                     |  | compliance. Reports will be presented the weekly Quality Assurance committing the Administrator to ensure correctivaction is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the | ee<br>ve<br>the               |                            |
|   | 12:45 PM, 3:10 PM  | s conducted on 2/15/22 at and at 4:50 PM. Resident d with no sensory items in his  |                     |  | Administrator, Director of Nursing, MD Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.   |                               |                            |
|   |  | s conducted on 2/16/22 at 8:40<br>2. He was lying in bed sleeping<br>ate his breakfast.  |                     |  |   |                               |                            |
|   |  | onducted on 2/16/22 at 8:45<br>e started employment about a  |                     |  |   |                               |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | IPLE CONSTRUCTION   |          | (X3) DATE SURVEY<br>COMPLETED                 |                            |
|---|---|--|---------------------|---|----------|---|----------------------------|
|   |   | 345532   | B. WING _           |   |          | 02/   | )<br>17/2022               |
|   | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY   |                     | STREET ADDRESS, CITY, STATE, 2 310 COMMERCE DRIVE SANFORD, NC 27332 | ZIP CODE | , <u>, , , , , , , , , , , , , , , , , , </u> |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE CROSS-REFERENCED                                   |          |   | (X5)<br>COMPLETION<br>DATE |
| F 679   | #42 up out of his bed interactive toys.  An interview was cor AM with the AD. She position in Decembe informed earlier toda NA #13 had been proabsence. The AD stated he was up in the nurses' station are objects. The AD stated he was up in the nurses' station are objects. The AD stated he was up in the nurses' station are objects. The AD stated Resident #42 had no bed since 2/14/22.  An observation was of 11:10 AM of Resident and appeared restlessensory objects within An observation was of 11:10 AM of Resident Broda chair self-proposonstant movements. An interview was cor AM with the Administration was of the Administration of Resident #42. Wheelchair at the nur interactive sensory s | and never observed Resident or playing with any aducted on 2/16/22 at 9:15 stated she just started her reconstruction 2021. She stated she was yethat the receptionist and oviding activities in her atted she was unable to find dence of 1:1 activities or or or for Resident #42 but his Broda wheelchair daily at his Broda wheelchair daily at his dwas provided sensory end she was not aware that the been observed out of his acconducted on 2/16/22 at his reach. | F                   | 679   |          |   |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDII  |  | CONSTRUCTION                        | (X3) DATE SURVEY<br>COMPLETED   |  |                            |
|--|--|--|--|-------------------------------------|---|--|----------------------------|
|  |  | 345532   | B. WING _  |                                     |   |  | C<br><b>17/2022</b>        |
|  | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY   | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332 |                                     | 10 COMMERCE DRIVE   |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG  | PREFIX (EACH CORRECTIVE ACTION SHOU |   |  | (X5)<br>COMPLETION<br>DATE |
| F 684<br>SS=D  | S 483.25 Quality of company of company of care is a function of a resist that residents receive accordance with professessment of a resist that residents receive accordance with professessment of a resist that residents receive accordance with professessment of a resist that residents receive accordance with professessment of a resist that residents receive accordance with professessment of a resident manual that resident receive sets (Resident #40) and for a surgical wound as Physician (Resident residents reviewed for The findings included 1) Resident #40 was 6/7/15 with diagnose osteoarthritis.  The physician orders 3/26/20 to apply genitor both hands/arms of Resident #40's active 12/2/21, included the Activities of Daily Lideficit. The interventing geri-sleeves to both lawake.  Fragile skin with incompany active to the second s | andamental principle that and care provided to sed on the comprehensive dent, the facility must ensure the treatment and care in fessional standards of thensive person-centered sidents' choices. This not met as evidenced friew, observations, staff and therviews, the facility failed to in coverings as ordered ailed to provide treatment to the recommended by the Wound #46). This was for 2 of 22 for well-being.  It:  admitted to the facility on the sthat included dementia and the revealed an order dated reverseled an order dated reverseled an order dated reverseled an integrity. The care plan, last reviewed on the following focus areas: for included to apply thands every shift while | F  | 584                                 | The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies.  To remain in compliance with all federa and state regulations the facility has ta 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.  F684  The facility failed to provide protective covering as ordered and to provide treatment to a surgical wound as order 1. Corrective action for resident(s) affected by the alleged deficient practic On 2/15/2022 treatment as ordered was provided to the rt lower back surgical wound by the wound nurse for resident 46. The treatment order was reviewed and corrected by the wound nurse to assure that the most current wound physician order was in place on | al<br>ken<br>on<br>skin<br>red.<br>ce: | 3/29/22                    |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBED:  |                     | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |       | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|---------------------|---|---|-------|-------------------------------|--|
|   |  | 345532  | B. WING _           |   |   |       | C<br>1 <b>17/2022</b>         |  |
| NAME OF PR  | ROVIDER OR SUPPLIER  |   |                     | 5                                       | STREET ADDRESS, CITY, STATE, ZIP CODE   | 1     |                               |  |
|   |  |   |                     | 3                                       | 310 COMMERCE DRIVE  |       |                               |  |
| LIBERTY   | COMMONS NSG AND RI   | EHAB CTR OF LEE COUNTY  |                     | 5                                       | SANFORD, NC 27332   |       |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | REFIX (EACH CORRECTIVE ACTION SHOULD    |   |       | (X5)<br>COMPLETION<br>DATE    |  |
| F 684   | Continued From page  | ∋ 86  | F 6                 | 684                                     |   |       |                               |  |
| to aspirin. The interve                             |  | entions included to wear  |                     |   | 2/15/2022. On 2/15/2022 the Nurse   |       |                               |  |
|   | protective sleeving to   | reduce the risk for skin  |                     |   | Consultant educated the wound nurse   | on    |                               |  |
|   | tears. Apply geri-slee   | ves to both hands/arms  |                     |   | the facility wound and treatment proces                                       | SS    |                               |  |
|   | every shift.   |   |                     |   | and transcription of wound physician  |       |                               |  |
|   |  |   |                     |   | orders timely and accurately.   |       |                               |  |
|   | The quarterly Minimu   | , ,   |                     |   |   |       |                               |  |
|   |  | 28/22 indicated Resident  |                     |   | 2. Corrective action for residents with                                       |       |                               |  |
|   | #40 had severe cogn  |   |                     |   | the potential to be affected by the alleg                                     | ed    |                               |  |
|   | was coded with skin t  | ssistance with dressing. She  |                     |   | deficient practice.  Beginning on 2/23/2022 the Director of                   | :     |                               |  |
|   | was coued with skill   | tears present.  |                     |   | Nurses and Wound Nurse began audit  |       |                               |  |
|   | A review of the Febru  | ary 2022 Treatment  |                     |   | all residents with non-pressure ulcers t                                      | •     |                               |  |
|   | Administration Recor   |   |                     |   | assure that the most current treatment  |       |                               |  |
|   |  | ned as being on Resident  |                     |   | order was in place and being provided   | as    |                               |  |
|   |  | /22 and 2/16/22 day shift   |                     |   | ordered. Results: 2_ of _2 residents wi                                       |       |                               |  |
|   | (7:00 AM to 3:00 PM)   | ).  |                     |   | non-pressure ulcers had an accurate   |       |                               |  |
|   |  |   |                     |   | treatment order in place as recommend   | beb   |                               |  |
|   |  | served on 2/14/22 at 11:30  |                     |   | by the physician/wound physician and  |       |                               |  |
|   |  | d with her eyes closed. Her   |                     |   | were receiving the treatment as ordere  | d.    |                               |  |
|   |  | top of the covers without any   |                     |   | This audit was completed as of 2/23   | • • • |                               |  |
|   | protective sleeves.  |   |                     |   | /2022. As of 2/23/2022 all residents with a pressure where were in compliance |       |                               |  |
|   | On 2/14/22 at 12:25 I  | DM Pooldont #40 was   |                     |   | non-pressure ulcers were in compliance As of 3/09/2022 wound orders received  |       |                               |  |
|   |  | PM, Resident #40 was<br>bed eating lunch. There                                       |                     |   | from the wound physician will be review                                       |       |                               |  |
|   | were no protective sle   | •   |                     |   | by the Wound Committee at the weekly  |       |                               |  |
|   | arms/hands.  |   |                     |   | wound meeting. The Wound Committee  |       |                               |  |
|   |  |   |                     |   | comprised of the Director of Nurses,  |       |                               |  |
|   | Resident #40 was ob  | served on 2/15/22 at 10:42  |                     |   | Registered Nurse Manager, Wound Nu  | ırse  |                               |  |
|   | AM sitting up in her b   | ed. She was dressed in a  |                     |   | and Minimum Data Set Nurse and Diet   | ary   |                               |  |
|   |  | t any protective sleeving to  |                     |   | Manger. Results: All wound care order   | s     |                               |  |
|   | her arms/hands.  |   |                     |   | current and reflect wound physician   |       |                               |  |
|   |  | , , <del>, ,</del> ,, , ,, ,, ,   |                     |   | orders.   |       |                               |  |
|   |  | was made of Resident #40  |                     |   | 0 Management (0)  |       |                               |  |
|   |  | PM with no protective sleeves   |                     |   | 3. Measures /Systemic changes to  | nt.   |                               |  |
|   | present to her arms/h  | ianus.  |                     |   | prevent reoccurrence of alleged deficie                                       | art   |                               |  |
|   | On 2/15/22 at 1:19 P   | M Resident #40 was  |                     |   | practice:   |       |                               |  |
|   |  |   |                     |   | Beginning on 3/09/2022 the Director of  | ;     |                               |  |
|   | observed lying in bed with her eyes closed. There were no protective sleeving on her arms/hands. |   |                     |   | Nurses, Nurse Consultant and RN   |       |                               |  |

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:             | 1 ` ′        |     | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                    |
|---|--|--|--------------|-----|--|-------------------------------|--------------------|
|   |  |  |              |     |  | (                             |                    |
|   |  | 345532   | B. WING _    |     |  | 02/                           | 17/2022            |
| NAME OF P   | ROVIDER OR SUPPLIER                            | •  | •            | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                    |
|   |  |  |              | 31  | 10 COMMERCE DRIVE  |                               |                    |
| LIBERTY   | COMMONS NSG AND I                              | REHAB CTR OF LEE COUNTY  |              | S   | ANFORD, NC 27332   |                               |                    |
| (X4) ID   | SUMMARY S                                      | STATEMENT OF DEFICIENCIES                                      | ID           |     | PROVIDER'S PLAN OF CORRECTION  |                               | (X5)               |
| PREFIX<br>TAG                                       | (EACH DEFICIEN                                 | ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION) | PREFI<br>TAG | X   | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                               | COMPLÉTION<br>DATE |
| F 684   | F 684 Continued From page 87                   |  | F            | 684 |  |                               |                    |
|   | •  | 9  |              |     | Supervisor began in-service education  | to                            |                    |
|   | Resident #40 was o                             | observed on 2/16/22 at 10:22                                   |              |     | all full time, part time, and as needed a  |                               |                    |
|   |  | ospital gown without protective                                |              |     | agency nurses Topics included:   | iid                           |                    |
|   | sleeving to her arms                           |  |              |     | <ul> <li>Following physician orders for wou</li> </ul>                               | ınd                           |                    |
|   | electing to her dimi                           | -,   |              |     | treatments.  |                               |                    |
|   | Nurse #2 was interv                            | viewed on 2/16/22 at 11:02                                     |              |     | Confirming that new orders provide   | ed                            |                    |
|   |  | the February 2022 TAR where                                    |              |     | by the wound doctor or other physician   |                               |                    |
|   |  | sident #40 had geri-sleeves                                    |              |     | are initiated timely and accurately.   | ,                             |                    |
|   | present to her arms/hands on 2/14/22, 2/15/22  |  |              |     | How to apply these principles to th  | eir                           |                    |
|   | and 2/16/22. She st                            | ated she "had assumed they                                     |              |     | daily practice.  |                               |                    |
|   | were on" when she                              | marked them on the TAR but                                     |              |     | This information has been integrated in  | ıto                           |                    |
|   | she had not verified                           | they were on. An observation                                   |              |     | the standard orientation training and in   | the                           |                    |
|   | was made of Reside                             | ent #40 with Nurse #2, who                                     |              |     | required in-service refresher courses for  | r                             |                    |
|   | confirmed they were                            | e not in place.  |              |     | all staff identified above and will be   |                               |                    |
|   |  |  |              |     | reviewed by the Quality Assurance  |                               |                    |
|   |  | was interviewed on 2/16/22 at                                  |              |     | process to verify that the change has  |                               |                    |
|   |  | she had worked at the facility                                 |              |     | been sustained. Any of the identified  |                               |                    |
|   |  | 21 and worked both the 7:00                                    |              |     | nursing staff who does not receive   |                               |                    |
|   |  | t) and 3:00 PM to 11:00 PM                                     |              |     | scheduled in-service training will not be  | ;                             |                    |
|   |  | #4 was familiar with Resident                                  |              |     | allowed to work until training has been  |                               |                    |
|   |  | assigned to care for her when was unaware Resident #40         |              |     | completed by March 28, 2022.   |                               |                    |
|   |  | es on her arms. NA #4 was                                      |              |     | 4. Monitoring Procedure to ensure th   | at                            |                    |
|   |  | guide available for Resident                                   |              |     | the plan of correction is effective and the  |                               |                    |
|   | #40.   | ,  |              |     | specific deficiency cited remains correct  |                               |                    |
|   |  |  |              |     | and/or in compliance with regulatory   |                               |                    |
|   | The Registered Nur                             | se (RN) Supervisor was   |              |     | requirements.  |                               |                    |
|   | -  | /22 at 3:45 PM and stated she                                  |              |     | The Director of Nursing and/or   |                               |                    |
|   | had just returned to                           | work at the facility 3 weeks                                   |              |     | designee will utilize the QA tool for the  |                               |                    |
|   | ago. She recalled R                            | Resident #40 required  |              |     | Quality of Care Process to monitor   |                               |                    |
|   |  | her fragile skin but could not                                 |              |     | compliance with timely and accurate  |                               |                    |
|   |  | ere not ensuring they were in                                  |              |     | transcription implementation of wound  |                               |                    |
|   | place as ordered.                              |  |              |     | physician orders. The Director of Nurse  |                               |                    |
|   |  |  |              |     | and/or designee will monitor two reside  | nts                           |                    |
|   |  | AM, NA #1 was interviewed                                      |              |     | with non-pressure ulcers weekly for 2  |                               |                    |
|   |  | ked both the first and second                                  |              |     | weeks, then monthly for 3 months for   |                               |                    |
|   |  | assigned to Resident #40                                       |              |     | accuracy and timely implementation of  |                               |                    |
|   |  | NA #1 was unaware Resident                                     |              |     | wound treatment orders by the wound  |                               |                    |
|   | #40 required geri-sleeves to her arms. She was |  |              |     | physician. This tool will be completed a   | s                             |                    |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | , ,                 | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|--|---------------------|--|---|-------------------------------|----------------------------|
|  |  | 345532   | B. WING _           |  |   | 1                             | C<br>/17/2022              |
| NAME OF PI                                       | ROVIDER OR SUPPLIER  | L  |                     | ST                                     | REET ADDRESS, CITY, STATE, ZIP CODE   | 1 02/                         | TITLULL                    |
|  |  |  |                     | 31                                     | 0 COMMERCE DRIVE  |                               |                            |
| LIBERTY  | COMMONS NSG AND R  | EHAB CTR OF LEE COUNTY   |                     | SA                                     | ANFORD, NC 27332  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | ×                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  |                               | (X5)<br>COMPLETION<br>DATE |
| F 684  | Continued From pag   | e 88   | F 6                 | 884                                    |   |                               |                            |
|  | unaware of a care graph 40.  The Director of Nurson 2/17/22 at 5:33 Pemployed at the faci DON felt the lack of Resident #40 had thordered was due to expected all orders to 2. Resident #46 was 1/10/22 with multiple post T10 (thoracic vespinal fusion and L4 for stabilizing comporting admission Minimassessment dated 1. Resident #46's cogn 1 unstageable press Resident #46 had a for Santyl (a debriding wound healing) - app for wound healing.  Resident #46's care reviewed. The care phave a pressure ulce for development of a to decreased ability incontinence. The a | ing (DON) was interviewed M, indicating she had been lity since January 2022. The follow through to ensure e geri-sleeves in place as ack of accountability and o be followed.  admitted to the facility on e diagnoses including status ertebra) - L 4 (lumbar spine) vertebroplasty (a procedure ession fractures in the spine). In mum Data Set (MDS) (17/22 indicated that ition was intact, and she had ure ulcer.  doctor's order dated 1/12/22 and agent that promotes olly to right lower back daily  plan dated 1/17/22 was olan problem was "I currently er to my back and I am at risk diditional pressure ulcers due to reposition and |                     | 904                                    | stated above or until such time that the QA Committee determines the need to change the frequency of the audit (who has been determined that sustained compliance has been achieved). Identified area of concern are to be immediately addressed. The DON will present the results to the QA Committee. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Thera Manager, Health Information Manager Dietary Manager, Maintenance Director Medical Director. | en it ee. y                   |                            |
|  | wound physician as  Resident #46 was fo Physician weekly. T notes were reviewed  |  |                     |  |   |                               |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                     |   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|---|--|--|---------------------|---|-------------------------------|----------------------------|--|
|   |  | 345532   | B. WING _           |   |                               | C<br><b>02/17/2022</b>     |  |
|   | ROVIDER OR SUPPLIER  | REHAB CTR OF LEE COUNTY  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332                |                               | 02/11//2022                |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE                      | (X5)<br>COMPLETION<br>DATE |  |
| F 684   | wound and was over The weekly notes in treatment plans were 1/18/22 - post surgic centimeter (cm) X (I - treatment plan - Stagys 1/25/22 - post surgic 1.4 cm - 100% neor daily for 23 days 2/4/22 - post surgica 1.5 cm - 95 % necrodaily 2/8/22 - post surgica cm - 95% necrosis - serosanguinous - treatment plan - t | erlaying part of the incision. Including assessments and the as follows:  Cal - right lower back - 4.2  Day) 2 cm. with 100% necrosis antyl ointment daily for 30  Cal - right lower back - 4 cm x cosis - treatment plan - Santyl  Cal - right lower back - 4 cm x cosis - treatment plan - Santyl  Cal - right lower back - 4 cm x cosis - treatment plan - Santyl  Cal - right lower back - 3.8 x 1.2 | F 6                 | , , , , , , , , , , , , , , , , , , ,   |                               |                            |  |
|   | 1:32 PM. She state<br>Wound Nurse in Oc<br>rounds with the Wor<br>transcribed the trea<br>She reviewed the W   | vas interviewed on 2/15/22 at d that she started as the tober 2021. She made und Physician weekly and tment plan as recommended. /ound Physician note dated that the wound on the right  |                     |   |                               |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDII   | TIPLE CONSTRUCTION  NG | (×  | (X3) DATE SURVEY<br>COMPLETED   |                        |  |
|--|--|---|------------------------|---|---|------------------------|--|
|  |  | 345532  | B. WING _              |   |   | C<br><b>02/17/2022</b> |  |
|  | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY  |                        | STREET ADDRESS, CITY, STATE, Z 310 COMMERCE DRIVE SANFORD, NC 27332 | IP CODE   | 02/11/2022             |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFII<br>TAG    | X (EACH CORRECTIVE A<br>CROSS-REFERENCED T                          | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |                        |  |
| F 684  | pressure ulcer. She to transcribe the Ger by the Wound Physicia 2/17/22 at 1:20 PM. rounds with the Wou Tuesday. She provid Nurse that same day transcribe the treatm recommended. She was not aware that the recommended (Gent She was informed late Gentamycin was not ordered to use Bacitr infection) instead. The explained that Reside the wound on her bathe wound was gettithere was a moderat attending physician of (an antibiotic) by more just an additional treatment of the Director of Nursion 2/17/2 at 3:34 PM started as the DON of the started as the DON of the started as the DON of the wound Physician of the process of the process of the started as the DON of the wound Physician of the process of the proc | rgical wound and not a also stated that she missed stamycin as recommended cian on 2/8/22.  In was interviewed on She reported that she made and Nurse weekly on ded her notes to the Wound and she expected her to ent plan she had further indicated that she he treatment she had amycin) was not transcribed. St Tuesday (2/15/22) that the available and so she reacin (used to prevent wound the Wound Physician ent #46 was admitted with the form her back surgery. In the sum of drainage. Her had already put her on Keflex with so the Gentamycin was atment.  In g (DON) was interviewed I. She reported that she just of the facility in January 2022. | F                      | 584   |   |                        |  |
|  | position but that was<br>transcribe the treatm<br>that she expected the<br>transcribed and imple<br>by the Wound Physic  | revent/Heal Pressure Ulcer  | F                      | 586   |   | 3/29/22                |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPI<br>A. BUILDING | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|--|-----------------------------|--|-------------------------------|--|
|  |   | 345532   | B. WING                     |  | C<br><b>02/17/2022</b>        |  |
| NAME OF PI                                       | ROVIDER OR SUPPLIER   |  |                             | STREET ADDRESS, CITY, STATE, ZIP CODE  | 02/11/2022                    |  |
|  |   |  |                             | 310 COMMERCE DRIVE   |                               |  |
| LIBERTY  | COMMONS NSG AND RE  | EHAB CTR OF LEE COUNTY   |                             | SANFORD, NC 27332  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  | DATE.                         |  |
| F 686  |   |  | F 68                        | 6  |                               |  |
|  | §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.  This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, staff, resident, facility Wound Physician, Medical Director (MD) and Wound Clinic Nurse |  |                             | The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies.  | do                            |  |
|  | (Resident #26) and fa<br>as ordered and as red<br>Physician (Resident #<br>for 4 of 6 residents re<br>The finding included:<br>1. Resident #26 was  | or a specialty mattress siled to provide wound care commended by the Wound #17, #54 and #14). This was viewed for pressure ulcers.  admitted on 3/5/21 with elitis and a stage 4 pressure                              |                             | To remain in compliance with all federa and state regulations the facility has ta 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. F686  The facility failed to provide an ordered  | ken<br>on                     |  |
|  | read an order to upgr<br>Clinitron bed (minimiz<br>and moisture. It also<br>oxygen to tissues to f<br>nutrients to the wound<br>(treats pressure ulcer  | clinic note dated 11/10/21 ade his bed to either a tes pressure, friction, heat can help restore the flow of acilitate the delivery of d areas) or a Dolphin Bed s by maintaining proper sustain blood flow, alleviate |                             | specialty mattress and to provide would care as ordered.  1. Corrective action for resident(s) affected by the alleged deficient praction on 2/17/2022 the Director of Nurses verified with the recommending wound clinic that the equalizer mattress was a acceptable level 2 specialty mattress for the special type of the special type | ce:                           |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBER:  |                    | 2) MULTIPLE CONSTRUCTION BUILDING  |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|--------------------|--|---|-------------------------------|--|
|   |  |   |                    |  |   | С                             |  |
|   |  | 345532  | B. WING            |  |   | 02/17/2022                    |  |
|   | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY  |                    | STREET ADDRESS, CITY, STATE, ZIP CODE  310 COMMERCE DRIVE  SANFORD, NC 27332   |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  | N SHOULD BE<br>E APPROPRIA  | DATE.                         |  |
| F 686   | note indicated the ME order on 11/11/21.  Review of Resident # record (EMR) reveale skin assessments and ulcer treatments.  Review of Resident # evaluation dated 11/3 stage 4 pressure ulce another stage 4 presischium on 1/26/22.  Review of Resident # care plan dated 12/16 pressure reducing maplanned on 12/16/21 and pressure relieving intervention read to a decisions about his transense of control.  Review of Resident # Data Set (MDS) dated cognitively intact and He was coded for three pressure relieving decisions and the was coded for three pressure relievin | nd promotes healing). The D was notified of the new 226's electronic medical ed evidence of refusals of d refusals of his pressure 226's weekly skin and wound 20/21 read he developed an er to his left ischium and sure ulcer to his right 226 revised pressure ulcer 26/21 read he was to have a attress. He was also care for resistance to wound care g measures. The 26 make reatment regime to promote 226's quarterly Minimum d 1/2/22 indicated he was coded for rejection of care. See pressure ulcers and a vice to his bed. | F                  | resident #26 wound needs. T mattress was applied to the r on 2/17/2022. On 2/16/2022 treatment as o provided to the left heel by the nurse for resident # 17. The forder was reviewed by the wand updated to assure that the current wound physician order place on 2/16/2022. On 2/16/2022 treatment as o provided to the rt buttock by nurse for resident # 54. The forder was reviewed by the wand updated to assure that the current wound physician order place on 2/16/2022. On 2/16/2022 treatment as o provided to the rt high and leader on 2/16/2022. On 2/16/2022 treatment as o provided to the rt thigh and leader on 2/16/2022. On 2/16/2022 treatment order reviewed by the wound nurse to assure that the most curre physician order was in place 2/16/2022.  2. Corrective action for resident practice. Beginning on 2/23/2022 the Information or a source that the most current order was in place and being ordered. Results: 5 of 5 resident pressure ulcers had an accurate that the physician/wound phy | resident's be ordered was ne wound treatment round nurse he most er was in ordered was the wound treatment round nurse he most er was in ordered was eft heel of nurse as round updatent wound on didents with y the allegound on treatment grovided dents with rate ecommence. | s e s ated as aled            |  |
|   |  | ducted on 2/14/22 at 10:44  |                    | · ·  | sician. This  |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:          | ` ′          | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |       | (X3) DATE SURVEY<br>COMPLETED |  |
|--|-------------------------|---|--------------|---|---|-------|-------------------------------|--|
|  |                         |   |              |   |   |       | С                             |  |
|  |                         | 345532  | B. WING      |   |   |       | /17/2022                      |  |
| NAME OF P  | ROVIDER OR SUPPLIER     | l   |              | S                                       | TREET ADDRESS, CITY, STATE, ZIP CODE  | 1 02/ | 1172022                       |  |
|  |                         |   |              | 31                                      | 10 COMMERCE DRIVE   |       |                               |  |
| LIBERTY  | COMMONS NSG AND R       | EHAB CTR OF LEE COUNTY                                      |              | S                                       | ANFORD, NC 27332  |       |                               |  |
| (X4) ID  | SUMMARY ST              | FATEMENT OF DEFICIENCIES                                    | ID           |   | PROVIDER'S PLAN OF CORRECTION   |       | (X5)                          |  |
| PREFIX<br>TAG                                    | (EACH DEFICIENC         | CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFI<br>TAG | X                                       | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  |       | COMPLETION<br>DATE            |  |
| F 686  | Continued From pag      | e 93  | F            | 686                                     |   |       |                               |  |
|  |                         | 6. He stated he went to the                                 |              |   | of 2/23/2022 all residents with pressure  | د     |                               |  |
|  |                         | ospital for a monthly wound                                 |              |   | ulcers were in compliance.  | ,     |                               |  |
|  |                         | luation. Resident #26 stated                                |              |   | On 2/21/2022 the Director of Nurses ar  | nd    |                               |  |
|  |                         | wrote an order for him to                                   |              |   | Wound Nurse audited all residents with  |       |                               |  |
|  |                         | tress in November 2021 and                                  |              |   | orders for specialty mattresses to assu   |       |                               |  |
|  | 1                       | on the same air mattress.                                   |              |   | the appropriate mattress was in place v   |       |                               |  |
|  | '                       | us Administrator apparently                                 |              |   | no other incidents found. On 2/23/202   |       |                               |  |
|  | 1                       | attress. Resident #26 stated                                |              |   | the Director of Nurses educated the   | _     |                               |  |
|  | he had developed 2      |   |              | wound nurse on the facility wound and   |   |       |                               |  |
|  | 1                       | sident #26 denied that he                                   |              |   | treatment process to include ensuring t   | :hat  |                               |  |
|  | refused his skin asse   | essments and wound  |              |   | recommendations by the wound physic   |       |                               |  |
|  | treatments.             |   |              |   | are being transcribed and implemented   |       |                               |  |
|  |                         |   |              |   | timely and accurately.  |       |                               |  |
|  | A wound care observ     | vation was completed on                                     |              |   | ,   |       |                               |  |
|  |                         | vith the Director of Nursing                                |              |   | 3. Measures /Systemic changes to  |       |                               |  |
|  | (DON). Resident #26     | was in bed on a low   |              |   | prevent reoccurrence of alleged deficie   | nt    |                               |  |
|  | pressure air mattress   | s. The DON stated Resident                                  |              |   | practice:   |       |                               |  |
|  | #26 had been on the     | same mattress and the                                       |              |   |   |       |                               |  |
|  | mattress was never t    | upgraded to her knowledge.                                  |              |   | Beginning on 3/09/2022 the Director of  |       |                               |  |
|  | She stated she was i    | not aware of the wound clinic                               |              |   | Nurses, Nurse Consultant and RN   |       |                               |  |
|  | recommendation dat      | ed 11/10/22 for a Clinitron                                 |              |   | Supervisor began in-service education   | to    |                               |  |
|  | bed or a dolphin surf   | ace mattress.   |              |   | all full time, part time, and as needed a   | nd    |                               |  |
|  |                         |   |              |   | agency nurses Topics included:  |       |                               |  |
|  |                         | nducted on 2/16/22 at 10:30                                 |              |   | <ul> <li>Following physician orders for wou</li> </ul>  | ınd   |                               |  |
|  | AM with the facility V  | Vound Nurse. She stated                                     |              |   | treatments.   |       |                               |  |
|  |                         | the wound clinic at the                                     |              |   | <ul> <li>Confirming that new orders provide</li> </ul>  |       |                               |  |
|  |                         | a wound evaluation. She                                     |              |   | by the wound doctor or other physician  | s,    |                               |  |
|  | I .                     | was noncompliant with his                                   |              |   | are initiated timely and accurately.  |       |                               |  |
|  |                         | ommendations. The Wound                                     |              |   | <ul> <li>Follow through on orders for speci</li> </ul>  | alty  |                               |  |
|  |                         | s not aware that there was                                  |              |   | mattress process  |       |                               |  |
|  |                         | about a Clinitron bed or a                                  |              |   | How to apply these principles to the control of the control o | eir   |                               |  |
|  | Dolphin bed.            |   |              |   | daily practice.   |       |                               |  |
|  | 0:: 0/40/00 + 0.40 5    | MA AL - E - 2004 - N.L.                                     |              |   | This information has been integrated in   |       |                               |  |
|  | On 2/16/22 at 3:10 P    | •   |              |   | the standard orientation training and in  |       |                               |  |
|  | 1                       | a invoice dated 12/20/21 for                                |              |   | required in-service refresher courses for   | ÞΓ    |                               |  |
|  |                         | nattress (a bed that provides                               |              |   | all staff identified above and will be  |       |                               |  |
|  |                         | sure and low air loss to                                    |              |   | reviewed by the Quality Assurance   |       |                               |  |
|  | 1                       | distribution) but it was back                               |              |   | process to verify that the change has   |       |                               |  |
|  | i ordered. She stated : | apparently the previous                                     |              |   | been sustained. Any of the identified   |       | 1                             |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         | ` ′          | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |       | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|--------------|---|--|-------|-------------------------------|--|
|   |   |  | A. BOILDI    |   | <del></del>  | ، ا   | c l                           |  |
|   |   | 345532   | B. WING      |   |  |       | 17/2022                       |  |
| NAME OF PI  | ROVIDER OR SUPPLIER                               |  |              | S                                       | TREET ADDRESS, CITY, STATE, ZIP CODE   | , , , |                               |  |
|   |   |  |              | 310 COMMERCE DRIVE                      |  |       |                               |  |
| LIBERTY   | COMMONS NSG AND RE                                | EHAB CTR OF LEE COUNTY                                     |              | S                                       | ANFORD, NC 27332   |       |                               |  |
| (X4) ID   | SUMMARY ST  | ATEMENT OF DEFICIENCIES                                    | ID           |   | PROVIDER'S PLAN OF CORRECTION  |       | (X5)                          |  |
| PREFIX<br>TAG                                       | (EACH DEFICIENC                                   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFI<br>TAG | X                                       | (EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |       | COMPLÉTION<br>DATE            |  |
| F 686   | Continued From page                               | e 94   | F            | 686                                     |  |       |                               |  |
|   | Administrator ordered                             | d the Equalizeaire Plus                                    |              |   | nursing staff who does not receive   |       |                               |  |
|   |   | comparable to a Clinitron or a                             |              |   | scheduled in-service training will not be  | ,     |                               |  |
|   | Dolphin bed. The bac                              |  |              |   | allowed to work until training has been  |       |                               |  |
|   |   | d by the current Administrator                             |              |   | completed by March 28, 2022.   |       |                               |  |
|   | with the date of 2/15/                            | 22. She stated the facility did                            |              |   |  |       |                               |  |
|   | have a Supra DPS al                               | ternating bubble pad                                       |              |   | 4. Monitoring Procedure to ensure th   | at    |                               |  |
|   | mattress available. Tl                            | he Nurse Consultant stated                                 |              |   | the plan of correction is effective and the  | ıat   |                               |  |
|   | the DON was waiting                               | on a return call from the                                  |              |   | specific deficiency cited remains correc   | ted   |                               |  |
|   |   | to confirm that the Supra                                  |              |   | and/or in compliance with regulatory   |       |                               |  |
|   | DPS alternating bubble pad mattress (low air loss |  |              |   | requirements.  |       |                               |  |
|   | mattress for the treatment of pressure ulcers)    |  |              |   | The Director of Nursing, and/o   | r     |                               |  |
|   |   | to use until the Equalizeaire                              |              |   | designee will utilize the QA tool for  |       |                               |  |
|   | Plus mattress arrived                             |  |              |   | Pressure Ulcer Prevention and Treatme  |       |                               |  |
|   |   |  |              |   | to monitor compliance with the timely a  |       |                               |  |
|   |   | ducted on 2/17/22 at 10:12                                 |              |   | accurately transcribing wound physicia   |       |                               |  |
|   |   | he stated she called the                                   |              |   | orders for implementation. The Directo   |       |                               |  |
|   |   | and they said the Supra                                    |              |   | Nurses, and/or designee will monitor th  |       |                               |  |
|   |   | ble pad mattress would be                                  |              |   | residents with pressure ulcers weekly f  |       |                               |  |
|   |   | Equalizeaire Plus mattress                                 |              |   | 2 weeks, then monthly for 3 months for   |       |                               |  |
|   | -   | She stated it would be                                     |              |   | accuracy of wound treatment orders ar  |       |                               |  |
|   | placed on his bed by                              | the end of the day.  |              |   | for placement of specialty mattresses a<br>ordered. This tool will be completed as   |       |                               |  |
|   | Λ telephone interview                             | was conducted on 2/17/22                                   |              |   | stated above or until such time that the   |       |                               |  |
|   |   | ospital wound clinic NP                                    |              |   | QA Committee determines the need to  |       |                               |  |
|   |   | S. She stated she was                                      |              |   | change the frequency of the audit (whe   |       |                               |  |
|   | T   | by the DON regarding his                                   |              |   | has been determined that sustained   |       |                               |  |
|   |   | she was not aware that the                                 |              |   | compliance has been achieved).   |       |                               |  |
|   |   | for the specialty bed was                                  |              |   | Identified area of concern are to be   |       |                               |  |
|   |   | e wound clinic NP stated                                   |              |   | immediately addressed. The DON will  |       |                               |  |
|   |   | t doing things to help with                                |              |   | present the results to the QA Committee  |       |                               |  |
|   |   | it the specialty bed would                                 |              |   | The monthly QA Meeting is attended by  |       |                               |  |
|   |   | ealing status as long as                                   |              |   | the Administrator, Director of Nursing,  |       |                               |  |
|   |   | mplaint. She stated she                                    |              |   | Minimum Data Set Coordinator, Therap   | oy    |                               |  |
|   |   | o provide what Resident #26                                |              |   | Manager, Health Information Manager,   | •     |                               |  |
|   | needed to promote w                               |  |              |   | Dietary Manager, Maintenance Directo Medical Director.                               |       |                               |  |
|   | An telephone interview was conducted on 2/17/22   |  |              |   |  |       |                               |  |
|   |   | MD. He stated Resident #26                                 |              |   |  | ĺ     |                               |  |
|   | was known to refuse                               |  |              |   |  |       |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIF   | PLE CONSTRUCTION  G | (X3) DATE SURVEY<br>COMPLETED  |          |                            |
|--|---|---|---------------------|--|----------|----------------------------|
|  |   | 345532  | B. WING             |  |          | C<br>02/17/2022            |
|  | ROVIDER OR SUPPLIER   | REHAB CTR OF LEE COUNTY   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332                           | <b>.</b> | <u> </u>                   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 686  | Continued From pag  | ge 95   | F 68                | 36   |          |                            |
|  | stated he expected  | recommendations made by   |                     |  |          |                            |
|  | PM with the DON. S wound clinic order for been implement with   | nducted on 2/17/22 at 6:00<br>the stated Resident #26's<br>or a specialty bed should have<br>in the type of bed<br>th a comparable mattress/  |                     |  |          |                            |
|  | facility on 3/1/21 wit<br>1/28/22. She had m<br>included osteomyeli<br>caused by an infecti                         | s originally admitted to the h a recent readmission on ultiple diagnoses that tis (inflammation of the bone on) of the vertebra and sacral e ulcer of the sacral region.  |                     |  |          |                            |
|  | 11/22/21, included a<br>to the sacral area ar<br>development of add   | re care plan, last reviewed a focus area for pressure ulcer and remained at risk for itional pressure ulcers. The led to administer treatments as a for effectiveness.  |                     |  |          |                            |
|  | #17 was cognitively   | 2/11/21 indicated Resident intact and had 1 stage 3 (a to the tissue beneath the skin   |                     |  |          |                            |
|  | indicated she was in<br>1/28/22 for treatmer<br>the sacral wound. U<br>there was an order to<br>dressing that forms | #17's medical record the hospital from 1/18/22 to at and surgical debridement of Jpon her return to the facility to continue with Aquacel (a a gel on contact with wound ling) placed with a border al wound daily. |                     |  |          |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDII | FIPLE CONSTRUCTION  NG  | (X:                          | 3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|-------------------------|---|------------------------------|-----------------------------|
|                          |  | 345532  | B. WING _               |   |                              | C<br><b>02/17/2022</b>      |
|                          | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY  |                         | STREET ADDRESS, CITY, STATE, ZIP COI<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332 | DE                           |                             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFII<br>TAG     | •   | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE  |
| F 686                    | A review of the active an order dated 1/31/2 with soap and water, protector every day finjury to the underlying surface that results fithat area) that was perfacility.  Review of the Wound Evaluation and Management and Management for the sacrum (cm) in length, 10 cm. The treatment recomment and wound with moderate Anasept gel (an antire wound with moderate Anasept gel (an antire wound healing) to the gauze and a foam become a foam become a foam become a foam | e 96 e physician orders included 22 to cleanse the right heel apply skin prep, and heel or a deep tissue injury (an ing tissue below the skin's rom prolonged pressure in resent on readmission to the depth of the deep tissue) pressure measured 10.5 centimeters in width and 4 cm in depth, mendation was for Calcium a sterile primary dressing for et to heavy drainage) and microbial gel that helps with the wound bed, cover with order dressing daily, issue injury of the right heel and hand 6 cm in width. The dation was to apply skin and keep heel off the bed. |                         |   |                              |                             |
|                          | measured 1.8 cm in The treatment recom   | issue injury of the left heel ength and 1.5 cm in width. mendation was to apply skin and keep heel off the bed.   |                         |   |                              |                             |
|                          | 2/8/22 revealed the s<br>with wound cleaner,<br>wound bed and cove<br>the right heel was cle   | uary 2022 Treatment d (TAR) from 2/1/22 to eacral wound was cleansed had Aquacel placed on red with dressing daily and eansed with skin prep applied ot reflect a treatment was   |                         |   |                              |                             |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION  IG  |           | DATE SURVEY<br>COMPLETED   |
|--------------------------|--|--|-------------------------|--|-----------|----------------------------|
|                          |  | 345532   | B. WING _               |  |           | C<br>02/17/2022            |
|                          | ROVIDER OR SUPPLIER  | REHAB CTR OF LEE COUNTY  |                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332           | I         | 02/11/2022                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 686                    | and Management S indicated Resident a - Stage 4 pressure of the resident and the stage of the st | Physician Wound Evaluation ummary dated 2/8/22 #17 revealed the following: wound of the sacrum length, 11 cm in width and 4.3 eatment recommendation was with Anasept gel to the with gauze and a foam border //. tissue injury of the right heel length and 5.3 cm in width. In mendation was to apply skin by and keep heel off the bed. It issue injury of the left heel length and 1.4 cm in width. In mendation was to apply skin by and keep heel off the bed. It issue injury of the left heel length and 1.4 cm in width. In mendation was to apply skin by and keep heel off the bed. It issue injury of the left heel length and 1.4 cm in width. In mendation was to apply skin by and keep heel off the bed. It is sacral area with wound accel cover with Mepilex twice with a sacral area with wound accel cover with Mepilex twice in the sacral wound was decleaner, had Aquacel placed covered with dressing twice a will be weekly wound assessment where weekly wound assessment in the transfer of the weekly wound assessment in the weekly wound assessment in the transfer of the weekly wound assessment in the transfer o | F 6                     | 886  |           |                            |
|                          | with the wound nurs  | e and facility Wound<br>2 at 10:20 AM, as Resident   |                         |  |           |                            |

|                          | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | , ,                 | TIPLE CONSTRUCTION  NG   |                              | (X3) DATE<br>COMP | SURVEY                     |
|--------------------------|--|---|---------------------|--|------------------------------|-------------------|----------------------------|
|                          |  | 345532  | B. WING _           |  |                              | l                 | C<br><b>17/2022</b>        |
| NAME OF PI               | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CO  | DDE                          | 1 02/             | 11/2022                    |
|                          |  |   |                     | 310 COMMERCE DRIVE   |                              |                   |                            |
| LIBERTY                  | COMMONS NSG AND RI   | EHAB CTR OF LEE COUNTY  |                     | SANFORD, NC 27332  |                              |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BI<br>HE APPROPRIA |                   | (X5)<br>COMPLETION<br>DATE |
| F 686                    | observed lying in her When asked if observed occur she stated. The wound nurse wa 10:30 AM and explain nurse at the facility si did the wound rounds who was at the facility evaluated the resider were not seen by the treatment orders from wound nurse stated s Wound Physician's W Management Summa Tuesdays and tried to Physician's recomme Resident #17's active February 2022 TARs and Management Su 2/8/22, the wound nu not as recommended and did not include th #17's left heel. The w "could do a better job making sure the treat with what the Wound The facility Wound Pl phone on 2/17/22 at unaware the wound to were not being follow." | PM, Resident #17 was bed looking out the window. vation of her wound care ed, "I'd rather not."  Is interviewed on 2/16/22 at ned she had been the wound nce October 2021 and only is with the Wound Physician, by every Tuesday. They not with pressure ulcers that wound clinic and received in the Wound Physician. The she was able to receive the wound Evaluation and any by the afternoon on | F6                  | 586  |                              |                   |                            |
|                          | The Director of Nursi  | ng (DON) was interviewed  |                     |  |                              |                   |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | 1   | TIPLE CONSTRUCTION  | (X  | (X3) DATE SURVEY<br>COMPLETED          |                            |
|--|---|---|---------------------|---|--|----------------------------|
|  |   | 345532  | B. WING             |   |  | C<br><b>02/17/2022</b>     |
|  | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY  |                     | STREET ADDRESS, CITY, STATE, Z 310 COMMERCE DRIVE SANFORD, NC 27332 | IP CODE                                | 02/1//2022                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICII       | ACTION SHOULD BE<br>TO THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 686  | on 2/17/22 at 5:33 PN<br>started employment a<br>2022. The DON state      | M and indicated she had<br>at the facility in January<br>ed it was her expectation for<br>ysician's recommendations                                   | F€                  | 586   |  |                            |
|  |   | admitted to the facility on<br>s that included diabetes type<br>gout.   |                     |   |  |                            |
|  | 12/6/21, included a for<br>impairment to skin in<br>The interventions inc | e care plan, last reviewed on<br>ocus area for actual<br>tegrity of the sacral area.<br>luded to keep skin clean and<br>e barrier ointment to sacrum. |                     |   |  |                            |
|  |   | Data Set (MDS)<br>26/22 indicated Resident<br>ntact and had 1 stage 3   |                     |   |  |                            |
|  | orders revealed an or<br>cleanse the wound to<br>cleanser, apply Hydro    | #54's active physician rder dated 1/11/22 to the right buttock with wound ofera blue and cover with every day and as needed.                          |                     |   |  |                            |
|  | revealed a Stage 3 p<br>buttock measured 4.5<br>width and 0.1 cm in d     | gement Summary for 2/4/22<br>ressure wound of the right<br>5 cm in length, 1.8 cm in<br>lepth. The treatment<br>s for Hydrofera blue covered          |                     |   |  |                            |
|  | Management Summa  | Vound Evaluation and<br>ary for 2/8/22 indicated<br>3 pressure area to the right  |                     |   |  |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDI |     | ONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>PLETED           |
|--------------------------|---|--|------------------------|-----|--|-------------------|----------------------------|
|                          |   | 345532   | B. WING _              |     |  |                   | C<br>17/2022               |
|                          | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY   |                        | 310 | COMMERCE DRIVE NFORD, NC 27332   | 1 02/             | 11/2022                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG     | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 686                    | Continued From pag  | e 100  | F                      | 686 |  |                   |                            |
| F 686                    | buttock measured 4. width and 0.1 cm in recommendation chaover collagen with A gauze every day.  Resident #54's Febr Administration Reco 2/15/22 indicated the with wound cleaner, a gauze dressing da  An observation of Rewas completed with Wound Physician on Resident #54 was of to preaching service pressure area to the cm in length, 1.6 cm The periwound was bed was white. The present. The facility wound had stalled in a change in the treat recently in hopes of the pressure wound.  On 2/15/22 the phys 2022 TAR, reflected buttock wound with vigel, cover with collagover and cover with | 2 cm in length, 2.0 cm in depth. The treatment order anged to Hydrofera blue foam masept gel covered with  uary 2022 Treatment (TAR) from 2/1/22 to e sacral wound was cleansed Hydrofera blue covered with ily and as needed.  esident #54's wound care the wound nurse and facility 2/15/22 at 10:23 AM. eserved lying in bed listening through headphones. The right buttock measured 4.2 in width and 0.1 cm in depth. Pink in color and the wound re was no drainage or odor Wound Physician stated the the healing process and that ment order had occurred seeing more improvement in ician orders and February a change to cleanse the right wound cleaner, apply Anasept gen, place Hydrofera blue gauze daily and as needed. | F                      | 586 |  |                   |                            |
|                          | 10:30 AM and explainurse at the facility siding the wound round who was at the facili   | as interviewed on 2/16/22 at<br>ned she had been the wound<br>ince October 2021 and only<br>s with the Wound Physician,<br>ty every Tuesday. They<br>nts with pressure ulcers that   |                        |     |  |                   |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDII | TIPLE CONSTRUCTION  NG  | (X3       | 3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|--|-------------------------|---|-----------|-----------------------------|
|                          |  | 345532   | B. WING _               |   |           | C<br><b>02/17/2022</b>      |
|                          | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY   |                         | STREET ADDRESS, CITY, STATE, ZIP COD<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332   | E         |                             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFII<br>TAG     | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE  |
| F 686                    | received treatment on Physician. The wound to receive the Wound Evaluation and Mana afternoon on Tuesda Wound Physician's reviewing Resident # the February 2022 The Evaluation and Mana 2/4/22 and 2/8/22, thoorders were not as resphysician, but she has 2/15/22. The wound better job of reviewin sure the treatment or what the Wound Physician wound the Wound Physician wound the Wound Physician wound for the Director of Nursion 2/17/22 at unaware the wound the were not being follow expect them to be followed expect them to be followed accurated the physician wound Physician wound for the Director of Nursion 2/17/22 at 5:33 Pl started employment 2022. The DON statt the facility Wound Physician wound for the physician wound physician wound for the | e wound clinic, and she riders from the Wound and nurse stated she was able of Physician's Wound agement Summary by the ys and tried to review the ecommendations. After 154's active physician orders, ARs and the Wound agement Summaries dated are wound nurse agreed the ecommended by the Wound and updated the orders on nurse stated she "could do a grate reports and making afters were accurate with sician recommended."  Thysician was interviewed via 1:00 PM and stated she was treatments recommendations are das written but would allowed for optimal wound  The provision of the facility in January and indicated she had at the facility in January and it was her expectation for a sician's recommendations at the facility on the facility of the facil | F                       | 586   |           |                             |
|                          |  | mpairment, dependent on the and had 1 stage 4 pressure   |                         |   |           |                             |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDII | TIPLE CONSTRUCTION  NG  |                                 | (X3) DATE SURVEY<br>COMPLETED |   |
|--------------------------|---|--|-------------------------|---|---------------------------------|-------------------------------|---|
|                          |   | 345532   | B. WING _               |   |                                 | C<br><b>02/17/2022</b>        |   |
|                          | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY   |                         | STREET ADDRESS, CITY, STATE, ZIP O<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332 | CODE                            |                               |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFII<br>TAG     |   | TION SHOULD BE<br>THE APPROPRIA |                               | 1 |
| F 686                    | reviewed. The care currently have a pres approaches included ordered and to monit consult with the Wouneeded/ordered.  Resident #14 was fol Physician weekly. The indicated that Reside pressure ulcers on his and left heel (unstage skin prep (a liquid for on intact or damaged irritation). The note of the right thigh pressure accentimeter (cm) x (necrosis and with moserosanguinous exuct to treat the right thigh Calcium with silver (at that promotes healing granulation tissue) dapressure ulcer measing cm with 70 % granulation to the treatment plan with the silver and Gentamyos skin infection) daily for Resident #14 had a control to the right thigh cleanser, apply Algin | plan dated 12/6/21 was plan problem was "I sure ulcer". The to administer treatments as or for effectiveness, and to and Physician as  Blowed by the Wound he note dated 12/14/21 and #14 had developed is right thigh (unstageable) eable) and were treated with raining skin protectant used if skin to help prevent ated 2/8/22 indicated that are ulcer measured by) 1.9 cm x 1 cm. with 10% orderate amount of date. The treatment plan was an pressure ulcer with Alginate and highly absorbent dressing grand formation of aily for 9 days. The left heel ared 5.5 cm x 3.8 cm x 0.1 action tissue and with serosanguinous exudate. Vas Alginate Calcium with in ointment (used to treat or 7 days. | F                       | 686   |                                 |                               |   |
|                          |   | an order to clean the left with wound cleanser, apply  |                         |   |                                 |                               |   |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDI |     | CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>PLETED           |
|--------------------------|--|--|------------------------|-----|--|-------------------|----------------------------|
|                          |  | 345532   | B. WING _              |     |  |                   | C<br><b>17/2022</b>        |
|                          | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY   |                        | 310 | REET ADDRESS, CITY, STATE, ZIP CODE  COMMERCE DRIVE  ANFORD, NC 27332  | 1 021             | 1112022                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG     | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 686                    | daily and as needed.  Resident #14 was ob change on 2/15/22 at   | served during the dressing<br>9:25 AM. The pressure  | F                      | 586 |  |                   |                            |
|                          | x 1.3 cm x 1.1 cm with pressure ulcer measure with 100 % granulation was observed to clear wound cleanser and agent that promotes and was covered with treatment that was rethe Wound Physician not followed. The Word clean the left heel precleanser and Gentam covered with dry dress kerlex. The treatment the Wound Physician not followed. | thigh ulcer measured 1.5 cm h 5% necrosis. The left heel ured 1 cm x 1.3 cm x 0.1 cm on tissue. The Wound Nurse in the right thigh ulcer with Santyl ointment (a debriding wound healing) was applied in dry dressing. The incommended and ordered by for Alginate Calcium was bound Nurse proceeded to be essure ulcer with wound in ointment was applied, asing, and secured with that was recommended by for Alginate Calcium was |                        |     |  |                   |                            |
|                          | 1:32 PM. She stated Wound Nurse in Octorounds with the Wour transcribed the treath She reviewed the Wo 2/8/22 and the order the right thigh pressu the nurses were provishe was not familiar valso stated that she right Alginate Calcium to the   | as interviewed on 2/15/22 at that she started as the ober 2021. She made and Physician weekly and ment plan as recommended. Sound Physician note dated to use Alginate Calcium to re ulcer. She indicated that iding the treatment daily and with the treatment order. She missed to transcribe the ne left heel as  |                        |     |  |                   |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDII | IPLE CONSTRUCTION  NG  |           | DATE SURVEY<br>COMPLETED   |
|--------------------------|--|---|-------------------------|--|-----------|----------------------------|
|                          |  | 345532  | B. WING _               |  |           | C<br><b>02/17/2022</b>     |
|                          | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY  |                         | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332                         |           | 02/11//2022                |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFII<br>TAG     | PROVIDER'S PLAN OF CORI<br>( (EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 686                    | Continued From page  | e 104   | F                       | 586  |           |                            |
|                          | rounds with the Wour Tuesdays. She prov Nurse that same day transcribe the treatmrecommended. She was not aware that the recommended was not implemented. The Word that Resident #14 was development of press quadriplegic (paralys developmental disord mattress and was on that his ulcers were used to the provide the same transcribed to the same transcribed to the provide that the same transcribed to the provide that the same transcribed to the provide transcribed transcribed to the provide transcribed transcribe | She reported that she made and Nurse weekly on dided her notes to the Wound and she expected her to ent plan she had further indicated that she he treatment she had ot transcribed and /ound Physician explained |                         |  |           |                            |
| F 689<br>SS=G            | on 2/17/2 at 3:34 PM started as DON of the She stated that the V position but that was transcribe and to follo DON stated that she to be transcribed and recommended and a Physician.  Free of Accident Haz CFR(s): 483.25(d)(1)  §483.25(d) Accidents The facility must ensight §483.25(d)(1) The reas free of accident has   | ow the treatment orders. The expected the treatment plan limplemented as sordered by the Wound ards/Supervision/Devices (2)   | F                       | 689  |           | 3/29/22                    |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′   | PLE CONSTRUCTION  G   |                               | TE SURVEY<br>MPLETED       |
|---|-----------------------|---|---|---|-------------------------------|----------------------------|
|   |                       | 345532  | B. WING   |   |                               | C<br><b>2/17/2022</b>      |
| NAME OF P   | ROVIDER OR SUPPLIER   | 0.0002  | <del>-1 -                                  </del> | STREET ADDRESS, CITY, STATE, ZIP CO   | •                             | 2/11/2022                  |
| NAME OF T   | NOVIDEN ON GOLF EIEN  |   |   |   | DE .                          |                            |
| LIBERTY   | COMMONS NSG AND       | REHAB CTR OF LEE COUNTY   |   | 310 COMMERCE DRIVE  |                               |                            |
|   |                       |   |   | SANFORD, NC 27332   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICI          | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                               | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | ON SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 689   | Continued From p      | page 105  | F 68  | 39  |                               |                            |
|   | supervision and a     | ssistance devices to prevent  |   |   |                               |                            |
|   | accidents.            |   |   |   |                               |                            |
|   |                       | ENT is not met as evidenced   |   |   |                               |                            |
|   | by:                   |   |   |   |                               |                            |
|   |                       | review, observation and staff   |   | The statements made on thi  | is plan of                    |                            |
|   |                       | ity failed to prevent repeated  |   | correction are not an admiss  |                               |                            |
|   | falls by not providi  | ing effective interventions after   |   | not constitute an agreement   | with the                      |                            |
|   | each fall (Residen    | t #16) for 1 of 4 sampled   |   | alleged deficiencies.   |                               |                            |
|   | residents reviewed    | d for accidents. Resident #16   |   | To remain in compliance with  | า all federal                 |                            |
|   |                       | of the fingers on 9/10/21 and   |   | and state regulations the fac   | ility has taken               |                            |
|   | left and right hip fr | actures on 9/24/21 after the fall.  |   | or will take the actions set fo   |                               |                            |
|   |                       |   |   | plan of correction. The plan  |                               |                            |
|   | Findings included:    | :   |   | constitutes the facility's alleg  |                               |                            |
|   |                       |   |   | compliance such that all alle   | •                             |                            |
|   |                       | admitted to the facility on   |   | deficiencies cited have been  |                               |                            |
|   |                       | le diagnoses including  |   | corrected by the dates indica   |                               |                            |
|   |                       | se and dementia. The quarterly  |   | F689 The facility failed to p   |                               |                            |
|   |                       | t (MDS) assessment dated  |   | repeated falls by not providir interventions after each fall.                             | ig ellective                  |                            |
|   |                       | that Resident #16 had severe ent and needed supervision   |   |   | vidont(a)                     |                            |
|   |                       | sical assist with transfers and   |   | Corrective action for res     affected by the alleged defici                              | , ,                           |                            |
|   |                       | n. The assessment further   |   | For resident #16, a PT safety   |                               |                            |
|   |                       | resident had 2 or more falls  |   | completed on the resident or  |                               |                            |
|   |                       | eentry, or prior assessment.  |   | by the Physical Therapist. To   |                               |                            |
|   | annos admission, i    | contrary, or prior decedement.  |   | meals and at bedtime was a  | -                             |                            |
|   | Resident #16's ca     | re plan that was initiated on   |   | intervention on 2/25/2022 to  |                               |                            |
|   |                       | wed. The care plan problem  |   | Falls for resident #16 were re  | •                             |                            |
|   |                       | ctual fall with risk for further".  |   | the last 60 days by the Direc   |                               |                            |
|   |                       | risk for future falls will be   |   | and MDS nurse on 3/07/202   |                               |                            |
|   |                       | n current interventions". The   |   | appropriate fall interventions  |                               |                            |
|   |                       | led encourage me to call for  |   | reflected on her care plan an   |                               |                            |
|   |                       | transfers (10/1/21), encourage  |   | carried out.  |                               |                            |
|   | me to lock my bre     | aks before standing up  |   |   |                               |                            |
|   | (10/1/21), encoura    | age me to use my walker when  |   | 2. Corrective action for res  | idents with                   |                            |
|   | ambulating ( 6/28/    | (21), encourage me to wear  |   | the potential to be affected b  | y the alleged                 |                            |
|   |                       | en not wearing shoes (6/28/21),   |   | deficient practice.   |                               |                            |
|   | ensure that call lig  | ht is within reach (6/28/21),   |   | On 3/09/2022 -03/11/2022 th   | ne Director of                |                            |
|   | Physical therapy (    | PT) to evaluate as needed   |   | Nursing and Minimum Data  | Set Nurse                     |                            |
|   | (6/28/21), hipster    | to be worn at all times   |   | audited all current residents   | with falls in                 |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ` '                 |     | CONSTRUCTION  | (X3) DATE<br>COMF      | SURVEY                     |
|--------------------------|--|---|---------------------|-----|---|------------------------|----------------------------|
|                          |  |   |                     |     |   |                        | С                          |
|                          |  | 345532  | B. WING _           |     |   | 02/                    | 17/2022                    |
| NAME OF P                | ROVIDER OR SUPPLIER  |   |                     | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |                        |                            |
| I IDEDTY                 | COMMONS NEG AND DE   | HAB CTR OF LEE COUNTY   |                     | 3′  | 10 COMMERCE DRIVE   |                        |                            |
| LIBERTT                  | COMMONS NOG AND RE   | EHAB CIR OF LEE COUNTY  |                     | S   | ANFORD, NC 27332  |                        |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   |                        | (X5)<br>COMPLETION<br>DATE |
| F 689                    | Continued From page  | <del>2</del> 106  | F 6                 | 689 |   |                        |                            |
| F 689                    | (10/15/21), make sure that fit appropriately (possible side effects affect my gait and ball have change in my gareinforce safety remire. Resident #16's incide The reports revealed since admission to the the resident sustained. The report dated 9/9/2 that Resident #16 was outside of her bathroor roommate yelling "she assessed for injury ar lower extremities. The determined to be self-intervention was to charm the thing that the plan until 10/1/21.  The report further ind was placed in bed, she right thumb and right informed, and x-ray was affected to the sure of the triangle of the tr | e that I have non-slip shoes 6/28/21), observe me for from medications that may lance and report to nurse if I lait or balance (10/7/21) and inders frequently (10/1/21).  Intreports were reviewed. that the resident had 5 falls e facility and 2 of the 5 falls, in the fractures.  21 at 12:20 AM revealed is observed on the floor or after hearing the efell". The resident was ind no deformity noted to the interport of the fall was included in the control of the fall was included in the care incated that after the resident included in the complained of pain to her hip/leg, the physician was | F                   | 389 | the past 30 days to ensure that all appropriate interventions were identified and in place on the care plan and carriculate out with no further concerns noted.  3. Measures /Systemic changes to prevent reoccurrence of alleged deficies practice: Beginning on 03/10/2022, the Nurse Consultant educated the interdisciplinate team (Director of Nursing, MDS Nurse, Dietary Manager, Business office manager, Medical Records director, Therapy manager, Activity Director and Administrator) on the following topics:  Root cause analysis and timely en of fall interventions to the care plan.  Review of falls at Daily Stand Up meeting (Monday thru Friday) by the interdisciplinary team with addition of appropriate interventions to the care planeting interventions to the care planeting on 3/10/2022 the Director of Nurses, Nurse Consultant at RN Supervisor  educated all nurses and CNA's Full Time, Part Time, as needed and agency on implementation of fall interventions and accessing the resider kardex/care plan. | ed Int Ty Itry an. Ind |                            |
|                          | • •  | e at base of first distal<br>luxation at first  |                     |     | This information has been integrated in the standard orientation training and in required in-service refresher courses for all staff identified above and will be   | the                    |                            |
|                          | physician was notified ordered to maintain the together.   | ed 9/11/21 at 4:32 AM, the d of the x-ray report, and he he broken fingers taped  |                     |     | reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training word be allowed to work until training has been completed by March 28, 2022.   | ill                    |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | IPLE CONSTRUCTION  |  | SURVEY<br>PLETED           |
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|  | 245522   | B WING              |  |  | С                          |
|  | 345532   | B. WING _           |  | 02/  | /17/2022                   |
| NAME OF PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |  |                            |
| LIBERTY COMMONS NSG AND REA  | HAB CTR OF LEE COUNTY  |                     | 310 COMMERCE DRIVE   |  |                            |
|  |  |                     | SANFORD, NC 27332  |  |                            |
| PREFIX (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CORRECTIV  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPROI  DEFICIENCY)   | ) BE   | (X5)<br>COMPLETION<br>DATE |
| floor at the doorway of assessed for injury. R extremities with no char The root cause of the find self-toileting at night. In check frequently for near reminders to get assist intervention added to the trying to stand up that her hips hurt. The with Tramadol (a narcouthe physician was notified find find find find find find find fin | r observed sitting on the room. Resident was ange of motion to all ange in limitations noted. If all was determined to be the intervention was to eds and frequent tance. There was no new the care plan until 10/1/21.  If 9/15/21 at 9:41 AM at #16 noted to be in pain p. When asked, she stated the resident was medicated offic used to treat pain) and fied, and he ordered x-ray elvis.  If 9/15/21 revealed no  If 9/23/21 revealed that the dot to bear weight on her the physician was notified ography CT) scan of the lated 9/24/21 revealed I right superior pubic ramus ced left inferior pubis.  If 9/25/21 at 5:12 PM sician called, and Resident ter right and left pelvis. The | F                   | 4. Monitoring Procedure to ensure the plan of correction is effective and specific deficiency cited remains con and/or in compliance with regulatory requirements.  The Director of Nursing or designee monitor compliance utilizing the F68 Quality Assurance Tool weekly x 2 vithen monthly x 3 months. The Direct Nursing will monitor to ensure fall interventions implemented are carried timely and have been entered into the resident car eplan. Reports will be presented to the weekly Quality Assurance committee by the Directon Nurses to ensure corrective action is initiated as appropriate. Compliance be monitored and the ongoing audit program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting and the Ongoing audity Assurance Meeting. The weekly Quality Assurance Meeting and the Ongoing audity Assurance Me | I that rected will Peeks or of d out e r of will ng lity ator, |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ' '                 | IPLE CONSTRUCTION  |         | TE SURVEY<br>MPLETED       |
|--------------------------|---|--|---------------------|--|---------|----------------------------|
|                          |   | 345532   | B. WING _           |  |         | C<br>2/17/2022             |
|                          | ROVIDER OR SUPPLIER   | REHAB CTR OF LEE COUNTY  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332                     |         | 2/11/2022                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| F 689                    | front of her bed. Co completed with no rareas noted. The rodetermined to be co awareness and self was hipster for protintervention added further falls except for the report dated 1/4. Resident #16 was cobathroom door. The lower back pain. The importance of using assistance by using stated that the residindependently to the help or use of whee administered for pain and x-ray was ordershow any acute fractifall was dementia who forgetfulness and not report did not include further fall and there added to the care purther fall.  The report dated 2/4. Resident #16 was coher bed. Head to to with no injury noted was determined to lagainst the side of the floor wearing improwas to ensure where wearing non-skid so | ge 108 vas observed on the floor in implete body assessment was edness, scratches or open oot cause of the fall was onfusion, poor safety -transfers. The intervention ection. There was new to the care plan to prevent for the hipster on 10/15/21.  4/22 at 8:30 AM revealed that observed on the floor by the eresident complained of the call bell. The report lent continued to ambulate the bathroom without calling for elchair. Tramadol was in. The physician was notified, ord. The x-ray report did not cture. The root cause of the fifth resident complaining of tot calling for assistance. The ele intervention to prevent ele was no new intervention lan after the fall to prevent  4/22 at 4:14 PM revealed that observed on the floor beside e assessment was completed and was found on the or resident was leaning the bed and was found on the or footwear. Intervention in out of bed, resident was ocks. There was new to the care plan after the fall to | F6                  | 589  |         |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MUL <sup>-</sup><br>A. BUILDI |     | CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED            |
|--------------------------|---|--|------------------------------------|-----|--|-------------------|----------------------------|
|                          |   | 345532   | B. WING                            |     |  |                   | C<br><b>17/2022</b>        |
|                          | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY   | •                                  | 31  | TREET ADDRESS, CITY, STATE, ZIP CODE  O COMMERCE DRIVE  ANFORD, NC 27332   | 1 02              | 11/2022                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                 | х   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 689                    | her room on 2/15/22 at 9:27 AM, and 1:40 (folded) noted between ightstand and was resident.  The Registered Nursinterviewed on 2/16/2 that they (Director of Nurse, MDS Nurse, FDietary Manager) used aily Monday through what and how it happed to put in place. The MDS Nurse was interventions discuss care plan. She state the clinical meeting of Nurse Aide (NA) #1, was interviewed on 2 stated that she started month ago. She state confused, frequently bladder and she wenneeded. She stated a toileting program. resident was ambula was better off using a walker folded agains: | eserved up in wheelchair in at 12:45 PM and on 2/16/22 PM. There was a walker en the wall and the not within reach of the  e (RN) Supervisor was 22 at 1:39 PM. She reported Nursing (DON), Support Rehabilitation Director and ed to have a clinical meeting in Friday and discussed falls, bened and what intervention RN Supervisor reported that | F                                  | 689 |  |                   |                            |
|                          |   | Resident #16, was<br>22 at 9:13 AM. NA #5 stated<br>is confused, high risk for falls   |                                    |     |  |                   |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (>                                | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|--|--|-----------------------------------|-------------------------------|--|
|   |  | 345532   | B. WING_                               |  |                                   | C<br><b>02/17/2022</b>        |  |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |  | STREET ADDRESS, CITY, STATE, ZIP C                                       | ODE                               | 02/11/2022                    |  |
| LIBERTY   | COMMONE NEC AND  | A DELIAD CED OF LEE COUNTY   |  | 310 COMMERCE DRIVE   |                                   |                               |  |
| LIDERIT   | COMMONS NSG AND  | REHAB CTR OF LEE COUNTY  |  | SANFORD, NC 27332  |                                   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICI   | / STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5) COMPLETION DATE          |  |
| F 689   | like to use the call could ambulate by continent of bowel that the resident was a the resident was a supervision to preservision to preservision to preservision to preservision to preservision and the grade of the bathroom used to follow directions to the bathroom used to the bathroom used they would supervise they would supervise they would suppreserve they would suppreserve the putting the resident to the pattern and they would suppreserve they would su | age 110 nember to follow instructions light or call for assistance. She at unsteady and she was mostly and bladder. She reported rould go to the bathroom ad been falling. She added that not on a toileting schedule. NA esident needed close went her from falling.  was conducted with the RN e Support Nurse on 2/17/22 at bith stated that Resident #16 alls, she was unsteady but walk. She would not remember s. She was not supposed to go hassisted, but she did it th indicated that the resident ervision, and frequent checks ggest moving her close to the d to involve her in activities. For revealed that they had not sident on a toileting schedule. | F                                      | 589  |                                   |                               |  |
|   | 2:15 PM. She stat<br>Nurse 4-5 months<br>Resident #16 was<br>confused and wou<br>instructions. She<br>was aware that so<br>to use the bathroot<br>the bathroom befo<br>bedtime might hel<br>but these had not<br>using a walker wo<br>but there was no s   | ed that she started as MDS ago. She revealed that high risk for falls, she was ald not remember to follow could walk but unsteady. She me of her falls were from trying m. She added that taking her to are and after meals and at p in preventing her from falling been tried. She reported that ald also help her from falling space in her room for the ed and stored away from her.  |  |  |                                   |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` ′                 | PLE CONSTRUCTION  G   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|---------------------|---|-------------------------------|----------------------------|
|   |  | 345532   | B. WING             |   | 02/                           | )<br>17/2022               |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                               |                            |
| LIBERTY (   | COMMONS NSG AND RE   | HAB CTR OF LEE COUNTY  |                     | 310 COMMERCE DRIVE  |                               |                            |
|   |  |  |                     | SANFORD, NC 27332   | I                             |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 689   | Continued From page  | ÷ 111  | F 68                | 39  |                               |                            |
|   | for falls and verified the intervention added to   | nat there was no new<br>the care plan after each fall.   |                     |   |                               |                            |
|   | stated that Resident #high risk for falls. Show unsteady. She had so and walk unassisted. The bathroom and she she reported that Residelting program, but in preventing her from think the staff has the bathroom as schedule saw her walking unasted that her every in the Director of Nursimon 2/17/2 at 3:34 PM. started as DON of the She stated that Resident walking on the hallwalling on the hallwalling on the hallwalling that the Sup Nurse were new to the | 2 at 4:56 PM. The nurse #16 was confused and was e was able to ambulate but everal falls trying to get up. She had falls trying to go to e knew when she has to go. sident #16 was not on a she thought that might help in falling, however she didn't time to take her to the ed. She reported that she esisted, and the staff could ininute.  It imports the staff could in the ed. She reported that she esisted, and the staff could in the ed. She reported that she esisted in the ed. She reported that she is the ed. She reported that she just established in January 2022. Hent #16 was high risk for at one day she saw her you nassisted. The DON in over of direct care staff and indicate concerns with falls. She oport Nurse and the MDS eir roles. |                     |   |                               |                            |
| F 692<br>SS=D                                       | Nutrition/Hydration St<br>CFR(s): 483.25(g)(1)-  |  | F 69                | 92  |                               | 3/29/22                    |
|   | (Includes naso-gastri  | nutrition and hydration.<br>c and gastrostomy tubes,<br>ndoscopic gastrostomy and  |                     |   |                               |                            |

|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDI |     | CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED            |
|--------------------------|---|--|------------------------|-----|--|-------------------|----------------------------|
|                          |   | 345532   | B. WING _              |     |  |                   | C<br><b>17/2022</b>        |
|                          | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY   |                        | 31  | TREET ADDRESS, CITY, STATE, ZIP CODE  10 COMMERCE DRIVE  ANFORD, NC 27332  | , , ,             |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG     | ×   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  |                   | (X5)<br>COMPLETION<br>DATE |
| F 692                    | enteral fluids). Based comprehensive asses ensure that a residen §483.25(g)(1) Mainta of nutritional status, s  | copic jejunostomy, and don a resident's ssment, the facility must t- ins acceptable parameters uch as usual body weight or   | F                      | 692 |  |                   |                            |
|                          | balance, unless the redemonstrates that thi preferences indicate §483.25(g)(2) Is offer maintain proper hydra §483.25(g)(3) Is offer  | ed sufficient fluid intake to  |                        |     |  |                   |                            |
|                          | provider orders a their This REQUIREMENT by: Based on record revious Director, Registered I interviews, the facility with meals as ordered loss (Resident #40) a resident's weights as interventions for weights was for 2 of 5 resident. The findings included 1) Resident #40 was 6/7/15 with diagnoses | rapeutic diet. is not met as evidenced lews, observations, Medical Dietician and staff failed to provide assistance d for a resident with weight nd failed to monitor a ordered and implement ht loss (Resident #52). This hts reviewed for nutrition. : admitted to the facility on s that included dementia, |                        |     | The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies.  To remain in compliance with all federa and state regulations the facility has ta 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.  F692 | ıl<br>ken         |                            |
|                          | dysphagia (difficulty s<br>The active physician<br>dated 10/15/15 to pro  | trition, glaucoma, and swallowing). orders revealed an order ovide assistance with meals ary day and evening shifts.   |                        |     | For clinical services, a corrective action was obtained on 3/3/2022.  Based on staff interviews, observations and record review nutrition and hydrati maintenance was not maintained for 2   | on                |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |      | (X3) DATE SURVEY<br>COMPLETED |  |
|---|----------------------|---|---------------------|---|--|------|-------------------------------|--|
|   |                      | 345532  | B. WING             |   |  |      | C<br>/ <b>17/2022</b>         |  |
| NAME OF P   | ROVIDER OR SUPPLIER  | 1 0.0002  | <u> </u>            | ST                                      | FREET ADDRESS, CITY, STATE, ZIP CODE   | 02   | 11112022                      |  |
| NAME OF T   | NOVIDER OR GOLT EIER |   |                     |   | 0 COMMERCE DRIVE   |      |                               |  |
| LIBERTY   | COMMONS NSG AND      | REHAB CTR OF LEE COUNTY   |                     |   |  |      |                               |  |
|   | I                    |   |                     | 3,                                      | ANFORD, NC 27332   |      | T                             |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICI         | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | ×                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |      | (X5)<br>COMPLETION<br>DATE    |  |
| F 692   | Continued From p     | age 113   | E                   | 592                                     |  |      |                               |  |
| 1 002   | Continued From p     | age 113   | -                   | 192                                     | Funcidants For Decident #40 accietor   |      |                               |  |
|   | Paviou of a Space    | oh Thorony Diochargo  |                     |   | 5 residents. For Resident #40 assistar at meals was not provided per orders  |      |                               |  |
|   |                      | ch Therapy Discharge<br>/16/16 indicated Resident #40   |                     |   | resident experienced significant weigh   |      |                               |  |
|   |                      | ng prompting and redirection to   |                     |   | loss. For Resident #40 meal assistance   |      |                               |  |
|   |                      | n task during meals.  |                     |   | was reviewed and modified to total as  |      |                               |  |
|   | Continue to stay o   | in task during meals.   |                     |   | and up with all meals. Hospice was   | 5151 |                               |  |
|   | A Registered Diet    | ician (RD) progress note dated  |                     |   | consulted for Resident #40 to liberalize   | 2    |                               |  |
|   | _                    | weight loss was present with  |                     |   | diet and to review weights; weights to   |      |                               |  |
|   |                      | d staff provided assistance with  |                     |   | obtained per Hospice guidance.   |      |                               |  |
|   |                      |   |                     |   | For Resident #54 significant weight los  | ss   |                               |  |
|   | Resident #40's ac    | tive care plan, last reviewed   |                     |   | was not identified by clinical team nor  |      |                               |  |
|   |                      | a focus area for "I have a  |                     |   | were consults made to interdisciplinary  | /    |                               |  |
|   | nutritional problen  | n related to receiving a  |                     |   | team and therefore interventions were  | not  |                               |  |
|   | · ·                  | ed diet and poor meal intakes.  |                     |   | implemented in a timely manner. For  |      |                               |  |
|   |                      | ts and an appetite stimulant in   |                     |   | resident #54 weights were reviewed by  | y    |                               |  |
|   | 1 .                  | intakes. At times I may need  |                     |   | clinical team; weekly weights  |      |                               |  |
|   |                      | eals or cueing.". The   |                     |   | implemented, Med Pass supplement   |      |                               |  |
|   |                      | ded to let resident feed herself  |                     |   | initiated, and meal assistance modified  | d to |                               |  |
|   |                      | als when needed as well as  |                     |   | set up meals with clock.   |      |                               |  |
|   | provide encourage    | ement and cueing.   |                     |   | 0  | ı_   |                               |  |
|   | A automborilo Minima | um Data Cat (MDC)   |                     |   | 2. Corrective action for residents with  |      |                               |  |
|   |                      | um Data Set (MDS)<br>I 1/28/22 indicated Resident   |                     |   | the potential to be affected by the alleg  | gea  |                               |  |
|   |                      | impaired cognition and required   |                     |   | deficient practice.  |      |                               |  |
|   |                      | inpaired cognition and required ight/encouragement of a staff                                   |                     |   | All residents have the potential to be   |      |                               |  |
|   |                      | g. She was coded with weight  |                     |   | affected by the alleged deficient practi   | ce   |                               |  |
|   |                      | e in the last month or a loss of  |                     |   | On 3/3/2022 in-service was completed   |      |                               |  |
|   | 10% or more in th    |   |                     |   | with nursing, nursing assistants, and  |      |                               |  |
|   |                      |   |                     |   | department heads. On 3/3/2022 all  |      |                               |  |
|   | A review of Reside   | ent #40's weight history was  |                     |   | resident orders were reviewed to creat   | te a |                               |  |
|   |                      | vealed the following weights  |                     |   | comprehensive list of residents that   |      |                               |  |
|   | over a 6-month tir   | ne period:  |                     |   | require assistance at meals and made   |      |                               |  |
|   | - 8/6/21 was 124.    |   |                     |   | available to staff via communication bo  | ook. |                               |  |
|   | - 12/19/21 was 11    |   |                     |   | Meal tickets were also altered to highli   | ght  |                               |  |
|   | - 1/17/22 was 105    |   |                     |   | meal assistant requirements. By  |      |                               |  |
|   |                      | revealed Resident #40 had a   |                     |   | 3/11/2022 all staff employed to work   |      |                               |  |
|   |                      | s in a month and 17.74 %  |                     |   | AM/day shifts had completed the Feed   | ling |                               |  |
|   | weight loss in 6 m   | onths.  |                     |   | Program and were classified as   |      |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′  | PLE CONSTRUCTION  G   |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|--|---|--|-------------------------------|--|
|   |  | 345532   | B. WING  |   | 0.0  | C<br>2/ <b>17/2022</b>        |  |
| NAME OF P   | ROVIDER OR SUPPLIER  | 0.0002   | <del>                                     </del> | STREET ADDRESS, CITY, STATE, ZIP CC   |  | 11112022                      |  |
| TO THE OT THE                                       | TO VIDER OIL OUT TELER   |  |  | 310 COMMERCE DRIVE  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  |                               |  |
| LIBERTY   | COMMONS NSG AND  | REHAB CTR OF LEE COUNTY  |  |   |  |                               |  |
|   |  |  |  | SANFORD, NC 27332   |  | 1                             |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICI   | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY  | ON SHOULD BE<br>HE APPROPRIATE   | (X5)<br>COMPLETION<br>DATE    |  |
| F 692   | Continued From p   | page 114   | F 6  | 92  |  |                               |  |
|   | The February 202<br>Record (MAR) inc<br>assistance with m  | 2 Medication Administration<br>licated Nurse #2 had initialed<br>eals/supplements had been<br>22 and 2/15/22 day shift (7:00   |  | competent to provide assista<br>On 3/7/2022 the dining room<br>reopened; staff scheduled to<br>to ensure staff available for<br>meals.  | n has been<br>o dining room  |                               |  |
|   | On 2/14/22 at 12:: observed sitting u in front of her. It w wrapped up in a n plate. Straws were on a regular plate and cheese and a orange sherbet w the plate. Resider right-hand fingers She had consume  Nurse Aide (NA) # of Resident #40 o stated she was no #40, was unsure w but was familiar w  | 35 PM, Resident #40 was p in her bed with the lunch tray ras noted the silverware was still apkin to the right side of the e in her cup of tea and juice and was butter beans, macaroni chopped-up meat. A cup of as opened and to the left side of at #40 was observed using her to feed herself butter beans. Ed 25% of the meal at that time. |  | <ul> <li>3. Systemic changes</li> <li>In-service education was provided to all full time, part time, and as needed staff. Topics included:</li> <li>ADL's Eating Presentation</li> <li>Tray Delivery and Set-up for Nursing/CNA Training</li> <li>Nursing and Nursing Assistant Mea Procedures</li> <li>Nutrition and Hydration Policies.</li> <li>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 Quanticular times.</li> </ul> |  |                               |  |
|   | unrolled the silverware and napkin and placed to the right side of the plate while Resident #40 continued to use her fingers to eat. She stated Resident #40 was independent with her meals, was unaware she required cueing or supervision with meals and left the room.  A phone interview occurred with a family member of Resident #40 on 2/14/22 at 2:31 PM who stated when Resident #40 first came to the facility she was able to feed herself, but her vision and dementia had progressively gotten worse and she had started to use her fingers. The family member stated she would assist Resident #40 with meals when she visited and assumed the |  |  | 4. Quality Assurance mon procedure.  The Dietary Manager or des monitor meal service 5 times weeks, then weekly x 2 mon monthly x 3 months using the Assurance Audit tool. Monitor include ensuring staff are us channels to review which rerequire assistance at meals, assistance with meals, and multiple channels to provide  | signee will s weekly x 4 nths, and then le Quality bring will sing the proper sidents providing updating |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | l ` ′               | PLE CONSTRUCTION  G  |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------------------|--|--|-------------------------------|--|
|   |  | 345532   | B. WING _           |  | 0.   | C<br>2/17/2022                |  |
| NAME OF P   | ROVIDER OR SUPPLIER  |  | <u> </u>            | STREET ADDRESS, CITY, STATE, ZIP CO  |  |                               |  |
|   |  |  |                     | 310 COMMERCE DRIVE   |  |                               |  |
| LIBERTY   | COMMONS NSG AND  | REHAB CTR OF LEE COUNTY  |                     | SANFORD, NC 27332  |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY   | ON SHOULD BE<br>HE APPROPRIATE   | (X5)<br>COMPLETION<br>DATE    |  |
| F 692   | Continued From p   | age 115  | F 6                 | 92   |  |                               |  |
|   | staff were doing the added Resident #4 eater never consumeals even prior to On 2/15/22 at 12:10 observed sitting up front of her. On the Salisbury steak an peas. A container of the plate with wand napkin were uside of the plate. Feating peas with haste so good but room and scooped placed where Res Resident #40 then brought it to her mpeas onto the sponherself. NA #1 the #40 returned to eat NA #1 was interview ho was familiar value who was familiar value on her own. "peas onto the sponwere watching her who was familiar value on her own." peas onto the sponwere watching her who was familiar value past" staff had "play" with her foo assist with meals. would go to the dir COVID-19 and reconstructions. | e same. The family member 40 had always been a small ming more than 50% to 75% of admission to the facility.  5 PM, Resident #40 was in bed with the lunch tray in e regular plate was chopped d gravy, mashed potatoes, and of orange sherbet sat to the left ater and tea. The silverware nrolled and present to the right desident #40 was observed er fingers and stating, "they cheir hot". NA #1 entered the lithe peas on a spoon and ident #40 could get to it. picked up the spoon and outh. NA #1 again scooped on to which Resident #40 fed en left the room and Resident ting with her fingers.  Evwed on 2/15/22 at 12:20 PM, with Resident #40. She stated Resident #40 required mg with her meals and that she When asked why she scooped on, she stated "because you |                     | information regarding assistmeals. The Dietary Manage will monitor nutrition and hydria weight review weekly in then monthly in a month with the monthly in a month weight sare obtained per posignificant weight changes a properly and timely to maintand hydration status. Report presented to the weekly Qual Assurance committee by the to ensure corrective action in appropriate. Compliance will and ongoing auditing prograthe weekly Quality Assurance The weekly QA Meeting is a Administrator, Director of Nu Coordinator, Therapy, Healt Manager, and the Dietary Mentager. | er or designee dration status 3 months, and ing the Quality audit. Weight insuring licy and are addressed ain nutrition ats will be ality a Administrator initiated as I be monitored am reviewed at the Meeting. Ittended by the aursing, MDS h Information |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULT<br>A. BUILDI  | TIPLE CONSTRUCTION |   | (X3) DATE SURVEY<br>COMPLETED   |                        |  |
|--|---|---|--------------------|---|---|------------------------|--|
|  |   | 345532  | B. WING            |   |   | C<br><b>02/17/2022</b> |  |
|  | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY  |                    | STREET ADDRESS, CITY, STAT<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332 | TE, ZIP CODE  | 02/1//2022             |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFI<br>TAG | (EACH CORRECT<br>CROSS-REFERENC                                       | PLAN OF CORRECTION<br>TIVE ACTION SHOULD BE<br>CED TO THE APPROPRIAT<br>FICIENCY) |                        |  |
| F 692  | provided now.  On 2/15/22 at 3:48 P She explained she w to 11:00 PM) shift and #40. NA #7 stated at Resident #40 with he and unroll silverware cues to eat with the since the room and would be resident as she liked on her fingers. NA #7 the order to provide a tried to supervise any #40 refusing assistant.  Nurse #2 was intervided AM. She had indicate with meals during the 2/15/22. Nurse #2 exherself after staff providing cueing with she had signed off or 2/14/22 and 2/15/22.  An observation was reassisted with her lund PM by Nurse #2. The accepting food from a how good it tasted.  An interview was con 2/16/22 at 2:00 PM w Resident #40. She estaff member, had be since November 202 | M, NA #7 was interviewed.  orked the second (3:00 PM d was familiar with Resident dinner she would provide r tray, open all containers, Stated she would provide dilverware as she walked by often get a sandwich for the them and was less messy stated she was unaware of desistance with meals but rway and denied Resident dece.  Ewed on 2/16/22 at 11:02 ded assistance was provided de first shift on 2/14/22 and plained Resident #40 fed wided set up of the tray and desistance with meals which is the reason of the MAR as completed for made of Resident #40 being the meal on 2/16/22 at 12:15 de resident was readily de spoon and kept stating ducted with NA #4 on | F                  | 592   |   |                        |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |                                 | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|---|--|---------------------------------|-------------------------------|--|
|   |  | 345532  | B. WING _                               |  |                                 | C<br><b>02/17/2022</b>        |  |
| NAME OF P   | ROVIDER OR SUPPLIER  |   |   | STREET ADDRESS, CITY, STATE, ZIP C   | CODE                            | OZ/11/2022                    |  |
| LIDEDTY   | COMMONE NEC AND D  | ELAB CTR OF LEE COUNTY  |   | 310 COMMERCE DRIVE   |                                 |                               |  |
| LIDERIT   | COMMONS NSG AND RI   | EHAB CTR OF LEE COUNTY  |   | SANFORD, NC 27332  |                                 |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE | TION SHOULD BE<br>THE APPROPRIA | DATE                          |  |
| F 692   | containers, made sur<br>and then checked on<br>walked by the room.<br>Resident #40 had an<br>A phone interview oc<br>2/17/22 at 5:10 PM.   | sident #40, she would open e everything was in place her frequently when she NA #4 was unaware order to assist with meals.  curred with the RD on She stated she assessed | F6                                      | 592  |                                 |                               |  |
|   | weight loss over the p<br>was due to the natura<br>process and was una<br>assisting with meals a<br>The Director of Nursi  | ng (DON) was interviewed<br>//, and stated she was  |   |  |                                 |                               |  |
|   | consistent assistance<br>cueing or physical as<br>her to be assisted as<br>2. Resident # 52 was  | with her meals, to include sistance, but she expected needed and ordered. admitted on 1/6/21 with s of breast cancer and  |   |  |                                 |                               |  |
|   |  | ented evidence of any<br>(RD) note since 1/18/21 on   |   |  |                                 |                               |  |
|   | revised on 5/6/21 rea<br>therapeutic, mechani<br>experienced weight k<br>observation/record/re<br>(MD) any significant v<br>10% over 6 months.<br>(RD) was to evaluate<br>recommendations as |   |   |  |                                 |                               |  |
|   | Review of Resident #   | 52' weight's revealed the   |   |  |                                 |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                    |     | (X3) DATE SURVEY<br>COMPLETED  |  |                     |
|---|--|--|--------------------|-----|--|--|---------------------|
|   |  | 345532   | B. WING            |     |  | 1  | C<br><b>17/2022</b> |
|   | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY   |                    | 310 | COMMERCE DRIVE NFORD, NC 27332   | 1 02/  | 11/2022             |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | H CORRECTIVE ACTION SHOULD BE<br>S-REFERENCED TO THE APPROPRIATE |                     |
| F 692   | A/14/21 for weekly we Review of a weight of Dietary Manager (DM read Resident #52 were no weight change note which read Resident pounds. The note was weekly weights.  Review of a weight of DM dated 11/8/21 at #52's weight was 164 that her weight was smonthly weights.  There was no docum for December 2021.  Resident #52's weight pounds. Her weight of 163.0 pounds. The of 6 months was 11.229.  Review of a ST evaluated 12/7/21 read Review of a ST evaluated 12/7/21 read Review of a ST evaluated 12/7/21 read Resident #52 was coregular food safely at aspiration. | ing the MD order dated eights.  Inange note written by the 1) dated 6/7/21 at 12:10 PM as 185.0 pounds. There ge notes until the DM wrote e dated 10/8/21 at 11:10 AM #52's weight was 166.4 s read to continue her  Inange note written by the 11:01 AM read Resident 4.8 pounds. The note read table and to continue  ented evidence of a weight weight loss.  Into no 7/7/21 was 183.6 on 1/17/22 (6 months) was alculated percentage lost in 6 weight loss.  Ination and Plan of Treatment resident #52 was picked up to her swallowing dysfunction in foods which were not led. Staff report that insuming thin liquids and | F                  | 692 |  |  |                     |
|   | dated 1/25/22 indicat  | ,  |                    |     |  |  |                     |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  G   |          | (X3) DATE SURVEY COMPLETED |  |  |
|--------------------------|--|--|--------------------------|---|----------|----------------------------|--|--|
|                          |  | 345532   | B. WING _                |   |          | C<br><b>02/17/2022</b>     |  |  |
|                          | ROVIDER OR SUPPLIER  | REHAB CTR OF LEE COUNTY  |                          | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332                              | <u> </u> | <u> </u>                   |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY) | OULD BE  | (X5)<br>COMPLETION<br>DATE |  |  |
| F 692                    | coded for any weight Her weight on 2/7/2 Review of a ST treat Resident #52 required decreased cognitive to complete task.  Review of Resident orders included an electric order dated 1/6/21 medication (Femara daily to treat her bree-Order dated 4/14/24/14/21 -Order dated 12/7/2 a potential diet upgre-Order dated 2/15/2 sugar added fortified  | #52' February 2022 Physician orders follows: for a daily chemotherapy to be administrated twice east cancer. I for speech therapy (ST) for | F 6                      |   |          |                            |  |  |
|                          | guide for the aides in nurse for intake of le refusals.  Review of Resident percentages from Nultiple meal refusals where she only ate  An observation was 12:30 PM of resider with the head of her degrees. In front of was her lunch tray, bite of her minced of the nurse for interest of the nurse for inter | t should be reported to the<br>ess than 25% or any meal<br>#52's meal consumption<br>ovember 2021 to 2/16/22<br>als and multiple occasions |                          |   |          |                            |  |  |

|                          |   |   | 3) DATE SURVEY<br>COMPLETED |  |                                |                            |
|--------------------------|---|---|-----------------------------|--|--------------------------------|----------------------------|
|                          |   | 345532  | B. WING _                   |  |                                | C<br>02/17/2022            |
|                          | OVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY  |                             | STREET ADDRESS, CITY, STATE, ZIP CO<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332           | •                              | 02/11//2022                |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
|                          | entered the room and in bed and raise the approximately 45 deg #52 was able to feed time.  An observation was 612:10 PM. Resident in upright with her lunch her. NA #2 was setting Resident #52 was able to feed time.  An interview was core PM with the DM. She monthly or more ofter reviewed the weekly something looked off obtain a reweight. Shimpression that Resident #52 eat meals but the stated Resident #52 eat meals but the state The DM stated nursing of the issue for not grant meals.  An interview was core PM with NA #2. She 25% of her lunch. She reported her intake to prior to leaving.  An interview was core PM with Nurse #3. Sereport Resident #5'2.  An observation was core properties was core properties. | Nursing Assistant (NA) #4 d repositioned Resident #52 head of her bed up to grees. NA #4 stated Resident herself but it took a long  conducted on 2/15/22 at #54 was sitting in the bed in tray positioned in front of ing up her tray and stated ble to feed herself.  Inducted on 2/15/22 at 12:20 e stated the RD came in if needed. She stated she and monthly weights and if if, she would ask the staff to the stated she was under the ident #52' weight loss was idiagnosis of cancer. The DM should be up out of bed to inff were not getting her up. Ing management was aware etting her up out of bed for  inducted on 2/15/22 at 1:40 stated Resident #52 ate the stated she had not of the nurse but she would  inducted on 2/15/22 at 4:10 he stated the aide did not | F                           | 592  |                                |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | I DENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION<br>G  |             | (X3) DATE SURVEY<br>COMPLETED |  |  |
|---|--|--|---------------------|--|-------------|-------------------------------|--|--|
|   |  | 345532   | B. WING             |  |             | C<br><b>)2/17/2022</b>        |  |  |
|   | PROVIDER OR SUPPLIER  COMMONS NSG AND REHAB CTR OF LEE COUNTY  STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332  |  | 211112022           |  |             |                               |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |  |
| F 692   | her. There was a sum on her tray open with had not tried her shad and tried her shad. An interview was copen with NA #4. She #52's dentures in too longer fit due to her Resident #52 ate apand approximately hake. She stated simportified shake. NA #Resident #52 up out lunch but the resident when visitors came, tolerate regular food her diet at present.  An observation was AM. Resident #52 wheelchair. She stated she had eaten breakfast and drank fortified shake.  An interview was copen AM with the Speech stated she was not weight loss and that responsibility. She simpore with the stated she recommendated she recommendat | th tray positioned in front of agar free fortified shake was he a straw in it. She stated she ake but would get to it.  Inducted on 2/16/22 at 1:54 stated she put Resident day for lunch but they no weight loss. She stated proximately 25% of her lunch half of the sugar free fortified he did not report Resident ce she drank half of her 44 stated she offered to get to feed at breakfast and not refused. NA #4 stated Resident #52 was able to but the ST said no change in conducted on 2/17/22 at 8:54 has out of bed sitting in her ted it felt good be up out of approximately 50% of 100% of her sugar free inducted on 2/17/22 at 11:12 Therapist (ST). The ST working with Resident #52 for | F 6                 | 92   |             |                               |  |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | l ` ′               | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |           |                         | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------------------|---|-----------|-------------------------|-------------------------------|--|
|   |  | 345532   | B. WING             |   |           | C<br><b>02/17/202</b> 2 | 2                             |  |
| NAME OF PI  | ROVIDER OR SUPPLIER  | 0.5552   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   | <u> </u>  | 02/11/2022              |                               |  |
|   |  |  |                     | 310 COMMERCE DRIVE  |           |                         |                               |  |
| LIBERTY   | COMMONS NSG AND RI   | EHAB CTR OF LEE COUNTY   |                     | SANFORD, NC 27332   |           |                         |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>( (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | D 47                    | ETION                         |  |
| F 692   | Continued From page  | e 122  | F 6                 | 592   |           |                         |                               |  |
|   | The ST confirmed that  | cause her discomfort but   |                     |   |           |                         |                               |  |
|   | at 5:15 PM with the F #52's weight's flagged but her weights appeed 2021 to January 2022/2/7/22 was 162 poun #52 was having contistated she was new to July 2021. She stated #52 was not on her counable to answer who Resident #52's weigh when Resident #5 | lent #52's weight loss was   |                     |   |           |                         |                               |  |
|   | at 4:56 PM with the M<br>Resident #52 never fi<br>stated the fact the Re<br>of cancer did not mea<br>MD stated she was b<br>chemotherapy medic<br>on the medication if s<br>stated he was not aw<br>weight was not being<br>that Resident #52 wa   | w was conducted on 2/17/22 MD. He stated apparently lagged for weight loss. He esident #52 has a diagnosis an she was terminal. The eing treated daily with a ation and she would not be whe were terminal. The MD are that a order for weekly followed. When informed s not on any appetite ry nutritional supplement |                     |   |           |                         |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|---|---------------------|---|-------------------------------|--|
|   |   | 345532  | B. WING             |   | C                             |  |
| NAME OF P   | ROVIDER OR SUPPLIER   | 343332  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   | 02/17/2022                    |  |
| LIBERTY (   | COMMONS NSG AND RE  | EHAB CTR OF LEE COUNTY  |                     | 310 COMMERCE DRIVE  |                               |  |
|   |   |   |                     | SANFORD, NC 27332   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)   | BE COMPLÉTION                 |  |
| F 692   | Continued From page   | e 123   | F 69                | 2   |                               |  |
|   |   | 2/15/22, he stated her weight<br>dressed and additional<br>ace.   |                     |   |                               |  |
| F 835<br>SS=F                                       | PM with the DON. Sh<br>have acted on her sig<br>continued weight loss<br>interventions. The DO<br>why this was not done<br>Administration   | and implanted<br>ON was unable to answer  | F 83                | 5   | 3/29/22                       |  |
|   | enables it to use its re efficiently to attain or practicable physical, it well-being of each rest This REQUIREMENT by:  Based on staff interv facility administration oversight to ensure the operational. The audit system has been non This deficient practice residing at the facility. This citation is cross.  Based on observation interviews and record have a fully functioning feature to assist with resident call lights on | ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident.  is not met as evidenced elews and record review, the failed to provide effective are call system was fully tory feature of the call functional since 8/14/21. eraffected all residents ereferred to F919-F: |                     | The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies.  To remain in compliance with all federand state regulations the facility has to a will take the actions set forth in this plan of correction. The plan of correctic constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.  1. To correct the defective call-syste the facility placed hand bells in each resident's room on 02/17/2022. Hand bells will serve as auditory part of call | al<br>aken<br>on              |  |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 |     | CONSTRUCTION  | (X3) DATE<br>COMP             | SURVEY                     |
|--------------------------|--|--|---------------------|-----|---|-------------------------------|----------------------------|
|                          |  | 345532   | B. WING             |     |   | l                             | C<br><b>17/2022</b>        |
| NAME OF PE               | ROVIDER OR SUPPLIER  | 3.5552   |                     | STI | REET ADDRESS, CITY, STATE, ZIP CODE   | 021                           | 17/2022                    |
| NAME OF T                | TOVIDEN ON SOLT LIEN   |  |                     |     |   |                               |                            |
| LIBERTY (                | COMMONS NSG AND RE   | HAB CTR OF LEE COUNTY  |                     |     | 0 COMMERCE DRIVE  |                               |                            |
|                          |  |  |                     | SA  | ANFORD, NC 27332  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | <   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  |                               | (X5)<br>COMPLETION<br>DATE |
| F 835                    | Continued From page  | e 124  | F 8                 | 335 |   |                               |                            |
|                          | AM with the interim A started at the facility of noted the call system that time. He asked that time. He asked that time. He asked that time. He stated he replacement as the corporate MS to its system replacement would be a stated her the corporate MS to its system replacement would be a stated her that the corporate MS to its system replacement would be a stated her that the control of the corporate MS to its system replacement. A telephone interview at 3:09 PM with the control of | was conducted on 2/17/22 orporate MS. He stated he he facility MS in getting the He stated the quote was but the call system selected actual date of the me. He instructed the facility e selected call system and the soonest they can em was 4/25/22 due to their OVID and the increased |                     |     | system until installation of the new nursicall system. Additionally, all residents where the rounded on by nursing staff hourly beginning 03/04/2022.  2. Vendor has been identified (Model Systems) to install new nurse call system with tentative installation date of 4/25/2022. The Department of Health Service Regulation, division of construction, must approve the design nurse call system. This date my change as a result.  3. On 3/11/2022, the Regional Direct of Operations educated the Inter-disciplinary Team (IDT) on need to initiate immediate use of hand-bells and hourly rounding at any point the nurse system is non-functional.  4. IDT will review nurse call system monthly beginning 04/01/2022 with initiate of hand bell system and hourly rounding. Audits will continue until 7/1/2022 or until automated system has | vill rn em  of e  or c d call |                            |
| F 842<br>SS=D            | Resident Records - Ic<br>CFR(s): 483.20(f)(5),<br>§483.20(f)(5) Resider<br>(i) A facility may not re-<br>resident-identifiable to<br>accordance with a co-<br>agrees not to use or co-   | dentifiable Information 483.70(i)(1)-(5)  nt-identifiable information. elease information that is the public. elease information that is   | F 8                 | 342 | been in place for 2 months.   |                               | 3/29/22                    |
|                          | §483.70(i) Medical re  | cords.   |                     |     |   |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | A. BUILDING         | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--|--|--|---------------------|--|-------------------------------|--|--|
|  |  | 345532   | B. WING             |  | C<br><b>02/17/2022</b>        |  |  |
|  | ROVIDER OR SUPPLIER  | REHAB CTR OF LEE COUNTY  | ;                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>310 COMMERCE DRIVE<br>SANFORD, NC 27332                           | , •==                         |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE COMPLETION             |  |  |
| F 842  | professional standa must maintain medi that are- (i) Complete; (ii) Accurately docur (iii) Readily accessil (iv) Systematically of \$483.70(i)(2) The far all information contained are gardless of the form records, except where (i) To the individual, representative where (ii) Required by Law (iii) For treatment, properations, as permically with 45 CFR 164.50 (iv) For public health neglect, or domestical activities, judicial and law enforcement purposes, research medical examiners, a serious threat to help and in compliance \$483.70(i)(3) The far record information and unauthorized use.  §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requirement in the serior of the contained and the period of time (iii) Five years from the there is no requirement in the serior of the contained are serior of the period of time (iii) Five years from the there is no requirement in the serior of the period of time (iii) Five years from the there is no requirement in the serior of the period of time (iii) Five years from the there is no requirement in the serior of the period of time (iii) Five years from the there is no requirement in the period of time (iii) Five years from the period of time (iiii) Five years from the period of time (iiiiii) Five years from the period of time (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii | cordance with accepted rds and practices, the facility cal records on each resident mented; ole; and rganized cility must keep confidential sined in the resident's records, and or storage method of the en release isor their resident e permitted by applicable law; resident, or health care itted by and in compliance 6; a activities, reporting of abuse, eviolence, health oversight d administrative proceedings, rposes, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted e with 45 CFR 164.512. cility must safeguard medical gainst loss, destruction, or | F 842               |  |                               |  |  |

|                          | DF DEFICIENCIES CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | PLE CONSTRUCTION  B   | (X3) DATE SURVEY COMPLETED   |
|--------------------------|--|---|---------------------|---|--|
|                          |  | 345532  | B. WING             |   | C<br>02/17/2022  |
|                          | ROVIDER OR SUPPLIER  | REHAB CTR OF LEE COUNTY   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332  | 1 02/1//2022   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | D BE COMPLETION  |
| F 842                    | Continued From page legal age under Sta  | -   | F 84                | 12  |  |
|                          | (i) Sufficient information (ii) A record of the recipion (iii) The comprehend provided; (iv) The results of an and resident review determinations condition (v) Physician's, nursiprofessional's progritus (vi) Laboratory, radiservices reports as This REQUIREMENT by:  Based on record refacility failed to have medical records in the (Residents #17 and coverings (Resident topical treatments (I of 22 residents review (in the findings included 1) Resident #17 was facility on 3/1/21 with 1/28/22. She had more included osteomyelic caused by an infect region and pressured A quarterly Minimum assessment dated 1/17 was cognitively | ducted by the State; se's, and other licensed sess notes; and ology and other diagnostic required under §483.50.  IT is not met as evidenced eviews and staff interviews, the se complete and accurate the area of wound care #26), protective skin t #40), medications and Resident #40). This was for 3 sewed.  ed: s originally admitted to the the a recent readmission on sultiple diagnoses that itis (inflammation of the bone ion) of the vertebra and sacral e ulcer of the sacral region.  In Data Set (MDS) I2/11/21 indicated Resident intact and had 1 stage 3 (a to the tissue beneath the skin |                     | The statements made on this plan correction are not an admission to a not constitute an agreement with the alleged deficiencies.  To remain in compliance with all fed and state regulations the facility has or will take the actions set forth in the plan of correction. The plan of corrections to compliance such that all alleged deficiencies cited have been or will corrected by the dates indicated.  F842  The facility failed to have complete accurate medical records in the are wound care.  1. Corrective action for resident(s affected by the alleged deficient pra On 2/22/2022 the wound nurse asset the sacral wound for resident # 17. with no observed changes to areas ordered treatment and provided and | and do e  leral s taken nis ection f  be  and a of ) cctice: essed |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` ′                |     | CONSTRUCTION   | (X3) DATE<br>COMP              | SURVEY<br>LETED            |
|--------------------------|---|--|--------------------|-----|--|--------------------------------|----------------------------|
|                          |   | 345532   | B. WING _          |     |  | 1                              | 17/ <b>2022</b>            |
| NAME OF PE               | ROVIDER OR SUPPLIER   |  |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   | 02/                            | 1772022                    |
|                          |   | HAB CTR OF LEE COUNTY  |                    | 31  | 10 COMMERCE DRIVE  |                                |                            |
|                          |   |  |                    | 3   | ANFORD, NC 27332   |                                |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  |                                | (X5)<br>COMPLETION<br>DATE |
| F 842                    | Continued From page   | e 127  | F                  | 842 |  |                                |                            |
| F 842                    | The physician orders to cleanse the sacral apply Aquacel (a drescontact with wound flucover with dressing to the review of the Febru Administration Recordance had been signed Resident #17's sacral and 2/10/22 on the expension of the review and 2/10/22 at 3:29 Plinterviewed. She was on 2/8/22, 2/9/22 and shift. Nurse #1 review and confirmed she has #17's sacral wound to completed. Nurse #1 treatment occurred as the TAR.  The Director of Nursin on 2/17/22 at 5:33 PN started employment at 2022. The DON state Resident #40's TAR to in regard to her wound | area with wound cleanser, sing that forms a gel on uid to promote healing), vice a day.  ary 2022 Treatment d (TAR) revealed no wound I off as completed to I wound, on 2/8/22, 2/9/22 vening (3:00 PM to 11:00  M, Nurse #1 was assigned to Resident #17 2/10/22 on the evening ved the February 2022 TAR and not signed off Resident eatment had been stated she was certain the as ordered but forgot to initial and indicated she had at the facility in January ed it was her expectation to be complete and accurate d care. | Fi                 | 842 | On 2/22/2022 the Director of Nursing a RN Supervisor assessed pressure ulce to the right and left ischium and right trochanter for resident #26 with no observed changes to areas of ordered treatment and provided and documented the treatments as ordered.  On 2/18/2022 the RN supervisor assessed both arms and hands for resident # 40 with no observed change and the bilateral geri sleeves were applied.  2. Corrective action for residents with the potential to be affected by the alleg deficient practice.  All residents are potentially at risk for the deficient practice.  On 3/9/2022 the Director of Nurses, Wound Nurse, Registered Nurse Supervisor (RN), initiated an audit of 100% of resident treatments for the last days for all current residents. The audiconsisted of a review of the Electronic Medical Administration Records notes to identify any treatments that were not documented as completed. On 3/9/202 the Director of Nurses notified the Medi Director and Responsible Parties of the treatments that were not administered at the steps that will be taken to prevent future occurrences. Results: 30 of 57 | ers ed s led t 7 it co 2, ical |                            |
|                          | 6/7/15 with diagnoses osteoarthritis.   | as admitted to the facility on that included dementia and  |                    |     | residents were in compliance for documentation of completed treatments and no other issues with documentation or application of geri sleeves was found   | n                              |                            |
|                          | 3/26/20 to apply geri-  | revealed an order dated sleeves (protective sleeves) very shift for skin integrity.  |                    |     | Measures /Systemic changes to prevent reoccurrence of alleged deficie practice:  | nt                             |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE IDENTIFICATION NUMBER:  A. BUILDING          |                     |             |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|---------------------|-------------|--|-------------------------------|----------------------------|
|   |   | 345532   | B. WING             |             |  | l                             | C<br><b>17/2022</b>        |
| NAME OF P   | ROVIDER OR SUPPLIER   | 0.0002   |                     | STRE        | EET ADDRESS, CITY, STATE, ZIP CODE   | 1 02/                         | 17/2022                    |
| TVAINE OF T   | TO VIDER OR GOLT EIER   |  |                     |             | COMMERCE DRIVE   |                               |                            |
| LIBERTY   | COMMONS NSG AND RE  | EHAB CTR OF LEE COUNTY   |                     |             | IFORD, NC 27332  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |                               | (X5)<br>COMPLETION<br>DATE |
| F 842   | Continued From page   | e 128  | F8                  | 342         |  |                               |                            |
|   | #40 had severe cogn coded with skin tears   | 28/22 indicated Resident itive impairment and was present.                             |                     | 1 3         | Beginning on 3/09/2022 the Director of<br>Nurses, Nurse Consultant and RN<br>Supervisor began in-service education<br>all full time, part time, as needed and  |                               |                            |
|   |   | d (TAR) revealed the<br>ned as being on Resident<br>22 and 2/16/22 day shift           |                     | i           | agency nurses The learner will understand the mportance of ensuring that treatments are administered as ordered by the Physician.  |                               |                            |
|   | Resident #40 was observed on 2/14/22 at 11:30 AM, while lying in bed with her eyes closed. Her arms were laying on top of the covers without any protective sleeves.  On 2/14/22 at 12:35 PM, Resident #40 was observed sitting up in bed eating lunch. There were no protective sleeves present to her arms/hands. |  |                     | 0           | Confirming that treatment orders a documented following completion of the ordered treatment.  Notification of the MD/RP of any missed or refused treatments.   |                               |                            |
|   |   |  |                     | t<br>r      | This information has been integrated in the standard orientation training and in required in-service refresher courses for all staff identified above and will be  | the                           |                            |
|   | AM sitting up in her b  | served on 2/15/22 at 10:42<br>ed. She was dressed in a<br>t any protective sleeving to |                     | r<br>s      | reviewed by the Quality Assurance<br>process to verify that the change has<br>been sustained. Any of the identified<br>nursing staff who does not receive<br>scheduled in-service training will not be<br>allowed to work until training has been  | e                             |                            |
|   |   | was made of Resident #40<br>PM with no protective sleeves<br>ands.                     |                     | 2           | completed by March 28, 2022.  4. Monitoring Procedure to ensure the plan of correction is effective and the plan of correction |                               |                            |
|   |   | M, Resident #40 was with her eyes closed. There eeving on her arms/hands.              |                     | s<br>a<br>r | specific deficiency cited remains correct<br>and/or in compliance with regulatory<br>requirements.<br>The Nursing Leadership Team will mon   | cted                          |                            |
|   |   | served on 2/16/22 at 10:22<br>pital gown without protective<br>hands.                  |                     | t<br>(      | reatment documentation as part of Dai<br>Clinical, Monday through Friday, to rev<br>EMAR progress notes. The audit will<br>nclude review of the EMAR progress  | ily                           |                            |
|   | Nurse #2 was intervie   | ewed on 2/16/22 at 11:02   |                     |             | notes to identify any residents who hav  | 'e                            |                            |

|                          | OF DEFICIENCIES<br>CORRECTION           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                              | ` '                                    |     | CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>PLETED           |
|--------------------------|---|---|--|-----|---|-------------------|----------------------------|
|                          |   | 345532  | B. WING                                |     |   |                   | C                          |
| NAME OF D                | DOVIDED OD CUIDDUED                     | 343332  | 1 20 _                                 |     | TREET ADDRESS CITY STATE ZID CODE   | 02/               | 17/2022                    |
| NAME OF PI               | ROVIDER OR SUPPLIER                     |   |  |     | TREET ADDRESS, CITY, STATE, ZIP CODE  |                   |                            |
| LIBERTY (                | COMMONS NSG AND RE                      | HAB CTR OF LEE COUNTY   |  |     | 10 COMMERCE DRIVE   |                   |                            |
|                          |   |   |  | S   | SANFORD, NC 27332   |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                         | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFI)<br>TAG                    | ×   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 842                    | Continued From page                     | e 129   | F 8                                    | 342 |   |                   |                            |
|                          | AM. She reviewed th                     | e February 2022 TAR where   |  |     | treatments that have not been   |                   |                            |
|                          |   | ident #40 had geri-sleeves  |  |     | documented as administered.   |                   |                            |
|                          |   | ands on 2/14/22, 2/15/22  |  |     | dodamontod do daminiotorod.   |                   |                            |
|                          |   | ted she "had assumed they   |  |     | The Director of Nurses, or designee wi  | II                |                            |
|                          |   | narked them on the TAR and  |  |     | monitor compliance utilizing the F 842  | 11                |                            |
|                          |   | were on. An observation was   |  |     | Treatment Audit Tool weekly x 2 weeks   | <u>.</u>          |                            |
|                          | made of Resident #4                     |   |  |     | then monthly x 3 months or until resolv   |                   |                            |
|                          | confirmed they were                     |   |  |     | The audit will review EMAR progress   | ou.               |                            |
|                          |   |   |  |     | notes for a random 7 day period to ide  | ntify             |                            |
|                          | The Director of Nursi                   | ng (DON) was interviewed  |  |     | any residents that have treatments tha  |                   |                            |
|                          |   | M, indicating she had been  |  |     | have not been documented as   |                   |                            |
|                          |   | ty since January 2022. The  |  |     | administered. Reports will be presente  | d to              |                            |
|                          |   |   | the weekly Quality Assurance committee |     |   |                   |                            |
|                          | •                                       | g the geri-sleeves with   |  |     | by the Administrator or Director of Nurs  |                   |                            |
|                          | nurses verifying they                   |   |  |     | to ensure corrective action is initiated a  |                   |                            |
|                          | documenting so.                         |   |  |     | appropriate. Compliance will be monito  | red               |                            |
|                          |   |   |  |     | and the ongoing auditing program  |                   |                            |
|                          |   |   |  |     | reviewed at the weekly Quality Assurar  | nce               |                            |
|                          | 2b) Resident #40 was                    | s admitted to the facility on   |  |     | Meeting. The weekly QA Meeting is   |                   |                            |
|                          | 6/7/15 with diagnoses                   | s that included dementia and  |  |     | attended by the Administrator, Director   | of                |                            |
|                          | anxiety disorder.                       |   |  |     | Nursing, MDS Coordinator, Therapy   |                   |                            |
|                          |   |   |  |     | Manager, Unit Manager, Health   |                   |                            |
|                          |   | revealed an order dated   |  |     | Information Manager, and the Dietary  |                   |                            |
|                          |   | m (a medication used to   |  |     | Manager.  |                   |                            |
|                          | • | ram (mg) one tablet by  |  |     |   |                   |                            |
|                          | mouth every morning                     | and at bedtime for anxiety.   |  |     |   |                   |                            |
|                          | The quarterly Minimu                    | m Data Set (MDS)  |  |     |   |                   |                            |
|                          |   | 28/22 indicated Resident  |  |     |   |                   |                            |
|                          |   | itive impairment and used   |  |     |   |                   |                            |
|                          | an antianxiety medica                   | •   |  |     |   |                   |                            |
|                          | an antianaloty modice                   | 2001. 7 days.   |  |     |   |                   |                            |
|                          | A review of the Febru                   | arv 2022 Medication   |  |     |   |                   |                            |
|                          | Administration Recor                    |   |  |     |   |                   |                            |
|                          |   | not signed out as given or  |  |     |   |                   |                            |
|                          |   | #40 for the bedtime dose on   |  |     |   |                   |                            |
|                          | 2/5/22, 2/6/22 or 2/9/2                 |   |  |     |   |                   |                            |
|                          | , <u> </u>                              |   |  |     |   |                   |                            |
|                          | A review of Resident                    | #40's Narcotic Count Sheet  |  |     |   |                   |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE A. BUILDING | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|---|--|---------------------------|--|-------------------------------|
|                          |   | 345532   | B. WING                   |  | C<br>02/17/2022               |
|                          | ROVIDER OR SUPPLIER   | REHAB CTR OF LEE COUNTY  | 3.                        | TREET ADDRESS, CITY, STATE, ZIP CODE<br>10 COMMERCE DRIVE<br>ANFORD, NC 27332                            | ,                             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOI<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE COMPLETION             |
| F 842                    | received the bedtim 2/5/22, 2/6/22 and 2 On 2/16/22 at 3:29 with Nurse #1, who on the evening shift 2/9/22. She reviewed and confirmed the cowas neither marked resident as well as I Narcotic Count She provided the medical sign on the MAR.  A phone interview of 2/16/22 at 4:10 PM. Resident #40 on 2/5 evening shift. After MAR with her, she is Resident #40's medical to sign it on the MA.  The Director of Nurson 2/17/22 at 5:33 Femployed at the fact DON stated it was it to be complete and | rired which revealed she had e dose of Lorazepam on 2/9/22.  PM, an interview occurred was assigned to Resident #40 (3:00 PM to 11:00 PM) on ed the February 2022 MAR dose of Ativan 1mg at bedtime as given or refused by the Resident #40's Lorazepam et. Nurse #1 stated she ation as ordered but forgot to ccurred with Nurse #5 on She was assigned to 5/22 and 2/6/22 on the reviewing the February 2022 stated she always provided lications to her and just forgot R.  sing (DON) was interviewed PM, indicating she had been illity since January 2022. The her expectation for the MAR's accurate. | F 842                     |  |                               |
|                          | antifungal shampoo<br>scalp topically every   | etoconazole Shampoo (an ) 2% to be applied to the y evening shift on Monday and yersicolor (a common fungus).  |                           |  |                               |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ´                 | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |           |           | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|---------------------|--|-----------|-----------|-------------------------------|--|
|   |  | 345532  | B. WING _           |  |           | C<br>02/1 | 7/2022                        |  |
|   | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332               |           | <u> </u>  | 112022                        |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE |           | (X5)<br>COMPLETION<br>DATE    |  |
| F 842   | shower days.  The quarterly Minimulassessment dated 1/#40 had severe cognized extensive as hygiene and bathing.  Resident #40's room indicated she had be 7/2/21 with a schedulated Tuesday and Friday of to 3:00 PM). She has room on the same has with the shower/shand Wednesday and Saturation Recorn Ketoconazole shamp to Resident #40 on Moordered (2/3/22, 2/7/2/2).  Nurse #1 was interview had signed the Resident #40 receives 2/14/22. The nurse swas done by the Nurdidn't tell her it wasn't had not verified the sas ordered.  On 2/16/22 at 8:30 A with Nurse #3. She is | m Data Set (MDS) 28/22 indicated Resident itive impairment and sistance with personal  history was reviewed and en in the same room since led shower/shampoo on during the day shift (7:00 AM d a short stay in a different illway from 1/25/22 to 2/9/22 hpoo scheduled on arday during the day shift.  lary 2022 Medication d (MAR) revealed the oo was signed as provided flonday and Thursdays as 22 and 2/14/22).  ewed on 2/15/22 at 3:54 PM, February 2022 MAR, that d Ketoconazole shampoo on stated she had assumed it se Aide (NA) because they t done. Nurse #1 added she hampoo had been provided  M, an interview occurred | F                   | 342  |           |           |                               |  |
|   | Nurse #3 stated she  | oo on 2/3/22 and 2/7/22.<br>didn't verify with the NA that<br>curred but had assumed it   |                     |  |           |           |                               |  |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ` ′               | TIPLE CONSTRUCTION  NG  |               | (X3) DATE S<br>COMPL |                            |
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|                          |   | 345532   | B. WING _           |   |               | 02/1                 | )<br>17/2022               |
| NAME OF P                | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP COD  | <u>'</u><br>E | UZ/                  | 172022                     |
|                          |   |  |                     | 310 COMMERCE DRIVE  |               |                      |                            |
| LIBERTY                  | COMMONS NSG AND RI  | EHAB CTR OF LEE COUNTY   |                     | SANFORD, NC 27332   |               |                      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE   | I                    | (X5)<br>COMPLETION<br>DATE |
| F 842                    | NA #4 was interviewed and worked at the fact and worked both the and 3:00 PM to 11:00 was familiar with Rest assigned to care for hwas unaware Reside shampooed with Keto On 2/17/22 at 9:35 A and stated she worked shifts and was often a when she worked. No #40 required Ketocor  | Inot told her otherwise.  Ind on 2/16/22 at 2:00 PM  Cility since November 2021  7:00 AM to 3:00 PM (first)  PM (second) shifts. NA #4  Cident #40 and was often  Cher when she worked. NA #4  Chert when she worked. NA #4  Chert was interviewed  Chert was interviewed  Chert was unaware Resident  | F                   | 342   |               |                      |                            |
|                          | 2/17/22 at 3:40 PM, we Resident #40 on the stated Resident was hampooed with Keto The Director of Nursi on 2/17/22 at 5:33 PM employed at the facility DON stated it was help be documented accurate. Resident #26 was Review of Resident #Data Set (MDS) date | who had been assigned to second shift of 2/14/22. She was scheduled for on the first shift, so she had er on 2/14/22. NA #12 are Resident #40 was to be occurazole.  Ing (DON) was interviewed M, indicating she had been ity since January 2022. The er expectation for the MAR to rately by the nursing staff. admitted on 3/5/21.  E26's quarterly Minimum d 1/2/22 indicated he was coded for rejection of care. ee pressure ulcers. |                     |   |               |                      |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | l ` ′               | IPLE CONSTRUCTION NG  |               | (X3) DATE SUI<br>COMPLET |                            |
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|                          |  | 345532   | B. WING _           |   |               | C<br><b>02/17</b> /      | /2022                      |
| NAME OF PI               | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   | <u>'</u><br>E | QZ/11/                   | LULL                       |
|                          |  |  |                     | 310 COMMERCE DRIVE  |               |                          |                            |
| LIBERTY                  | COMMONS NSG AND R  | EHAB CTR OF LEE COUNTY   |                     | SANFORD, NC 27332   |               |                          |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>( (EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE     | -                        | (X5)<br>COMPLETION<br>DATE |
| F 842                    | Continued From page  | e 133  | F 8                 | 342   |               |                          |                            |
|                          | February 2022 revea  | ds (TAR) for January and<br>led multiple omissions on<br>1/22, 2/5/22, 2/6/22, 2/9/22  |                     |   |               |                          |                            |
|                          |  | #26 's February 2022<br>uded treatment orders for his  |                     |   |               |                          |                            |
|                          | on 12/16/21 read he  | d. Resident #26 was also   |                     |   |               |                          |                            |
|                          | AM with Resident #2 not providing his trea   | nducted on 2/14/22 at 10:44<br>6. He stated the facility was<br>tments as ordered and that<br>atment on occasion himself.  |                     |   |               |                          |                            |
|                          | PM with the facility W<br>Resident #26 went to<br>hospital monthly for a<br>stated Resident #26<br>wound care and reco<br>she would not initial t<br>Resident #26 was go<br>care so she could try<br>wound care. She sta | ducted on 2/14/22 at 2:00 /ound Nurse. She stated the wound clinic at the a wound evaluation. She was noncompliant with his emmendations. She stated the TAR until she knew if sing to refuse his wound to convince him to allow his sted she sometimes forgot to or indicted on the TAR his |                     |   |               |                          |                            |
|                          | AM with Nurse #4. So<br>weekends occasiona<br>treatments. Nurse #4<br>noncompliant with his  | nducted on 2/17/22 at 9:30 he stated worked on lly and would assist with stated Resident #26 was s wound treatments. She s forgot to document his  |                     |   |               |                          |                            |

|                          | OF DEFICIENCIES CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION  G  | (X3) DATE SURVEY COMPLETED |
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|                          |   | 345532  | B. WING_            |  | C<br><b>02/17/2022</b>     |
|                          | ROVIDER OR SUPPLIER   | REHAB CTR OF LEE COUNTY   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332                                   | 02/1//2022                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE COMPLETION            |
| F 842                    | PM with the DON. Semployment at the factor DON stated it was hear a TAR to be completed his wound care. The Resident #26's refudocumented in his management of the Resident Formust test residents a resident set of the Resident | Inducted on 2/17/22 at 6:00 She indicated she had started acility in January 2022. The er expectation Resident #26 ' e and accurate in regard to DON also expected isals of wound care to be nedical record. Residents & Staff I)-(6)  19 Testing. The LTC facility and facility staff, including services under arrangement COVID-19. At a minimum, facility staff, including services under arrangement LTC facility must:  duct testing based on by the Secretary, including | F 84                | 42   | 3/29/22                    |
|                          | this paragraph diagr<br>COVID-19 in the fac<br>(iii) The identification<br>this paragraph with s<br>consistent with COV<br>suspected exposure<br>(iv) The criteria for c<br>asymptomatic individe<br>paragraph, such as<br>COVID-19 in a coun   | nosed with ility; n of any individual specified in symptoms IID-19 or with known or to COVID-19; onducting testing of duals specified in this the positivity rate of  |                     |  |                            |

|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                 |     | CONSTRUCTION  | (X3) DATE<br>COMF | SURVEY                     |
|--------------------------|---|--|---------------------|-----|---|-------------------|----------------------------|
|                          |   | 345532   | B. WING_            |     |   |                   | C<br>/ <b>17/2022</b>      |
| NAME OF P                | ROVIDER OR SUPPLIER   | V 1000=  | <del>-</del>        | ST  | REET ADDRESS, CITY, STATE, ZIP CODE   | 1 02/             | 17/2022                    |
|                          |   |  |                     | 310 | O COMMERCE DRIVE  |                   |                            |
| LIBERTY                  | COMMONS NSG AND RE  | EHAB CTR OF LEE COUNTY   |                     | SA  | ANFORD, NC 27332  |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                    | ID<br>PREFI)<br>TAG | (   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 886                    | Continued From page   | e 135  | F 8                 | 886 |   |                   |                            |
|                          | (vi) Other factors spe<br>help identify and prev<br>transmission of COVI  |  |                     |     |   |                   |                            |
|                          | . , , , ,   | uct testing in a manner that<br>rent standards of practice for<br>9 tests;                               |                     |     |   |                   |                            |
|                          | (i) Document that test<br>results of each staff to<br>(ii) Document in the rowas offered, complete  | esident records that testing   |                     |     |   |                   |                            |
|                          | individual specified in symptoms  | D-19, or who tests positive ctions to prevent the  |                     |     |   |                   |                            |
|                          | residents and staff, in   | procedures for addressing acluding individuals providing gement and volunteers, who unable to be tested. |                     |     |   |                   |                            |
|                          | emergencies due to to<br>contact state<br>and local health depa<br>efforts, such as obtain<br>processing test result<br>This REQUIREMENT<br>by: | is not met as evidenced  |                     |     |   |                   |                            |
|                          | Consultant and staff i  | iew, observation and Nurse<br>nterview, the facility failed to<br>er and facility's policy by not        |                     |     | The statements made on this plan of correction are not an admission to and not constitute an agreement with the       | do                |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |                           | (X3) DATE SURVEY<br>COMPLETED |  |
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|   |   |   |                     |   |  |                           | С                             |  |
|   |   | 345532  | B. WING _           |   |  | 02/                       | 17/2022                       |  |
| NAME OF P   | ROVIDER OR SUPPLIER   | •   |                     | S                                       | TREET ADDRESS, CITY, STATE, ZIP CODE   |                           |                               |  |
|   |   |   |                     | 3                                       | 10 COMMERCE DRIVE  |                           |                               |  |
| LIBERTY   | COMMONS NSG AND RI  | EHAB CTR OF LEE COUNTY  |                     | s                                       | ANFORD, NC 27332   |                           |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | x                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | SHOULD BE COMPLETI        |                               |  |
| F 886   | Continued From page   | e 136   | F 8                 | 386                                     |  |                           |                               |  |
|   | placing a resident whetesting on enhanced outbreak for 1 of 1 sat (Resident #14). The coronavirus pandemine Findings included:  The facility's policy of 2/2022 was reviewed "If a resident is asymmetesting at the time of on placing the reside Precautions for COV should be based on vevidence suggesting (i.e., confirmed infection (HCP) or nursing hor resident)". | o had refused COVID-19 precaution during an impled resident reviewed failure occurred during a c.  n COVID-19 testing dated The policy indicated in part ptomatic and declines facility wide testing, decision nt on Transmission Based ID-19 or providing usual care whether the facility has SARS-CoV-2 transmission on in healthcare personnel ne onset infection in a  mitted to the facility on iagnoses including |                     |   | alleged deficiencies.  To remain in compliance with all federal and state regulations the facility has tall 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.  F886 The facility failed to follow a physician order and facility policy by no placing a resident who had refused Co 19 testing on enhanced precautions during an outbreak.  1. Corrective action for resident(s) affected by the alleged deficient practic On 2/15/2022 the Infection Control Preventionist placed an isolation sign for Enhanced Droplet Precautions on Resident #14 door and an isolation with the appropriate Personal Protective Equipment outside of the room. | ken on ot vid ce: or cart |                               |  |
|   | 2/4/22 was reviewed. "I am on Enhanced D COVID testing". The symptoms of highly o infection". The approdroplet precaution: st protection (goggles), prior to entry, hand h upon entering the roo protective equipment as much disposable of   | plan with the revision date of The care plan problem was proplet Precaution: I refused goal was "I will be free of ontagious respiratory paches included Enhanced raff should don eye mask, gown and gloves ygiene should be performed  |                     |   | 2. Corrective action for residents with the potential to be affected by the alleg deficient practice.  Any resident who refuses testing during Covid 19 outbreak or any resident who has orders for Enhanced Droplet Precautions could be affected.  On 2/15/2022 the Director of Nurses/Infection Control Preventionist audited all resident rooms with orders of Enhanced Droplet Precautions to assu isolation signage was in place with no other identified residents without appropriate isolation signs in place. All residents who had refused testing had  | g a<br>for<br>re          |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | · /                 | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |   | (X3) DATE SURVEY<br>COMPLETED |  |
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|   |  | 345532   | B. WING             |   | 0.5   | C<br>2/17/2022                |  |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   | 02  | ./1//2022                     |  |
|   |  |  |                     | 310 COMMERCE DRIVE  |   |                               |  |
| LIBERTY   | COMMONS NSG AND R  | EHAB CTR OF LEE COUNTY   |                     | SANFORD, NC 27332   |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY)   | HOULD BE  | (X5)<br>COMPLETION<br>DATE    |  |
| F 886   | Continued From pag   | e 137  | F 88                |   | : <b></b>   |                               |  |
|   |  | doctor's order dated 2/4/22<br>ition due to refusal for COVID  |                     | Enhanced Droplet Precaution s door and an isolation cart with t appropriate PPE outside of the On 2/15/2022 the Nurse Consu educated the Director of Nurses   | he<br>room.<br>Itant  |                               |  |
|   | #14 was observed in in a private room. TI  | AM and 4:02 PM, Resident In his room. He was residing there was no isolation sign or isolation cart outside his  |                     | Infection Control Preventionist of policy related to Covid 19 progresting, resident refusal of testing Covid 19 outbreak and placing on enhanced droplet precaution physician order and supplying a   | on facility<br>am and<br>ng during a<br>residents<br>ns per                 |                               |  |
|   | was interviewed on 2   | assigned to Resident #14,<br>2/15/22 at 9:05 AM. She<br>#14 was not on any isolation.  |                     | cart with appropriate PPE outsic<br>resident⊡s door.  3. Measures /Systemic chang<br>prevent reoccurrence of alleged  | de of the<br>jes to   |                               |  |
|   | interviewed on 2/15/2<br>reported that Reside<br>When asked to chec<br>reported and verified<br>doctor's order dated<br>precaution due to ref<br>ICP was observed to   | fusal for COVID testing. The put enhanced precaution door and isolation cart   |                     | practice: On 03/09/2022 Director of Nurs Consultant and the Nurse Mana education to all full time, part tir and agency Nurses and CNA following:  " Covid 19 Testing Policy " Refusal of testing by a resi an outbreak isolation practices This information has been integ the standard orientation training  | es, Nurse ager began ne, PRN s on the dent during                           |                               |  |
|   | on 2/15/22 at 9:30 A started as ICP in Oct that Resident #14 hat testing since end of not aware that there quarantine. She add the facility's policy to he/she was refusing  The Nurse Consultar 2/16/22 at 12:05 PM | was conducted with the ICP M. She explained that she tober 2021. She was aware ad been refusing COVID January 2021, but she was was an order to place him on ded that she was not aware of quarantine the resident if testing during the outbreak.  In the was interviewed on The Nurse Consultant spolicy dated 2/2022 on |                     | required in-service refresher co<br>all staff identified above and wil<br>reviewed by the Quality Assurar<br>process to verify that the chang<br>been sustained. The facility spe<br>in-service will be provided to all<br>Nurses and CNA swho give re<br>care in the facility. Any nursing<br>does not receive scheduled in-straining will not be allowed to we<br>training has been completed by<br>2022. | urses for I be nce e has ecific agency esidents staff who service ork until |                               |  |

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|   |  | 345532   | B. WING _           |     |  | l                             | C<br><b>17/2022</b>        |
| NAME OF PR  | ROVIDER OR SUPPLIER  |  |                     | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   | 1 02/                         | 17/2022                    |
|   |  |  |                     |     | 10 COMMERCE DRIVE  |                               |                            |
| LIBERTY (   | COMMONS NSG AND RE   | EHAB CTR OF LEE COUNTY   |                     |     | ANFORD, NC 27332   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | <   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   |                               | (X5)<br>COMPLETION<br>DATE |
| F 886   | Continued From page  | e 138  | F8                  | 386 |  |                               |                            |
|   | was refusing COVID the resident was place until the end of the out the facility had been of the facility had been of the Minimum Data S interviewed on 2/17/2 that she had transcrib the care plan for enhalm for Resident #14. She (unable to remember enhanced precaution)  The Director of Nursii on 2/17/2 at 3:34 PM started as DON of the She stated that she eand the doctor's orde placing the resident of spread of infection. To for communication and | 22 at 2:50 PM. She verified bed the order and initiated anced precaution on 2/4/22 e had notified the nurse name) of the new order for  In (DON) was interviewed She reported that she just e facility in January 2022. Expected the facility's policy r to be followed regarding on quarantine to prevent the The DON indicated that lack d big turn-over of staff lure of not following doctor's |                     |     | 4. Monitoring Procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements:  The Director of Nurses or Infection Control Preventionist will monitor compliance utilizing the F886 Quality Assurance Tool weekly for 2 weeks the monthly x 3 months or until resolved. T Director of Nursing or Infection Control Preventionist will monitor compliance wit facility policy for Covid 19 testing for the residents who refuse testing during a Covid 19 outbreak. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance with be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed no necessary for compliance with ADL Ca The weekly QA Meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary | en the vith ose of the the S  |                            |
| F 919<br>SS=F                                       | Resident Call System<br>CFR(s): 483.90(g)(2)   |  | F9                  | 919 | Manager.   |                               | 3/29/22                    |
|   | residents to call for st communication syste   | Call System dequately equipped to allow raff assistance through a m which relays the call nber or to a centralized staff   |                     |     |  |                               |                            |

|                          | DF DEFICIENCIES<br>CORRECTION  |   |         |   |   |                                     |              |
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|                          |  | 345532  | B. WING |   |   | l                                   | C<br>47/2022 |
| NAME OF P                | ROVIDER OR SUPPLIER  | 0.0002  | 1       | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  | 02/                                 | 17/2022      |
| NAME OF T                | TOVIDER OR SOLT LIER   |   |         |   |   |                                     |              |
| LIBERTY                  | COMMONS NSG AND RE   | EHAB CTR OF LEE COUNTY  |         |   | 10 COMMERCE DRIVE<br>SANFORD, NC 27332  |                                     |              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOL |         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |   | (X5)<br>COMPLETION<br>DATE          |              |
| F 919                    | Continued From page  | e 139   | F 9     | 919   |   |                                     |              |
|                          |  | and bathing facilities.<br>is not met as evidenced                            |         |   |   |                                     |              |
|                          | interviews and record have a fully functioning feature to assist with resident call lights on practice has been one findings included:  During initial tour on 2 noted that the call light resident door but ther at the one centralized the resident rooms.  The facility Maintenar provided an email dath he sent to the corporal lightning struck and k facility. The generator was restored but pho expect for line 2 that a until the phone provided. | re was no audio sound heard<br>I nursing station or outside                   |         |   | The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies.  To remain in compliance with all federa and state regulations the facility has tall 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.  1. To correct the defective call-system the facility placed hand bells in each resident's room on 02/17/2022. Hand bells will serve as auditory part of call system until installation of the new nursicall system. Additionally, all residents we be rounded on by nursing staff hourly beginning 03/04/2022.  2. Vendor has been identified (Model Systems) to install new nurse call systems). | il<br>ken<br>on<br>m,<br>se<br>vill |              |
|                          | know if there was any There was no mention functioning properly in The facility Maintenar provided an email datasent by the corporate contact that read a casturday 8/28/21 to a was determined that the unserviceable due to lack of parts. A copy of   | rthing else, he could do.<br>n of the call lights not<br>n this email.        |         |   | with tentative installation date of 4/25/2022. The Department of Health Service Regulation, division of construction, must approve the design nurse call system. This date my change as a result. 3. On 3/11/2022, the Regional Direct of Operations educated the Inter-disciplinary Team (IDT) on need to initiate immediate use of hand-bells an hourly rounding at any point the nurse system is non-functional. 4. IDT will review nurse call system  | of<br>e<br>or<br>o<br>d             |              |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 |     | CONSTRUCTION  |       | SURVEY<br>PLETED           |
|--------------------------|---|--|---------------------|-----|---|-------|----------------------------|
|                          |   | 345532   | B. WING _           |     |   | 1     | C<br>/ <b>17/2022</b>      |
| NAME OF P                | ROVIDER OR SUPPLIER   |  | 1                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  | 1 02/ | TITLOLL                    |
| LIBERTY                  | COMMONS NSG AND   | REHAB CTR OF LEE COUNTY  |                     | 3′  | 10 COMMERCE DRIVE   |       |                            |
| LIBERT                   | - Commond Noc And   | REMADE OF LEE GOOM?  |                     | S   | ANFORD, NC 27332  |       |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  | 3E    | (X5)<br>COMPLETION<br>DATE |
| F 919                    | worksheet dated 10 different call syster indicated the call sy upgraded and a state a quote.  The facility MS pro 12/2/21 from the faservice provider ab promised after the facility MS provided                                    | ovider.  vided a copy of a service 0/26/21 completed by a m provider. The worksheet ystem would need to replaced, aff person would follow up with  vided a copy of an email dated acility MS asking the second bout the status of the quote 10/26/21 service call. The d a copy of the second call   | FS                  | 919 | monthly beginning 04/01/2022 with init use of hand bell system and hourly rounding. Audits will continue until 7/1/2022 or until automated system habeen in place for 2 months. |       |                            |
|                          | system provider's of The Administrator provider and the earliest the would be 4/25/22.  An observation was 10:44 AM room nuresiding in the room activated in the room there was no audib the resident door willight from activating | provided a copy of an email at the selected call system addressed to the corporate MS be system could be replaced as conducted on 2/14/22 at a system was an The call light system was an and in the bathroom but all sole sound. Outside and above was observed a white flashing at the call light in his room and from activating his bathroom |                     |     |   |       |                            |
|                          | AM with Nurse #2. out the call system yet. She stated the with all three halls stated was not diffi   | onducted on 2/14/22 at 10:57 She stated lightening knocked and it had not been repaired are was only one nurses station were visible from it. Nurse #2 cult to see who's call light was stance. Nurse #2 stated at the   |                     |     |   |       |                            |

| <b>345532</b> B. WING  | C<br><b>02/17/2022</b>     |
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| NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY  STREET ADDRESS, CITY, STATE, ZIP CODE  310 COMMERCE DRIVE  SANFORD, NC 27332  |                            |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE |
| F 919 Continued From page 141 time that the audio feature of the call system went down in August 2021, the aides have been making hall rounds every 10 minutes and to her knowledge, that appeared to be working.  During an observation on 2/16/22 at 11:00 AM, Resident #26°s call light was observed on. There was no audible sound. At 12:18 PM, Nursing Assistant (NA) #5 was observed answering his call light.  An interview was conducted on 2/16/22 at 12:20 PM with NA #5. She stated she was aware that some residents were upset over long waits for responses to call lights. She stated she tried to round on her halls every 10 minutes or so but during meals and morning ADLs, she was unable to ensure call lights were always answered timely. She stated there was only one nurses station and all the halls could been seen from the nurses station and all the halls could been seen from the nurses station. NA #5 stated the call light system lost the audio feature sometime last summer and that management was aware.  An observation was conducted on 2/14/22 at 11:06 AM of room number 308. Resident #29 was residing in this room. After pushing his call light, NA #4 responded within 5 minutes. There was a visible white light above his door but there was no audible sound. His bathroom call light was activated with a red flashing light observed outside his door but there was no audible sound heard.  An interview was conducted on 2/14/22 at 1:00 PM with NA #4. She stated she was an agency aide and had been working at the facility since |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDI |     | CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>PLETED           |
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|                          |   | 345532  | B. WING                |     |   | 1                 | C<br><b>17/2022</b>        |
|                          | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY  | 1                      | 310 | REET ADDRESS, CITY, STATE, ZIP CODE  COMMERCE DRIVE  ANFORD, NC 27332   | 1 02              | 11/2022                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG     | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI.<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 919                    | to observe the light a stated she had been assigned hall every management was awknowledge.  An observation was 11:06 AM of room not residing in this room in his room and bath the resident door was activating the call light flashing light from activating the call light.  An interview was con PM with NA #4. She aide and had been won November 2021. She has never made and need to be at the nut to observe the light a stated she had been | rses station or on the 300 hall above a resident's door. She told to round on her 10 minutes. She stated ware of the problem to her conducted on 2/14/22 at 1 mber 201. Resident #31 was 1. His call light was engaged room. Outside and above is a white flashing light from 1 minute in his room and a red 1 tivating his bathroom call 1 minute on 2/14/22 at 1:00 stated she was an agency 1 working at the facility since 1 e stated the call light system 1 audible sound and staff would 1 ses station or on the 200 hall 1 above a resident's door. She | F                      | 919 | DEFICIENCY)   |                   |                            |
|                          | An observation cond of room 305. Reside room. He engaged habove the resident d The was no audible call light at 9:10 AM.  An interview was con AM with NA #1. She supposed to walk up   | ucted on 2/16/22 at 8:30 AM Int #4 was residing in this is call light Outside and oor was a white flashing light. sound. NA #1 answered his Inducted on 2/16/22 at 9:12 Install the stated the aides were and down their assigned hall at sometimes there was a   |                        |     |   |                   |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDII |       | NSTRUCTION   |             | PLETED                     |
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|                          |  | 345532   | B. WING _               |       |  |             | C<br>1 <b>17/2022</b>      |
|                          | ROVIDER OR SUPPLIER  | EHAB CTR OF LEE COUNTY   |                         | 310 C | COMMERCE DRIVE FORD, NC 27332  | <u>  UZ</u> | 11/2022                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | (     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |             | (X5)<br>COMPLETION<br>DATE |
| F 919                    | Continued From pag   | e 143  | F                       | 919   |  |             |                            |
|                          | delay during meals, r<br>change.   | morning ADLs and shift   |                         |       |  |             |                            |
|                          | AM with the facility S she had been at the and most of the department and most of the department and most of the department had be only a few nurses an employed August 20: stated she was work struck knocking the call system and the pinstructed the staff to minutes. She stated the previous Administ staff to make hall rour recalled the rationale a bell was because a able to use a bell. | en recently replaced and d aides would have been 21. The Support Nurse ng at the time the lightning but the audio portion of the previous Administrator round the halls every 10 bells were not given out, but trator directed the nursing nds every 10 minutes. She for not giving each resident alot of the residents were not |                         |       |  |             |                            |
|                          | bell in each resident'   | 16/22 3:25 PM, the  N) Supervisor was putting a room and instructed the ell if staff did not respond   |                         |       |  |             |                            |
|                          | PM with the RN Supe<br>worked at the facility<br>returned about a mon<br>uncertain when the c  | iducted on 2/16/22 at 4:41<br>ervisor. She stated she had<br>in the past but had recently<br>inth ago. She stated she was<br>all system stopped the audio<br>nistrator instructed her to<br>h resident.  |                         |       |  |             |                            |
|                          | AM with Nurse #4. S<br>of the call system ha   | nducted on 2/17/22 at 9:30 he stated the sound portion d been out for a while, but still functioning properly.   |                         |       |  |             |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | , ,                    | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|---|---|------------------------|-------------------------------|--|
| 345532  |   | B. WING _  |   |   | C<br><b>02/17/2022</b> |                               |  |
| NAME OF PROVIDER OR SUPPLIER                        |   |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE   |                        | ZITITZUZZ                     |  |
|   |   |  |   | 310 COMMERCE DRIVE  |                        |                               |  |
| LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY     |   |  |   |   |                        |                               |  |
|   |   |  |   | SANFORD, NC 27332   |                        |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE                | (X5)<br>COMPLETION<br>DATE    |  |
| F 919   | Continued From page   | e 144  | F 9                                     | 19  |                        |                               |  |
| F 919   | Continued From page 144  She stated none of her residents had complained about their call light's not making any sound. She stated she could see all three halls from the nurses station and the aides were making rounds every 10 minutes. Nurse #4 stated bells were given out yesterday as an extra measure.  An interview was conducted on 2/17/22 at 10:09  AM with the facility MS. He stated he recalled the Support Nurse calling him sometime in mid-August stating lightning struck the phone lines, but the generator had started. He stated he went to the facility right after the call to assess the problem and everything came back on except for the audio portion of the call system. He stated he contacted his corporate MS that same evening via email. The facility MS stated he understood there was a device that looked like a telephone that would give an audible alert at the nurses station. He stated the staff were instructed to round on each of the three halls every 10 minutes. He was instructed by the corporate MS |  | F 9                                     | 19  |                        |                               |  |
|   | to obtain the call syst system and give the form the first quote was properly sent it to the corporation instructed to obtain an call system provider. Contacted another properly availability of 10/26/2 on, he thought the coreviewing the quotes. 12/2/21 with the interine realized he had not from the 10/26/21 procalled and emailed the received their quote of the system.  | em provider to assess the facility a quote on 8/28/21. Tovided on 9/7/21 and he e MS. He stated he was nother quote with a different. The facility MS stated he ovider with the soonest 1. He stated from that point reporate office was still. He stated it wasn't till im Administrator arrived that of received the second quote ovider visit. He stated he e provider on 12/2/21 and on 12/2/21 and he forwarded orate supervisor. He stated |   |   |                        |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |           | (X3) DATE SURVEY COMPLETED |  |  |
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|   |   | 345532  | B. WING_                                |   |           | C<br><b>02/17/2022</b>     |  |  |
|   | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY  |   | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332                  | E         | 02/11/2022                 |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                                       | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |  |  |
| F 919   | call system provider date for the replacen never received the countered the replacement date. An observation was station on 2/17/22 at MS. A tan colored delike a regular telephonurses station with a device had 10 digits telephone. A call light room. The call light was tation.  An interview was con AM with the interiment of the facility only had on three halls were visit resident's call lights prolonged delays. He staff working at the facensus. The interiment of difficult for the staminutes or see a call He stated he asked out the bells to the rering the bell if not prolight. He stated he aspass out bells on 2/1 call system would not the Administrator state could use a bell and continue to complete halls.  A telephone interview. | call system and the selected<br>were to contact him with a<br>nent. He stated he must have<br>all and forgot to inquire about | F 9                                     | 19  |           |                            |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIP         | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
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|  |  | 345532   | B. WING             |   | C<br><b>02/17/2022</b>        |
|  | ROVIDER OR SUPPLIER  | REHAB CTR OF LEE COUNTY  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332                  | OZHINZOZZ                     |
| (X4) ID<br>PREFIX<br>TAG                         | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF | D BE COMPLETION               |
| F 919  | replacement. He sta  | the facility MS to get needed<br>ated the first delays were due  | F 91                | 9   |                               |
| F 947<br>SS=B                                    | come and give a que corporate MS stated replacement of the quote was approved system selected corporate MS replacement. The replacement is or each out to the property of the replacement of the pass out the bells and happened but apparts of the pass out the bells and happened but apparts of the pass out the bells and happened but apparts of the pass out the bells and happened but apparts of the pass out the bells and happened but apparts of the pass out the bells and happened but apparts of the pass out the bells and happened but apparts of the pass out the bells and happened but apparts of the pass out the bells and happened but apparts out the bells and happened but apparts of the pass out the bells and happened but apparts out the pass out the bells and happened but apparts out the pass out the bells and happened but apparts out the pass out the bells and happened but apparts out the pass out the bells and happened but apparts out the pass out the bells and happened but apparts out the pass out the bells and happened but apparts out the pass out the bells and happened but apparts out the pass out the bells and happened but apparts out the pass out the bells and happened but apparts out the pass out the pass out the bells and happened but apparts out the pass out the pass out the bells and happened but apparts out the pass out the pass out the bells and happened but apparts out the pass o | e Training for Nurse Aides 1)-(4)  d in-service training for nurse nust-  ufficient to ensure the nuce of nurse aides, but must hours per year.  de dementia management at abuse prevention training.  ess areas of weakness as a aides' performance reviews nent at § 483.70(e) and may needs of residents as | F 94                | .7  | 3/18/22                       |

|                              |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |  | -   | (X3) DATE<br>COMP      | SURVEY<br>LETED            |
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|                              |   | 345532  |  |  | _   | C<br><b>02/17/2022</b> |                            |
| NAME OF PROVIDER OR SUPPLIER |   |   | •  | STREET ADDRESS, CITY, S  | TATE, ZIP CODE  | , , ,                  |                            |
|                              |   |   |  | 310 COMMERCE DRIVE   |   |                        |                            |
| LIBERTY                      | COMMONS NSG AND RI  | EHAB CTR OF LEE COUNTY  |  | SANFORD, NC 27332  |   |                        |                            |
| (X4) ID<br>PREFIX<br>TAG     |   |   | ID<br>PREFIX<br>TAG                              | PREFIX (EACH CORRECTIVE ACTION SHOULD BE   |   |                        | (X5)<br>COMPLETION<br>DATE |
| F 947 Continued From page    |   | e 147   | F9   | 47   |   |                        |                            |
|                              | §483.95(g)(4) For nute to individuals with contact address the care of the This REQUIREMENT   | rse aides providing services<br>gnitive impairments, also<br>ne cognitively impaired.   |  |  |   |                        |                            |
|                              | address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:  Based on record review and staff interviews, the facility failed to provide Nursing Assistants (NAs) with annual dementia training for 4 of 5 sampled Nurse Aides reviewed for required in-service training (NAs #6, #7, #8 and #9).  The findings included:  NA #6's date of hire was 4/13/17. Review of in-service records revealed she was not provided annual dementia training.  NA #7's date of hire was 7/1/10. Review of in-service records revealed she was not provided annual dementia training.  NA #8's date of hire was 6/16/09. Review of in-service records revealed she was not provided annual dementia training.  NA #9's date of hire was 6/17/13. Review of in-service records revealed she was not provided annual dementia training. |   |  | correction are not not constitute an a alleged deficiencie. To remain in compand state regulation or will take the act plan of correction. constitutes the fact compliance such the deficiencies cited by the deficiency. The plan of corrected by the deficiency. The plan of corrected: The facility failed the assistant annual deficiency act affected by the allegations. | oliance with all federations the facility has tallions set forth in this. The plan of correction cility's allegation of that all alleged thave been or will be attended at the specific an should address the did to the deficiency of provide nursing lementia training. | al<br>ken<br>on        |                            |
|                              | (DON) stated she rev<br>for NA's #6, #7, #8 ar<br>documentation that the<br>training last year.  During an interview w<br>2/17/22 at 1:54 PM, s<br>been the former Staff  | M, the Director of Nursing riewed the in-service records and #9 and could not find ney were provided dementia with the MDS Coordinator on the indicated that she had a Development Coordinator r to September 2021. She |  | Cognitively Impair Care Academy on 03/18/2022.  2. Corrective act the potential to be deficient practice. Beginning on 02/2 Nurses began aud   | tion for residents with<br>affected by the alleg<br>5/2022 the Director o   | n<br>ed<br>of          |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                | ED.   ` '  |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |  |                            |
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|  |   | 345532 B. WING 02   |  |   | 1   | C<br>/ <b>17/2022</b>                              |                            |
|  | ROVIDER OR SUPPLIER   | EHAB CTR OF LEE COUNTY  | STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332 |   |   | 1 02/  | 11/2022                    |
| (X4) ID<br>PREFIX<br>TAG                         | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFI<br>TAG   | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |
| F 947  | (Healthcare Academy with which staff did o training.  The DON was intervi and indicated she stafacility in January 202 there was no oversigher employment at the required NA training completed. She added. | nentia training was<br>n electronic learning system<br>/) but she did not keep up | F  | col sta an agg col col the Im Ac an pro 3/2 be on for ass 3. pre pra On fire Ac pa ass ed nu De tim be cel pro 3/2 Th | ementia training. This audit was impleted as of 02/25/2022. 1 certified aff nursing assistant had completed inual Dementia Education and no ency nursing assistants were in impliance. Any CNA identified without impleted Dementia training will completed Dementia training will complete course "Care of the Cognitively paired Resident" in Health Care rademy online training by 03/28/2022 and any agency nursing assistants will povided Dementia education by 28/2022. The Director of Nurses will gin monitoring as of 2/25/2022 for going compliance on a quarterly base both staff and agency certified nursic sistants.  Measures /Systemic changes to event reoccurrence of alleged deficiency actice: In 02/25/2022, the Director of Nurses and Dementia Training (in Health Care addemy online training) via Health Care addemy on line training to all full time art time and as needed nursing sistants that did not have the annual funcation documented. All identified arising assistants will complete the ementia training by 03/28/2022 at when all identified nursing assistants must in-serviced prior to working. All agentified nursing assistants will be ovided Dementia education by 28/2022 prior to working.  In information has been integrated in estandard orientation training and in a quired in-service refresher courses for the part of the standard orientation training and in a quired in-service refresher courses for the part of the part of the standard orientation training and in a quired in-service refresher courses for the part of | at plete  2 be sis ing ent e are c, l nich ust ncy |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ' '   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING         |  |                                    | (X3) DATE SURVEY<br>COMPLETED   |  |                            |  |
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|  |  | 7 50.25 |   |  | С                                  |   |  |                            |  |
| <b>345532</b> B. WING                            |  |         | 02/17/2022                                      |  |                                    |   |  |                            |  |
| NAME OF PROVIDER OR SUPPLIER                     |  |         | STF   | REET ADDRESS, CITY, STATE, ZIP CODE  |                                    |   |  |                            |  |
| LIBERTY COMMONS NSG AND R                        | EHAB CTR OF LEE COUNTY   |         |   | COMMERCE DRIVE   |                                    |   |  |                            |  |
|  |  |         | SA  | NFORD, NC 27332  |                                    |   |  |                            |  |
| PREFIX (EACH DEFICIENC                           | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |         | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI |  |                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |  |
| F 947 Continued From page                        | e 149  | FS      |   | all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the identified nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by March 28, 2022.  4. Monitoring Procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements.  The Director of Nurses/Support Nurse monitor compliance utilizing the Demer Training Quality Assurance Tool weekly 2 weeks then monthly x 3 months. The Director of Nursing will monitor all nurse assistants for compliance with the completion of annual Dementia training 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 weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting. The weekly Quality Assurance of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. | at nat tted will ntia / x ing J. / |   |  |                            |  |