PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-0391

		` IDENTIFICATION NUMBED:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345532	B. WING _		C	_	
NAME OF D	ROVIDER OR SUPPLIER	343332		STREET ADDRESS, CITY, STATE, ZIP CODE	02/09/2023	3	
NAME OF T	NOVIDER OR SOLT EIER			310 COMMERCE DRIVE	•		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLE	ETION	
E 000	Initial Comments		E 0	00			
E 039	complaint investigation through 1/26/23. The	See #KJ6011	ΕO	39	3/17/23	3	
SS=F	CFR(s): 483.73(d)(2)						
	§460.84(d)(2), §482. §483.475(d)(2), §484 §485.542(d)(2), §485	113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), .102(d)(2), §485.68(d)(2), .625(d)(2), §485.727(d)(2), .12(d)(2), §494.62(d)(2).					
	at §485.542, OPO, "0	§485.920, RHCs/FQHCs at					
		ity] must conduct exercises plan annually. The [facility] pwing:					
	community-based every (A) When a community accessible, conduct a exercise every 2 year (B) If the [facility] natural or man-made activation of the emerical exempt from engaging community-based or functional exercise for actual event.	ity-based exercise is not a facility-based functional rs; or experiences an actual emergency that requires rgency plan, the [facility] is					
ABORATORY	, ,	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE		

02/27/2023

**Electronically Signed** 

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.

NAME OF PROVIDER OR SUPPLIER   LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE   310 COMMERCE DRIVE   310 COMME			345532	B. WING			1	
ECACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   TAG   CROSS-REFERENCE TO THE APPROPRIATE   CROSS-REFERENCE TO THE APPROP			EHAB CTR OF LEE COUNTY		31	0 COMMERCE DRIVE	, , , , ,	
years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:  (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or  (B) A mock disaster drill; or  (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.  (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.  *[For Hospices at 418.113(d):]  (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:  (i) Participate in a full-scale exercise that is community based every 2 years; or  (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	х	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.  (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional	E 039	years, opposite the y functional exercise up this section is conduct not limited to the follow (A) A second full-scal community-based or functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator and include a narrated, clinically-scenario, and a set of directed messages, of designed to challeng (iii) Analyze the [facility and the maintain documentate exercises, and emergifacility's] emergency  *[For Hospices at 418 (2) Testing for hospic patient's home. The exercises to test the annually. The hospic (i) Participate in a full community based even (A) When a community community based even (B) If the hospice expension of the emergency plan, engaging in its next recommunity-based exfacility-based function onset of the emerger (ii) Conduct an additional exercise (iii) Conduct an additional exercise (iiii) Conduct an additional exercise (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	ear the full-scale or	E	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILD			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING			1	09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	•	31	TREET ADDRESS, CITY, STATE, ZIP CODE  10 COMMERCE DRIVE  ANFORD, NC 27332	1 0-1	00:2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
E 039	is conducted, that may to the following:  (A) A second full-sca community-based or exercise; or  (B) A mock disaster of the following:  (C) A tabletop exercing a facilitator and include a narrated, clinically-scenario, and a set of directed messages, of the designed to challenge of the following designed to challenge of the following designed to challenge of the following for hospic care directly. The hospic exercises to test the following designed to challenge of the following designed function (B) If the hospice expension of the emergency plan, engaging in its next repassed or facility-based following the onset of (ii) Conduct an additional may include, but is not (A) A second full-sca community-based or exercise; or (B) A mock disaster of (C) A tabletop exercificacilitator that included the community of the following that included the following that included the following that included the following design of the following that it is not the following the one of the following that it is not the following the following that it is not the foll	raph (d)(2)(i) of this section by include, but is not limited alle exercise that is a facility based functional drill; or see or workshop that is led by des a group discussion using relevant emergency for problem statements, or prepared questions an emergency plan.  The set that provide inpatient spice must conduct emergency plan twice per sust do the following: Innual full-scale exercise that or ty-based exercise is not an annual individual hal exercise; or seriences a natural or experiences a natural or ty that requires activation of the hospice is exempt from equired full-scale community and functional exercise that or the emergency event. It is a facility based functional annual exercise that is a facility based functional	E	039			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345532	B. WING		C 02/09/2023		
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 02/00/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
E 039	messages, or prepa challenge an emerg (iii) Analyze the hos maintain documenta	n statements, directed red questions designed to ency plan. epice's response to and tion of all drills, tabletop reency events and revise the	E 03	9			
	§482.15(d), CAHs a (2) Testing. The [PR conduct exercises to twice per year. The do the following: (i) Participate in an is community-based (A) When a commun accessible, conduct facility-based functio (B) If the [PRTF, Ho actual natural or ma requires activation of [facility] is exempt for required full-scale co facility-based function onset of the emerge (ii) Conduct an and that may include following: (A) A second full-sc community-based of functional exercise; (B) A mock (C) A tabletop e led by a facilitator an discussion, using a	TF, Hospital, CAH] must test the emergency plan [PRTF, Hospital, CAH] must annual full-scale exercise that ; or nity-based exercise is not an annual individual, anal exercise; or spital, CAH] experiences an in-made emergency that if the emergency plan, the omengaging in its next formunity based or individual, anal exercise following the incy event. [additional] annual exercise or e, but is not limited to the ale exercise that is individual, a facility-based or disaster drill; or exercise or workshop that is					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			C <b>02/09/2023</b>		
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP 310 COMMERCE DRIVE SANFORD, NC 27332	CODE	1 02/03/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
E 039	questions designed plan.  (iii) Analyze the maintain documenta exercises, and emerifacility's] emergence  *[For PACE at §460 (2) Testing. The PACE exercises to test the annually. The PACE following: (i) Participate in an is community-based (A) When a community-based (A) When a community-based function (B) If the PACE expressible, conduct facility-based or individual, exercise following the event.  (ii) Conduct an years opposite the yexercise under parais conducted that mathe following: (A) A second full-second full-second functional exercise; (B) A mock disaster	I messages, or prepared to challenge an emergency  [facility's] response to and action of all drills, tabletop regency events and revise the sy plan, as needed.  [84(d):]  [CE organization must conduct emergency plan at least a organization must do the emergency plan at least a organization must do the emergency plan at least a organization must do the emergency plan at least annual full-scale exercise that annual individual, and exercise; or enity-based exercise is not an annual individual, and exercise; or enity-based exercise and actual natural or exercise for exercise functional graph full-scale community facility-based functional graph (d)(2)(i) of this section and include, but is not limited to eale exercise that is a individual, a facility based or a drill; or	E	039				
	a facilitator and inclusing a narrated, cli	cise or workshop that is led by udes a group discussion, nically-relevant emergency of problem statements,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , , , , , , , , , , , , , , , , , , ,			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C 02/09/2023	
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		210312023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 039	designed to challeng (iii) Analyze the PAC maintain documental exercises, and emer PACE's emergency p  *[For LTC Facilities at (2) The [LTC facility] test the emergency p including unannounce emergency procedur ICF/IID] must do the (i) Participate in an at is community-based; (A) When a communaccessible, conduct facility-based functio (B) If the [LTC facility actual natural or mar requires activation of LTC facility is exemp required a full-scale individual, facility-base following the onset of (ii) Conduct an addit may include, but is n (A) A second full-scale community-based or functional exercise; of (B) A mock disaster (C) A tabletop exerce a facilitator includes narrated, clinically-re and a set of problem messages, or prepar challenge an emerger	or prepared questions e an emergency plan. E's response to and cion of all drills, tabletop gency events and revise the plan, as needed.  It §483.73(d):] must conduct exercises to plan at least twice per year, ed staff drills using the es. The [LTC facility, following: annual full-scale exercise that or ity-based exercise is not an annual individual, hal exercise. I facility experiences an hamade emergency that if the emergency plan, the trom engaging its next community-based or sed functional exercise f the emergency event. ional annual exercise that ot limited to the following: ale exercise that is an individual, facility based or drill; or ise or workshop that is led by a group discussion, using a levant emergency scenario, statements, directed ed questions designed to	EO	39			

AND DUAN OF CODDECTION		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345532	B. WING			C
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE  310 COMMERCE DRIVE  SANFORD, NC 27332		02/09/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 039	and maintain docume exercises, and emerge [LTC facility] facility's *[For ICF/IIDs at §48 (2) Testing. The ICF/to test the emergency The ICF/IID must do (i) Participate in an axis community-based; (A) When a communaccessible, conduct a facility-based function (B) If the ICF/IID expman-made emergency plan, engaging in its next rommunity-based or functional exercise for emergency event. (ii) Conduct an additional may include, but is not in (A) A second full-scat community-based or functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and inclusing a narrated, cliniscenario, and a set of directed messages, of designed to challeng (iii) Analyze the ICF/I maintain documental	entation of all drills, tabletop gency events, and revise the emergency plan, as needed.  3.475(d)]: IID must conduct exercises y plan at least twice per year. the following: nnual full-scale exercise that or ity-based exercise is not an annual individual, nal exercise; or. eriences an actual natural or cy that requires activation of the ICF/IID is exempt from equired full-scale individual, facility-based ollowing the onset of the onal annual exercise that ot limited to the following: le exercise that is an individual, facility-based or drill; or see or workshop that is led by des a group discussion, iically-relevant emergency of problem statements, or prepared questions e an emergency plan. ID's response to and iion of all drills, tabletop gency events, and revise the plan, as needed.	EC	039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER: A. BUIL			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING				C 09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		31	TREET ADDRESS, CITY, STATE, ZIP CODE 10 COMMERCE DRIVE ANFORD, NC 27332	, , ,	
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E 039	to test the emergency least annually. The H (i) Participate in a full community-based; or (A) When a community-based; or accessible, conduct a facility-based function or.  (B) If the HHA end or man-made emergency platengaging in its next recommunity-based or functional exercise for emergency event. (ii) Conduct an addition opposite the year the exercise under paraging is conducted, that limited to the following (A) A second full community-based or functional exercise; on (B) A mock disass (C) A tabletop exercise under paraging is conducted, that limited to the following (A) and the following (B) and the following (C) at abletop exercise; on (B) and the following and the	HA must conduct exercises of plan at HA must do the following: -scale exercise that is munity-based exercise is not an annual individual, and exercise every 2 years; experiences an actual natural ency that requires activation in, the HHA is exempt from equired full-scale individual, facility based allowing the onset of the ency that is every 2 years, full-scale or functional raph (d)(2)(i) of this section it may include, but is not exercise exercise that is an individual, facility-based or ercise or workshop that is dincludes a group earrated, clinically-relevant and a set of problem ency exercises, or prepared or challenge an emergency exercises, and individus, tabletop exercises, and individus the HHA's needed.	E	039			

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345532	B. WING		C 02/09/2023		
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 02/03/2020		
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E 039	(d)(2) Testing. The Oto test the emergency following: (i) Conduct a paperworkshop at least ar led by a facilitator ar discussion, using a remergency scenario statements, directed questions designed plan. If the OPO expman-made emergency plan, engaging in its next following the onset of (ii) Analyze the OPO documentation of all emergency events, a OPO's] emergency plan. (d)(2) Testing. The fexercises to test the must do the following (i) Conduct a paperleast annually. A tab discussion led by a folinically-relevant en of problem statemer prepared questions emergency plan. (ii) Analyze the RNH maintain documental and emergency ever emergency plan, as This REQUIREMEN by: Based on staff inter	DPO must conduct exercises by plan. The OPO must do the based, tabletop exercise or anually. A tabletop exercise is a dincludes a group parrated, clinically relevant and a set of problem messages, or prepared to challenge an emergency periences an actual natural or cy that requires activation of a the OPO is exempt from required testing exercise of the emergency event. It's response to and maintain tabletop exercises, and and revise the [RNHCl's and colan, as needed.  148]:  RNHCl must conduct emergency plan. The RNHCl g:  based, tabletop exercise at letop exercise is a group facilitator, using a narrated, mergency scenario, and a set ats, directed messages, or designed to challenge an and color of all tabletop exercises, and and revise the RNHCl's	E 03	The statements made on this plan of correction are not an admission to an			

PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245520				С		
		345532	B. WING _			02	/09/2023	
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
I IBERTY (	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY		310	0 COMMERCE DRIVE			
LIBERT				SA	ANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
E 039	Continued From page	9	EO	39				
E 039	any emergency prepared rills. The findings in Review of the EP plan The last documented drills was on 9/8/21 was conducted.  An interview was come AM with the Maintena had only been employmonths and that he hor attempted to coord EP testing. He stated any other documente active shooter drill do A telephone interview and 1/26/23 with mest facility Maintenance E as of exit on 1/26/23.  An interview was come PM with Administrato expect the previous Note that the EP was recently started as the	aredness (EP) testing or cluded:  In was reviewed on 1/25/23.  evidence of any testing or when an active shooter drill  Inpleted on 1/25/23 at 11:20 ance Director. He stated he yed at the facility for 3 and not conducted any drills inate an tabletop or actual he was not able to locate did drill or testing since the ne on 9/8/21.  It was attempted on 1/25/23 sages left for the previous Director with no return calls  Inpleted on 1/26/23 at 12:16 at #1. He stated he did not Maintenance Director to and suspected he removed a of testing and drills  1. He stated he was not s not up to date and that he a interim Administrator on	EO	039	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 constitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.  E0039  1. Corrective action for resident(s) affected by the alleged deficient practice.  Review of the EP plan was completed 1/25/23. The last documented evidence of any testing or drills was on 9/8/21 what are active shooter drill was conducted.  2. Corrective action for residents with potential to be affected by the alleged deficient practice.  All residents are affected by the facility completing any Emergency Preparednerills. There was an actual emergency that happened in the facility on 02/07/2023 at approximately 3:00 pm. This event qualified as an annual	ken on ce: on ce hen the not ess		
	1/3/23. Administrator expectation that the fa and complete an actuminimum a tabletop to	acility conduct monthly drills al live EP test or at			community based full-scale exercise. Another exercise or drill will be schedu within the next 6 months.  3. Measures /Systemic changes to prevent reoccurrence of alleged deficie practice: The facility will conduct an emergency			

Facility ID: 980156

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		C 02/09/2023	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		
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E 039	Continued From pag	e 10	E 03	preparedness drill twice during a rollicalendar year. The drills will consist a. an annual community based full-sexercise (facility experiences an actunatural or man-made emergency tha requires activation of the emergency the LTC facility is exempt from engagits next required a full-scale community-based or individual, facility-based functional exercise folke the onset of the emergency event), a (one of the following)  b. a second full-scale exercise that i community-based or an individual, facility-based functional exercise; or  c. mock disaster drill; or  d. a tabletop exercise or workshop to led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenar and a set of problem statements, directly messages, or prepared questions designed to challenge an emergency exercise, and emergency events, and revise the facility's emergency events, and revise the facility's emergency plan, and revise the facility's emergency prepared compliance with emergency prepared compliance with emergency prepared corporate policies.	of: cale al t plan, ging owing nd s cility  nat is o, ected oplan e the d as	

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		345532	B. WING _		02/09/2023	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
I IBERTY (	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY		310 COMMERCE DRIVE		
LIBERT	EIDERT I COMMICTO NOC AND RELIAD OTH OF EEE COCKET			SANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
E 039	Continued From page	· 11	E 0:	Administrator was educated on the		
				Administrator was educated on the company policy and procedures for Emergency Operations Plan and or CMS guidelines on having two exerper year on 02/23/23. Audits will be conducted by the Administrator and designee one week prior to the more QAPI meeting to ensure that the fain compliance. The Regional Direct Operations will complete biannual to ensure that compliance is being by the facility and Administrator.  4. Monitoring Procedure to ensure the plan of correction is effective ar specific deficiency cited remains compliance with regulator requirements.  Administrator and/or designee are responsible for implementing the acceptable plan of correction. Star 2/24/23, the Administrator or design monitor utilizing E039 Emergency Preparedness monitoring QA tool. Monthly audits will be completed for months of consecutive audits or un	n the roises e l/or nthly cility is tor of check upheld  that d that rrected y  ting on nee will	
				months of consecutive audits or un 100% compliance has been achiev Administrator will bring this to QAP monthly basis for twelve months.  Date of Compliance: 03/17/2023	ed.	
F 000	INITIAL COMMENTS		F 00	·		
	to conduct a recertific	ered the facility on 1/23/23 ation and complaint and exited on 1/26/223. The				

			TE SURVEY MPLETED			
		345532	B. WING _			C 2/09/2023
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		210312023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	survey team returne obtain additional info 2/9/23. Therefore, the 2/9/23. Event ID # In The following intake NC 197977, NC1948, NC195047, NC1952, NC193714  13 of the 27 complain deficiencies.  Immediate Jeopardy CFR 483.10 at tag F (J) CFR 483.25 at tag F (K) CFR 483.70 at tag F (K).  The tag F686 constitution CFR (S): 483.10(f)(1) §483.10(f) Self-dete The resident has the	d to the facility on 2/7/23 to ormation and exited on the exit date was changed to (J6011.  Is were investigated: 392, NC196912, NC189490, 55, NC192347, NC193823, & ant allegations resulted in was identified at: 580 at a scope and severity 6866 at a scope and severity futed Substandard Quality of the began on 9/6/22 and was An extended survey was -(3)(8)	F 0			3/17/23
	(K) CFR 483.70 at tag F (K). The tag F686 constit Care. Immediate Jeopardy removed on 2/8/23. conducted. Self-Determination CFR(s): 483.10(f)(1) §483.10(f) Self-dete The resident has the promote and facilitate through support of resident support supp	tuted Substandard Quality of began on 9/6/22 and was An extended survey was -(3)(8) rmination. e right to and the facility must be resident self-determination esident choice, including but ints specified in paragraphs (f)	F 5	61		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		C 02/09/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/09/2023	
				310 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY		SANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 561	Continued From page	e 13	F 56	1		
	§483.10(f)(1) The res activities, schedules (waking times), health care services consists assessments, and pla applicable provisions §483.10(f)(2) The res	ident has a right to choose including sleeping and care and providers of health ent with his or her interests, an of care and other of this part.				
	choices about aspect facility that are signific	s of his or her life in the cant to the resident.				
	with members of the	ident has a right to interact community and participate in both inside and outside the				
	religious, and commu interfere with the right facility.	ident has a right to tivities, including social, nity activities that do not ts of other residents in the				
	Based on record revi and staff interviews, t resident's choice rela	ew, observations, resident he facility failed to honor a ted to showers (Resident nt reviewed for choices.		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 tart	al	
	7/8/20 with diagnoses muscle weakness, co and diabetes type 2.	mitted to the facility on that included a stroke, ngestive heart failure (CHF)		plan of correction. The plan of correcticonstitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.		
	had moderately impa	Data Set (MDS) 7/23 indicated Resident #10 red cognition, required h transfers and extensive		F561 1. Corrective action for resident(s) affected by the alleged deficient praction	ce:	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		L. TDENTIEICATION NITIMBED:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C 02/09/2023		
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	03/2023	
					10 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY			SANFORD, NC 27332			
	I				T			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 561	Continued From page	e 14	F 5	561				
	assistance with bathin	ng. She displayed no						
	behaviors or refusal of				Resident #10 discharged from the facil on 1/29/2023.	ity		
	A review of Resident	#10's active care plan, last						
	reviewed 1/12/23, inc	luded a focus area for			2. Corrective action for residents with	the		
	Activities of Daily Livi	ng (ADL) self-care			potential to be affected by the alleged			
	performance deficit.				deficient practice.			
	I .	#10's nursing progress			All residents have the potential to be			
	notes from 12/1/22 to				affected by the alleged deficient practic	æ.		
	refusals of showers d	ocumented.			On 02/21/2023, the Nurse			
	Daview of the Number	Aida (NA) Cara Cuida			Manager/Minimum Data Set nurse interviewed all current alert and oriente			
	I .	Aide (NA) Care Guide I0 was scheduled to receive			residents for their preference regarding			
		day and Saturday day shift			shower days. The Director of Nursing			
	(7:00 AM to 3:00 PM)				Minimum Data Set nurse will then task			
	(7.007411110 0.001 111)	·			requested shower schedule to Point Cl			
	Resident #10's Nurse	Aide Flow Records for			Care task to fire to the Certified Nursing			
	December 2022 and	January 2023 were reviewed			Aides for documentation. This will be	5		
		ere not initialed as a shower			completed by 03/06/2023. For current			
	received nor refused	on 12/17/22, 12/24/22,			non-alert and oriented residents, the			
	12/28/22, 12/31/22, 1	/4/23, 1/7/23, and 1/11/23.			Certified Nursing Aides were educated	by		
					the nurse manager on the new facility			
		M, an interview occurred			shower schedule and that it should be			
	with Resident #10 wh				followed as posted. Showers will be			
	I .	received a shower last but			documented in the personal care task			
		e. She stated she got a			Point Click Care. This will be complete	d		
		nings. Resident #10 was			by 03/17/2023.			
		dors, but her skin was dry in			0 Management (Occatancia altanoma ta			
	appearance, at the tir	ne of the interview.			3. Measures /Systemic changes to	4		
	An interview occurred	d with Nurse Aide (NA) #1 on			prevent reoccurrence of alleged deficie practice:	ait		
	1/25/23 at 3:28 PM.	` ,			practice.			
		s often assigned to care for			On 2/23/2023, Director of Nursing, Nur	'SE		
	I .	NA #1 reviewed Resident			Consultant and the Nurse Manager be			
		w Records for showers,			education to all full time, part time, PRI	-		
	which indicated she h	•			and agency Nurses and Certified Nursi			
	I .	3. NA #1 stated this was			Aides on the following: new revised	9		
	marked because B be				shower schedule, refusal documentation	on,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L , IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C 02/09/2023		
NAME OF PI	ROVIDER OR SUPPLIER		·	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				310	0 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		SA	ANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 561	PM). NA #1 reviewed Care Guide and Nurs verified they stated son Wednesday and SNA #3 was assigned (Saturday) and 1/4/2 marked shower provi was unable to be interested to be interested to the was unable to be interested to the was unable to be interested to the was unable to be interested (Saturday) and had blank.  NA #5 was assigned (Saturday) and had lewas unable to be interested to 1/26/2 reviewed Resident # for showers and confinite missing showers and applicable. The actinested to the province of December 2020.	ing shift (3:00 PM to 11:00 I Resident #10's Nurse Aide se Aide Flow Record and she was to receive a shower Saturday day shift.  Ito Resident #10 on 12/31/22 I (Wednesday) and had ded as not applicable. NA #3 erviewed.  Itempts were made for NA #4 ul. NA #4 was assigned to 24/22 (Saturday) and 1/7/23 d left the entry for showers  Ito Resident #10 on 12/17/22 eft the entry blank. NA #5 erviewed.  Ing (DON) #1 was 23 at 10:00 AM. She 10's Nurse Aide Flow Record irmed there were some I showers marked as not I g DON explained Resident I the A bed to the B bed at the 22, changing her showers	F 5	561	and documentation of completion in Poclick Care tasks. 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 be 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 Certified Nurse Aides who give residents care in the facility. As of 3/17/2023, any nursing so who does not receive scheduled in-service training will not be allowed to work until training has been completed.  4. Monitoring Procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements.  The Director of Nursing and/or designed will monitor compliance utilizing the F50 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor resident spreference of shower and shower compliance. The	f y r The ed sing staff  t nat cted		
	stated the NA Care C were not changed to required on the even Saturdays, thus caus	ing shift of Wednesdays and ing Resident #10 to miss The acting DON stated she			Social Worker or designee will monitor satisfaction with showers weekly x 2 ar monthly x 3 or until resolved. Reports be presented to the weekly Quality Assurance committee by the Director or Nursing to ensure corrective action is initiated as appropriate. Compliance who be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed no	nd will of vill		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345532	B. WING		C 02/09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	02/03/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 561	Continued From pag	e 16	F 56	necessary for compliance with ADL C The weekly QA Meeting is attended b Administrator, Director of Nursing, Minimum Data Set nurse, Therapy Manager, Health Information Manage and the Dietary Manager.  Date of Compliance: 03/17/2023	y the
F 580 SS=J	CFR(s): 483.10(g)(14) Notificity A facility must immonsult with the residence consistent with his or representative(s) who (A) An accident involvesults in injury and I physician interventio (B) A significant charmental, or psychosor deterioration in healt status in either life-the clinical complications (C) A need to alter the aneed to discontinuate treatment due to advect of the commence and the fact of (D) A decision to transident from the fact \$483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informat is available and proviphysician. (iii) The facility must	cation of Changes. nediately inform the resident; dent's physician; and notify, r her authority, the resident en there is- ving the resident which has the potential for requiring n; nge in the resident's physical, cial status (that is, a h, mental, or psychosocial ureatening conditions or s); eatment significantly (that is, e an existing form of terse consequences, or to rm of treatment); or nsfer or discharge the	F 580		3/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345532	B. WING		C 02/09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	02/03/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLÉTION
F 580	as specified in §483. (B) A change in resid State law or regulation (e)(10) of this section (iv) The facility must update the address ophone number of the representative(s).  §483.10(g)(15) Admission to a compathat is a composite of §483.5) must discloss its physical configural locations that compropart, and must speciforom changes between the section of Nursing (MD) #2, and Nurse interviews, the facilit NP #2 that Resident to her left lateral calf 9/6/22 resulting in nountil 9/13/22 when the unstageable pressure and tissue loss in which damage within the ubecause the wound eschar). The Wound the pressure ulcer as (cm) by 5 cm with 59 necrotic tissue (eschar).	n or roommate assignment (10(e)(6); or dent rights under Federal or ons as specified in paragraph in.  record and periodically (mailing and email) and expecite distinct part. A facility distinct part (as defined in see in its admission agreement ation, including the various ise the composite distinct fy the policies that apply to been its different locations of the composite distinct for the policies that apply to be the composite distinct for the policies that apply to be the composite distinct for the policies that apply to be the composite distinct for the policies that apply to be the composite distinct for the policies that apply to be the composite distinct for the policies that apply to be the policies that apply th	F 58	The statements made on this plan of 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 correctionstitutes the facility allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.  F580  1. Corrective action for resident(s) affected by the alleged deficient practice.	nd do e eral taken is ection of

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTI			(X3) DATE SURVE COMPLETED				
		345532	B. WING _			02/	) 09/2023
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	03/2023
				31	10 COMMERCE DRIVE		
LIBERTY (	LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY				ANFORD, NC 27332		
(X4) ID		FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 580	Continued From pag	e 18	F 5	580			
	granulation tissue.	This was for 1 of 4 residents			For resident #16, a corrective action wa	as	
		e ulcers (Resident #16).			obtained on 9/16/2022. The Medical		
					Director and Responsible Party were		
		began on 09/06/22 when an			notified on 9/16/2022 by the Director of		
		#16's left lateral calf was			Nurses that resident #16 had develope	d	
		the leg immobilizer and did			an abrasion to the left lateral calf that		
	_	MD #2 for wound treatment opardy was removed on			resulted in the development of an		
	2/8/23 when the facil	•			unstageable pressure ulcer to the area under her immobilizer and that an error		
		eptable credible table			timely assessment and initiating ordere		
		ate jeopardy removal. The			treatment had occurred.	-	
	•	f compliance at a lower					
	scope and severity o	f D (no actual harm with the			2. Corrective action for residents with	the	
	· ·	an minimal harm that is not			potential to be affected by the alleged		
	immediate jeopardy)				deficient practice.		
		aining and ensure monitoring					
	systems put into place	ce are eπective.			All residents have the potential to be		
	The findings included	١.			affected by the alleged deficient practic On 2/7/2023, the Interim Director of	æ.	
	The infantys included	1.			Nurses audited notification for resident	9	
	Resident #16 was ac	lmitted on 7/24/19 with			that were potentially impacted by this		
		s of Dementia, Congestive			practice by reviewing 100% of post		
	_	c Kidney Disease, Coronary			appointment documents and any result	ting	
	Artery Disease and o	esteoporosis.			orders received from the appointment,	for	
					the last 30 days. The audit was done f		
	•	note dated 8/17/22 at 5:20			completion of notification of the attendi	•	
		d from the emergency room			physician and the responsible party. T	ne	
	_	left leg immobilizer due to a ure with orders to wear the			results included: No other concerns identified.		
		as evaluated on 9/6/22 by the			identined.		
		and to check her skin daily			3. Measures /Systemic changes to		
		emity due to the presence of			prevent reoccurrence of alleged deficie	ent	
	the leg immobilizer.	,			practice:		
	Davieus of est 11	dia Dhyminia Assista ( /DA)			Root Cause Analysis was completed o	n	
	T	edic Physician Assistant (PA)			2/07/2023 with the following staff in		
		ad there was an observed ower lateral leg. The note			attendance: Administrator, Interim Director of Nurses, Regional Operation	ie –	
		nd the area under her			Manager, the Quality Assurance Nurse		
ORM CMS-256	7(02-99) Previous Versions Ob	solete Event ID: KJ601	1	Fac	cility ID: 980156 If continua	ation sheet F	Page 19 of 162

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		ELE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345532	B. WING			C 02/09/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		J2/09/2023	
				310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 580	Continued From page	e 19	F 58	30			
	immobilizer and cons wound care orders.	sult wound management for  was completed on 2/6/23 at		Consultant and the Medical Direction Root cause analysis was conducted to staff failure to notify the attending physician, upon return	ucted he		
	9:00 AM with the Ortl	hopedic Physician Assistant /6/22, he observed an		appointment, of newly received Upon interview of the nursing s	orders.		
	abrasion to Resident	#16's left lower leg and		it was determined that the root	cause was		
		note orders to pad the area		that the nurse failed to put the delectronic health record so that			
	for wound care order	consult the wound provider s.		treatment was initiated and the			
	Review of the electro	nic medical record (EMR)		could have been followed up or			
	-	ocumented evidence that		daily clinical meeting. This resu			
	MD #2 was notified of the orthopedic visit of	f the abrasion discovered at		physician not being notified of tabrasion and ordered treatmen			
	-	was completed on 2/2/23 at		facility administration ☐s failed t			
		und Nurse. She stated she		effective oversight and leadersh	-		
	thought she recalled	a blister on Resident #16's		ensure effective systems were			
	left lower leg under h	er immobilizer that popped		related to follow up of orders ar	ıd		
		st covered it with a dry		notification to the physician of r	ew orders		
		ed the orthopedic PA would		or recommendations received f	rom an		
		ers. She stated she did not 22 when the abrasion was		appointment.			
	_	orthopedic PA. The Wound		On 02/7/2023, the Interim Direct	tor of		
	Nurse stated she did	not read the orthopedic		Nurses/Quality Assurance Nurs			
		2 because the receiving		Consultants began in-service of			
		ould have reviewed it and		all licensed nurses, full time, pa			
	implemented any nev	v orders.		as needed nurses, including ag education included: The Chang	-		
	Review of a Wound F	Physician note dated		Condition/Notification/Documer			
		ked to assess Resident #16		Process of the attending			
		ressure to her left lateral calf		physician/responsible party/res	ident, to		
	on 9/13/22.			include notification of changes	in		
	Λ <b>t</b> alamban - !t '			skin/wounds, newly received or			
		was completed on 2/2/23 at		following return from an appoint			
		He stated he was not		the importance of following the			
		ent #16's pressure ulcer to		appointment process. When a			
		til 9/13/22 when the Wound		returns from an appointment, the			
	about the appearance	because she was concerned		to obtain the post visit note and for new orders or recommendate			
	about the appearance	o or and wound and	1	I TO THOSE OF GOOD IN TOUR HITERING		1	

Facility ID: 980156

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I` ′	TIPLE CONSTRUCTION (X3) DATE S  NG			
			A. BOILDI			l ,	c l
		345532	B. WING _				09/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				31	10 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 TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 580	Continued From page	e 20	F t	580			
	suspected an infectio	n. He stated nobody from			nurse is to notify the physician and		
		n of a pressure ulcer until			responsible party/resident. The nurse	is	
	then. He stated he wo	ould have expected to be			to transcribe any new orders. The pos	t	
	notified due to the risk	k associated with a pressure			visit note is sent to medical records and	b	
	ulcer getting infected	and he would have given			will be uploaded into the electronic hea	lth	
	wound care orders or	n 9/6/22 if the orthopedic PA			record within 72 hours post visit. The		
		Resident #16's pressure			interdisciplinary team will review the po	st	
		underneath an immobilizer			visit note and any applicable orders as		
	was avoidable and any pressure ulcer that was not treated would deteriorate and could lead to interdisciplinary team will review the hard						
		od infection) and possible			copy information from the post visit not	е	
	osteomyelitis.				to confirm that needed orders are		
					contained in the electronic medical rec	ord.	
	-	was completed on 2/1/23 at				:.	
		2. She stated apparently			If the resident returns without a post vis		
		ne area identified by the			note or orders, it is the responsibility of	ıne	
	T	0/6/22 until a staff member			nurse to follow up and call the		
		e that there was drainage t #16's immobilizer on			physician⊡s office to obtain any new orders and then transcribe those orders	•	
	9/13/22. She stated				The nurse will as well notify the	5.	
		ite until 9/13/22 when it was			responsible party/resident and docume	nt	
	T	#16 had an unstageable			the notification.	111	
	pressure ulcer. DON				On 2/7/2023, the Interim Director of		
	· ·	etermined that Nurse #14			Nurses/Administrator and interdisciplin	arv	
		wound care orders from			team were educated on the expectation	•	
		consult. She stated an			that the post appointment process, to		
	•	underneath an immobilizer			include newly received orders/progress	3	
		ould lead to complications			notes or other physician/NP/PA		
	such as a wound infe	ction sepsis (blood infection)			information received from an appointm	ent	
	and possible osteomy	elitis.			involving a change in condition such as	а	
					wound, will be followed as part of the D	aily	
		notified of the immediate			Clinical Review Process. The process	is	
	jeopardy on 2/6/23 at	5:33 PM.			to include review of notification of the		
					attending physician and responsible pa		
	-	ided the following credible			and that the notification is documented	in	
	allegation for the imm	iediate jeopardy removal:			the electronic health record. This		
					education was completed by the Qualit	У	
		nts who have suffered, or			Assurance Nurse Consultant. As of		
	are likely to suffer, a s	serious adverse outcome as			2/8/2023, no Licensed Nurses will work	(	1

Facility ID: 980156

B. WING			С	
I				
NTY	311	REET ADDRESS, CITY, STATE, ZIP CODE	02/09/2023	
NTY				
		0 COMMERCE DRIVE		
	SA	ANFORD, NC 27332		
				ON
F	580			
gave  vas er leg. ne s t be consult it as was rs t note rders. tting area went rs se of t  to  dd, r 14 days. to the as to and	580	to include agency and licensed nurse staff. The Interim Director of Nurses ar Administrator are responsible to ensure applicable staff are educated, as well at to maintain monitoring and tracking of sustained compliance for staff that still require education to include newly hired licensed nurses and agency nurses as well as any newly hired interdisciplinary team members.  After 2/08/23, the Interim Director of Nursing will continue to be responsible ensure new Licensed Nurses/agency a educated on the applicable policies and procedures related to nursing follow up post appointment to assure the notification process is completed and the new orders are initiated to prevent serie complications that might occur for failing to follow these processes. Education were completed by the Interim Director of Nurses/RN Unit Manager prior to working their first shift. This information has be integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained.  4. Monitoring Procedure to ensure that the plan of correction is effective and the	all so to the last bus grill lang en et	
The social of the social socia	ULL PREF ION) TAG	ULL ID PREFIX TAG  F 580  Gave  vas er leg. he so the sonsult it as was rs it note orders. Ifting the area it went rs rse of the solution of t	SANFORD, NC 27332    ID	ID PREFIX TAG Without the education completed. This is to include agency and licensed nurse staff. The Interim Director of Nurses and Administrator are responsible to ensure all it note in the education to the applicable to ensure new Licensed Nurses/agency are educated on the applicable to ensure new Licensed Nurses/agency are educated to nursing follow up post appointment to assure the notification process is completed and that new orders are initiated to prevent serious complications that might occur for falling and in the required in the staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained.  4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

OLIVILIY	O I OIT MEDIO/ITE G	WEDIO/ WE CEIT VIOLO				<u> </u>	<del>3. 0000 000 1</del>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	' '	SURVEY PLETED	
							С	
		345532	B. WING				/09/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LIDEDTV	COMMONS NEC AND D	EHAD CTD OF LEE COUNTY		31	10 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		S	ANFORD, NC 27332			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	٧	(X5)	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE	
F 580	Continued From pag	e 22	F	580				
		tment documents and any			Utilizing the F580 Quality Assurance	Audit		
		ived from the appointment,			Tool, the Director of Nurses or design			
	_	The audit was done for			will monitor the post appointment pro			
	completion of notification				for compliance with notification of the			
	physician and the res				Medical Director/Responsible Party for			
	Root Cause Analysis				changes in condition/new orders and			
	I .	ollowing staff in attendance:			implementation of new orders/neede	Ł		
	Administrator, Interin				assessments weekly x 4 weeks then			
	Regional Operations			monthly x 3 months or until resolved.				
	_	onsultant and the Medical			Appointment follow up will be monitor	ea		
	I .	e analysis was conducted			as part of the Daily Clinical Meeting.  Reports will be presented to the weel	zh.		
		e to notify the attending rn from an appointment, of			Quality Assurance committee by the	ау	′	
		rs. Upon interview of the			Administrator to ensure corrective ac	ion		
		it was determined that the			initiated as appropriate. Compliance			
		the nurse failed to put the			be monitored and ongoing auditing			
		c health record so that the			program reviewed at the weekly Qua	ity		
	treatment was initiate	ed, and the referral could			Assurance Meeting. The weekly QA	-		
	have been followed t	up on in the daily clinical			Meeting is attended by the Administra	ator,		
	_	ed in the physician not being			Director of Nursing, MDS Coordinato			
	notified of the new al				Therapy, Health Information Manage	·,		
		y administration's failed to			and the Dietary Manager			
	·	rsight and leadership to			Data of Carrellian and 00/47/0000			
	1	ems were in place related to			Date of Compliance: 03/17/2023			
	follow up of orders a	ers or recommendations						
	received from an app							
	Specify the actions tl	he entity will take to alter the						
	process or system fa	illure to prevent a serious						
		m occurring or reoccurring						
	and when the action							
	On 02/7/2023, the In							
		rance Nurse Consultants						
		00% of all licensed nurses,						
	full time, part time ar							
		e education included: The						
	_	/Notification/Documentation						
		an ia Di ivoloidi // GODU (ODD)©	1				i.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						'	С	
		345532	B. WING			02/	/09/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE			
I IDEDTY	COMMONS NSG AND	REHAB CTR OF LEE COUNTY		310 C	OMMERCE DRIVE			
LIDERII	COMMONS NSG AND	REHAB CIR OF LEE COUNTY		SANF	FORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 580	Continued From p	age 23	F:	580				
	-	nclude notification of changes						
	' '	ewly received orders, following						
		pointment and the importance of						
		appointment process. When a						
		om an appointment, the nurse						
		st visit note and review it for						
		ommendations. The nurse is to						
	notify the physicial							
		e nurse is to transcribe any new						
	orders. The post v	isit note is sent to medical						
	records and will be	e uploaded into the electronic						
		in 72 hours post visit. The						
	interdisciplinary te	am will review the post visit						
		icable orders as part of the						
	_	ess. The interdisciplinary team						
		d copy information from the						
	· .	onfirm that needed orders are						
		ectronic medical record.						
		rns without a post visit note or						
		sponsibility of the nurse to follow						
		ysician's office to obtain any						
		en transcribe those orders. The						
		notify the responsible						
	On 2/7/2023 the Ir	document the notification.						
		tor and interdisciplinary team the expectation that the post						
		ess, to include newly received						
	•••	otes or other physician/NP/PA						
		ed from an appointment						
		e in condition such as a wound,						
		part of the Daily Clinical						
		The process is to include review						
		e attending physician and						
		and that the notification is						
		e electronic health record. This						
		npleted by the Quality						
	Assurance Nurse							
		Licensed Nurses will work						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345532	B. WING		C 02/09/2023
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 02/03/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION
F 580	include agency and Director of Nurses a responsible to ensu well as to maintain r sustained compliance ducation to include and agency nurses interdisciplinary teal After 2/08/23 the Int be responsible to er educated on the approcedures related appointment to assu completed and that prevent serious comfailing to follow thes Alleged date of imm 02/08/23.  On 02/09/23, the facilimediate Jeopardy was validated by sta	on completed. This is to new staff. The Interim and Administrator are re all staff are educated as monitoring and tracking of the for staff that still require remely hired licensed nurses as well as any newly hired members.  The important of Nursing will require the notification process is new orders are initiated to applications that might occur for the processes rediate jeopardy removal effective 02/08/23 aff interviews and record	F 58		
F 600 SS=G	service completion. and order follow up completed. Review follow up sheet was Assurance (QA) Co appointment/order fi Immediate jeopardy Free from Abuse an CFR(s): 483.12(a)(1) §483.12 Freedom fr Exploitation	was removed on 2/8/23. d Neglect	F 60	00	3/17/23

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED		
		345532	B. WING	·····	C 02/09/2023		
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 600		e 25 ation of resident property, efined in this subpart. This	F 60	00			
	includes but is not lin corporal punishment	nited to freedom from , involuntary seclusion and nical restraint not required to					
	§483.12(a) The facili	ty must-					
	physical abuse, corp involuntary seclusion This REQUIREMEN by: Based on staff famil	ι; Γ is not met as evidenced y, Emergency Room (ER)		The statements made on this plan			
	(NP) #1 interviews at failed to protect the r unknown origin (right fracture) resulting in	pirector #2, Nurse Practitioner and record review, the facility esident from injury of proximal tibia/fibula physical harm. This was for a residents reviewed for		correction are not an admission to a not constitute an agreement with th 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 the facility is allegation of constitutes the facility is allegation of constitutes.	deral s taken his ection		
	cumulative diagnose	Imitted on 7/24/19 with s of Dementia, Congestive c Kidney Disease, Coronary		compliance such that all alleged deficiencies cited have been or will corrected by the dates indicated. F600  1. Corrective action for resident(s) affected by the alleged deficient pra	be		
	care plan for osteopo dated last revised on included observation signs or symptoms o compression fracture complaints of back p care planned on 9/11			On 01/18/2023, Resident#16 had a to toe assessment was completed assigned nurse with the following reno other areas of concern from the attending nurse or the resident.  Telephone order obtained for RLE Doppler to rule out Deep Vein Throusince resident has a history of Deep Thrombosis. Attending nurse practi	mbosis		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION		PLETED
		345532	B. WING				C ( <b>09/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	00/2020
				3.	10 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		s	ANFORD, NC 27332		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 600	Continued From page	e 26	F	600			
	transfers dated 10/23	/19.			also directed staff to assess pedal and		
					popliteal pulses and perform test for		
		m Data Set (MDS) dated			Homan's Sign on RLE. Follow-up	_	
		e had moderate cognitive			appointment with orthopedics obtained	for	
	impairment, exhibited no behaviors, required extensive to total assist with her activities of daily				01/23/2023		
	living.	ist with her activities of daily			Corrective action for residents with	the	
	iiviiig.				potential to be affected by the alleged	liic	
	Review of a nursing r	note dated 1/18/23 at 10:50			deficient practice.		
	_	6 was transferred to the			On 1/ 25/2023 the DON/assigned nurs	es	
	hospital due to right lower extremity (RLE) pain.				identified residents that were potentiall	y	
					impacted by this practice by completing	3	
		note dated 1/18/23 at 10:50			head to toe audits on all resident on the		
		6 was transferred to the			CNA's assignment with a BIMS less th		
	hospital due to right l	ower extremity (RLE) pain.			13. The results included: No concerns		
	Daview of the emerge	on our no one (ED) Dhyraidiante			identified. On 2/01/2023, residents wit		
	_	ency room (ER) Physician's read as follows: Resident			BIMS of 13 or above were interviewed SW for any concerns related to care or	•	
		g pain for several days and			any unidentified falls within the last 14		
	today the facility note				days. Results included: No concerns		
		LE. The report read the			identified. On 2/1/2023 the Nurse		
	facility was concerned				Consultant audited all resident care pla	ans	
	thrombosis (DVT) and	d transferred her to the ER			for compliance with an identified transf	er	
		sident #16 has dementia and			status. The results included: 43 of 53		
		#16 stated her RLE had			were in compliance. On 2/1/2023 the		
	_	ral day after she fell. She			nurse consultant updated the care plar		
		nember exactly how or when			to reflected the current resident transfe	r	
		at anyone hurt her. The			status. On 2/01/2023 the DON began	_	
		le facility's concern for a rance was concerning for a			observation of Nurses/CNA s/Med Aide s/Agency s scheduled to work day and		
		pruising and swelling. X-rays			evening shift s ability to access the		
		ibia fracture and osteopenia			Kardex via demonstration. The results		
	· ·	d with osteopenia, Resident			included: 8 of 9 nursing staff were able	to:	
			access the Kardex and identify how to				
		curred during a position			locate the transfer status. On 2/01/202	3	
	change or during a tra	ansfer and doubtful it			the DON educated the one nursing sta	ff	
	occurred from a fall.				and they were able to demonstrate		
	contacted NP #1 at th				understanding via return demonstration	١.	
	reported Resident #16 had complained of leg						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED	
			A. BOILDIN	<u> </u>		С	
		345532	B. WING _			2/09/2023	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		2/03/2023	
				310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
	CUIMMA DV CT	ATEMENT OF DEFICIENCIES			TION	0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 27	F 6	00			
	pain for several days	but denied any known falls		3. Measures /Systemic changes to	<b>o</b>		
		advised for the need for		prevent reoccurrence of alleged de			
	orthopedic follow up	and she was placed in an		practice:			
		harged back to the facility		On 2/23/2023, the Director of Nurs			
	with orders for Tylend	orders for Tylenol or Motrin for pain.  Manager began in-service of all nursin					
				staff (including agency) on access	•		
	1	was completed on 1/25/23		Kardex prior to care, how to acces	s the		
	I .	1:20 AM with ER Physician. She stated she  Kardex, using the correct transfer					
		on 1/18/23 and noted her		technique and reporting any incide			
	_	bia/fibula fracture was acute		occur while caring or transferring a			
		pain and bruising. She		resident to the assigned nurse as			
	_	1 and informed her of her d for Resident #16 to see an		the definition of injuries of unknow and what relates to abuse/neglect.	-		
		as soon as possible and		Director of Nursing will ensure that			
		ylenol as needed for pain.		the above identified staff who does	•		
		,		complete the in-service training by			
	Review of a nursing i	note dated 1/18/23 at 3:30		3/17/2023 will not be allowed to we			
	PM read the emerger			the training is completed.			
		on Resident #16. The note					
	read the ER nurse re	ported the following: "The		Monitoring Procedure to ensure th	at the		
	good thing is that it lo	ooks to be an old fracture		plan of correction is effective and t	hat		
	based on calcification	n and callus formation and		specific deficiency cited remains c	orrected		
		ted it was indicative of an old		and/or in compliance with regulato	ry		
		notified, and she stated she		requirements.			
		R Physician and let the facility		The DON/RN Unit Manager will me			
		next step were needed. NP		Transfer Safety and Kardex Acces			
		formed the writer that she		weekly for 4 weeks and monthly for			
		nysician and confirmed the ed an old RLE fracture. This		months or until resolved for compli with safe and appropriate resident			
		Director of Nursing (DON) #1.		transfers. Staff will be observed or			
	HOLO WAS WILLEIT DY L	on the state of th		various shifts and days of the wee			
	An interview was con	npleted on 2/7/23 at 11:30		include weekends for compliance			
		e stated she assessed		accessing the Kardex and perform			
	Resident #16's right l			appropriate transfer.	J		
	_	A) #8 reporting her right knee					
		d swollen but she did not		Reports will be presented to the w	eekly		
		, and nobody had reported		Quality Assurance Committee by t			
	1	ne days prior. She stated		Director of Nurses to ensure corre	ctive		
	1	en complain of pain all over		action is initiated as appropriate.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7 50.25.			(	
		345532	B. WING			02/	09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		31	TREET ADDRESS, CITY, STATE, ZIP CODE  10 COMMERCE DRIVE  ANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	he ordered to be sent She stated she called get an update of Res spoke to an ER Nurse name. She stated info 1/18/23 what was rep Nurse. DON #1 state suspect staff error the neglectful.  An interview was com PM with NA #8. She is #16's right leg the mobruising and swelling did not complain of pagot DON #1 to assess assigned Resident 16 there was no evidence pain.  An interview was com PM with NA #10. She Resident #16 on night did not observe any exidence with NA #9. She conf #16 on second shift of observe any evidence #16's right leg and shift of Review of a NP #1 no read Resident #16 re and staff noted her Review of a Resident #16 re and staff noted her Resident #16 re	sis. She notified MD #2 and at to the ER for an evaluation. If the hospital on 1/18/23 to ident #16's condition and a but did not recall her formed Administrator #1 on norted to her by the ER at at no time did the facility are did not perceive it as a recalled seeing Resident forning of 1/18/23 and noted. She stated Resident #16 ain to her right leg, but she is it. She stated she was a on first shift on 1/17/23 and are of injury or any voiced an injury or any voiced and she did not complain and she evidence of an injury to eg and she did not complain and she did not complain of pain.  The untimed dated 1/20/23 ported RLE pain on 1/18/23 LE was significantly more at to the ER and NP #1	F	600	Compliance will be monitored and the ongoing auditing program reviewed at weekly Quality Assurance Meeting untideemed no longer necessary for compliance with splint application. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therap Manager, Health Information Manager, and the Dietary Manager.  Date of Compliance: March, 17, 2023	l Dy	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRI	UCTION	(X3) DATE	SURVEY
		345532	B. WING			1	C / <b>09/2023</b>
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	1	310 COMM	DDRESS, CITY, STATE, ZIP CODE  MERCE DRIVE  D, NC 27332		00,2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	severe osteopenia, n reports of a fall or injudocumentation and s  A telephone interview at 1:43 PM with NP # with the ER Physician their conversation incompacture was old, calcustated documented R pain for several days DON #1 and facility s stated DON #1 and A around the same time	ximal right tibia/fibula likely an acute finding due to on-ambulatory and no ury according to the	F	600			
	the same interpreted #1 stated she did not and was not aware R fracture until she retu appointment on 1/23/not think there was an eglecting to provide related to Resident #  An observation and faconducted on 1/23/23 was sitting up in her vieg immobilizer to helpain at this time. The week she was notified fracture to Resident # stated Administrator affracture diagnosed in old fracture and that sfalls, staff had not repand it was suspected	information as she did. NP read the ER documentation esident #16 had an acute rned from her orthopedic 23. NP #1 stated she did ny evidence of staff all safety precautions 16.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE COMF	SURVEY PLETED
		345532	B. WING _				C <b>09/2023</b>
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	•	STREET ADDRESS, CITY, STATE, ZIP COE 310 COMMERCE DRIVE SANFORD, NC 27332	)E	, 02.	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 600	Continued From page		F 6	600			
		the mechanical lift. She Physician she saw today old fracture but new.					
	PM with Administrato informed by NP #1 or	npleted on 1/23/23 at 1:57 r #1 who stated he was r DON #1 that Resident an acute injury and was due					
	PM with Administrato should considered the right leg suspicious b identified on 1/18/23	and due to inconsistencies derstood and what was					
F 610 SS=D	1:30 PM with MD #2. not say for sure, but h shower was the "antic fracture. He further st Resident #16 may no medication immediate have swollen days aff	ely and that the leg may ter the break. Correct Alleged Violation	F€	610			3/17/23
		se to allegations of abuse, or mistreatment, the facility					
	§483.12(c)(2) Have e violations are thoroug	vidence that all alleged hly investigated.					
		t further potential abuse, or mistreatment while the					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345532	B. WING			C 2/09/2023	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 610	designated represent accordance with State Survey Agency, with incident, and if the at appropriate corrective. This REQUIREMENT by:  Based on staff famil Physician, Medical Equipment (NP) #1 interviews a failed to provide evide an injury of unknown tibia/fibula fracture) to facility failed to invest surveyor began interestive of the State State of the State of the State State of the State of th	the results of all administrator or his or her tative and to other officials in the law, including to the State in 5 working days of the eleged violation is verified to action must be taken.  This not met as evidenced by, Emergency Room (ER) birector #2, Nurse Practitioner and record review, the facility lence of an investigation for a origin (right proximal that occurred on 1/18/23. The estigate the injury until the evention and investigation on failed to provide evidence ordance with State law to Survey Agency were notified and made aware of the injury 8/23 and evidence that an evas submitted within the eaven of the incident. This was of 8 residents reviewed for the incident of the incident. This was of 8 residents reviewed for the incident of the incident of the incident of the incident. This was of 8 residents reviewed for the incident of the incident of the incident of the incident. This was of 8 residents reviewed for the incident of the incident. This was of 8 residents reviewed for the incident of t	F6	The statements made on this plan correction are not an admission to not constitute an agreement with talleged deficiencies.  To remain in compliance with all feand state regulations the facility has or will take the actions set forth in plan of correction. The plan of corconstitutes the facility sallegation compliance such that all alleged deficiencies cited have been or with corrected by the dates indicated.  F610  1. Corrective action for resident(saffected by the alleged deficient put the facility failed to provide evider an investigation for an injury of un origin (right proximal tibia/fibula frathat occurred on 1/18/23 for Resid The facility failed to provide evider other officials in accordance with sale with sale with sale survey	e and do the ederal as taken this rrection of II be  c) ractice: nce of known acture) dent #16. nce State		
	11/23/22 indicated sl	um Data Set (MDS) dated ne had moderate cognitive d no behaviors, required		were notified within 2 hours of being aware of the injury that occurred of 1/18/23 and evidence that an investigation.	on		

Facility ID: 980156

PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN			С	
		345532	B. WING _		02	2/09/2023	
NAME OF PI	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	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLETION DATE	
F 610	Continued From page	e 32	F6	310			
	extensive to total ass	ist with her activities of daily		report was submitted within the	required 5		
	living.	,		working days of the incident. Th			
				report was submitted to N.C. De			
	Review of a nursing i	note dated 1/18/23 at 10:50		of Health Human Services by the	9		
	AM read Resident #1	8 was transferred to the		administrator on 01/24/2023 after	er		
	hospital due to right l	ower extremality (RLE) pain.		receiving a conflicting report fror			
				01/23/2023 orthopedic appointm			
		ency room (ER) Physician's		5 day follow up was submitted to			
		read as follows: Resident		DHHS was submitted by the adr	nınıstrator		
	today the facility note	g pain for several days and		on 01/30/2023 at 5:36 pm.			
	, ,	RLE. The report read the		Corrective action for resident	e with the		
	facility was concerne			potential to be affected by the al			
		d transferred her to the ER		deficient practice.	legeu		
	, , ,	sident #16 has dementia and					
		#16 stated her RLE had		On 2/20/23, the administrator ar	ıd		
	been hurting for seve	eral day after she fell. She		corporate clinical nurse complete	ed an		
	stated she did not rei	member exactly how or when		audit of 100% of all injuries of ur	nknown		
		nat anyone hurt her. The		origin for the past 6 months to in			
		ne facility's concern for a		electronic resident health record			
		rance was concerning for a		state reportable files. All other in			
		bruising and swelling. X-rays		unknown origin were reported to			
		ibia fracture and osteopenia id with osteopenia, Resident		within specified time frames set CMS guidelines.	forth by		
	· ·	us, it was suspected the		Civio guidelliles.			
		curred during a position		3. Measures /Systemic changes	s to		
		ansfer and doubtful it		prevent reoccurrence of alleged			
	occurred from a fall.			practice:			
	contacted NP #1 at tl			'			
	reported Resident #1	6 had complained of leg		On 2/20/23, the regional clinical	nurse		
		but denied any known falls		began 100% of administrative st			
	or injuries. NP #1			Abuse Prohibition Policy. All tra	•		
		eed for orthopedic follow up		be completed by 2/24/23. If train			
	-	in an immobilizer then		completed, the employee will no			
		ne facility with orders for		allowed to work until completed.			
	Tylenol or Motrin for	yallı.		Monitoring Procedure to ensure	ire that		
	Δ telephone interview	was completed on 1/25/23		the plan of correction is effective			
	-	Physician. She stated she		specific deficiency cited remains			

Facility ID: 980156

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345532	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	0-10002	1	-	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	09/2023
NAIVIE OF P	ROVIDER OR SUPPLIER				, , ,		
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY			10 COMMERCE DRIVE		
				S	SANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From pag	je 33	F 6	310			
	_	on 1/18/23 and noted her			and/or in compliance with regulatory		
		ibia/fibula fracture was acute			requirements.		
		pain and bruising. She			requirements.		
		41 and informed her of her			Administrator and/or designee are		
		ed for Resident #16 to see an			responsible for implementing the		
	_	as soon as possible and			acceptable plan of correction. On		
		Tylenol as needed for pain.			2/24/23, the Administrator or designee	will	
		, p			begin monitoring compliance utilizing		
	Review of a nursing	note dated 1/18/23 at 3:30			F-tag 610 Investigate/Prevent /Correct		
	PM read the emerge				Alleged Violation monitoring QA tool.		
	contacted for report	on Resident #16. The note			Monitoring will include review of reside	ent	
	read the ER nurse re	eported the following: "The			clinical notes as part of the Daily Clinic	al	
	good thing is that it le	ooks to be an old fracture			Review Process for 5 residents daily x	4	
	based on calcificatio	n and callus formation and			then weekly x 3, and then monthly x 2	or	
	the ER Physician sta	ated it was indicative of an old			until resolved. The ongoing auditing		
	fracture. NP #1 was	notified, and she stated she			program will be reviewed at the month	y	
	would contact the Ef	R Physician and let the facility			Quality Assurance Meeting until deeme	∍d	
	know what orders or	next step were needed. NP			as no longer necessary for compliance	;	
	**	nformed the writer that she			with reporting abuse and neglect.		
	- ·	hysician and confirmed the					
	, ,	ed an old RLE fracture. This			Date of Compliance: 03/17/2023		
	note was written by l	Director of Nursing (DON) #1.					
		mpleted on 2/7/23 at 11:30					
		ne stated she assessed					
		leg on 1/18/23 due Nursing					
	' '	porting her right knee					
		nd swollen but she did not					
		n, and nobody had reported					
		the days prior. She stated					
		often complain of pain all over					
		osis. She notified MD #2 and					
		nt to the ER for an evaluation.					
		d the hospital on 1/18/23 to					
		sident #16's condition and					
		se but did not recall her					
		formed Administrator #1 on					
		ported to her by the ER					
	Nurse.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			02/0	09/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE .	,	0.2020
				310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 610	Continued From page	e 34	F 6	510			
	PM with NA #8. She #16's right leg the moderate bruising and swelling did not complain of pagot DON #1 to assess assigned Resident #7 and there was no evipain.  An interview was con PM with NA #12. She Resident #16 on night did not observe any experience and the resident #16's right I of pain.  An interview was con with NA #9. She confied with NA #10 with NA #10 with NA #10 with the ER Phydiagnosed with a profracture that was not severe osteopenia, not reports of a fall or injudocumentation and she interview at 1:43 PM with NP #10 with the ER Physician their conversation inconfied with the ER Physician their conversation in the ER Phy	likely an acute finding due to on-ambulatory and no ury according to the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345532	B. WING			1	09/2023	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	•	STREET ADDRESS, CITY, S 310 COMMERCE DRIVE SANFORD, NC 27332	·	, <u>v-</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORR	R'S PLAN OF CORRECTION LECTIVE ACTION SHOULD BI LENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 610	stated DON #1 and A around the same time ER and spoke with a the same interpreted #1 stated she did not and was not aware F fracture until she retu appointment on 1/23. An observation and f conducted on 1/23/2 was sitting up in her leg immobilizer to he pain at this time. The week she was notifie fracture to Resident stated Administrator fracture diagnosed in old fracture and that falls, staff had not regand it was suspected happened during rou transferring her using stated the orthopedic told her it was not an An interview was cor PM with Administrator incident report and he DON #1 that Resider acute injury and due did not investigate the the injury to the state On 1/25/23 at 8:33 A an investigation date Resident #16 did not injury and interview was continuously a	staff reported to her. She administrator #1 were notified be when DON #1 called the in ER Nurse who reported information as she did. NP is read the ER documentation desident #16 had an acute irrned from her orthopedic irred Resident #16 denied irred Resident #16 denied irred from from her stated last irred on 1/18/23 of a possible irred from reg. She irred from rolling her or irred from from her saw today old fracture but new. Inpleted on 1/23/23 at 1:57 Irred from from the stated from the stated her irred from rolling her or irred from from her or irred from rolling her or irred from from her or irred from her or irred from her orthopedic income	F	510				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345532	B. WING			C / <b>09/2023</b>
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		103/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 610	on 1/24/23 at 10:30 as sent to the stated du unknown origin. He dinvestigation on 1/23  An interview was cor PM with Administrate should have investig was identified on 1/1 inconsistencies in whand what was documed in the stated hereturning from her or 1/23/23.  A telephone interview 1:30 PM with MD #2 not say for sure, but shower was the "antifracture.  Notice Requirements CFR(s): 483.15(c)(3)  §483.15(c)(3) Notice Before a facility transmesident, the facility representative(s) of the reasons for the nanguage and mannefacility must send a crepresentative of the Long-Term Care Om (ii) Record the reason discharge in the residence with paragonal	AM, a 24-hour report was e to Resident #16's injury of confirmed he began his b/23.  Impleted on 1/26/23 at 12:16 or #1. He stated the facility ated the injury at the time it 8/23 but due to nat the facility understood mented in the ER report, he began the investigation after thopedic appointment on www. was completed on 2/8/23 at . He stated although he could he felt that the transfer the icipated etiology" for the selection of the Before Transfer/Discharge (a)-(6)(8)  It before transfer and the resident's the transfer or discharge and move in writing and in a cert they understand. The copy of the notice to a coffice of the State abudsman.  In so or the transfer or dent's medical record in agraph (c)(2) of this section;	F 62			3/17/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345532	B. WING		02/09/2023	
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 02/03/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 623	(c)(8) of this section discharge required a made by the facility resident is transferred; (ii) Notice must be in before transfer or di (A) The safety of incide endangered und this section; (B) The health of incide endangered, und this section; (C) The resident's hallow a more immediate the required by the resident paragraph (c) (D) An immediate the required by the resident has industry and the section of the control of the reason for the control of the reason for the control of the	g of the notice. ed in paragraphs (c)(4)(ii) and , the notice of transfer or under this section must be at least 30 days before the ed or discharged. hade as soon as practicable scharge when- lividuals in the facility would er paragraph (c)(1)(i)(C) of dividuals in the facility would ler paragraph (c)(1)(i)(D) of ealth improves sufficiently to liate transfer or discharge, (1)(i)(B) of this section; ansfer or discharge is dent's urgent medical needs, (1)(i)(A) of this section; or ot resided in the facility for 30 ents of the notice. The written aragraph (c)(3) of this section owing: ansfer or discharge; e of transfer or discharge; which the resident is arged; he resident's appeal rights,	F 62	3		
	and telephone numl receives such reque to obtain an appeal	address (mailing and email), per of the entity which ests; and information on how form and assistance in and submitting the appeal				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345532	B. WING				09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	•	310	REET ADDRESS, CITY, STATE, ZIP CODE  COMMERCE DRIVE  NFORD, NC 27332	<u>,                                    </u>	00:2020
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 623	telephone number of Long-Term Care Oml (vi) For nursing facilit and developmental d disabilities, the mailir telephone number of the protection and ac developmental disab C of the Developmental disable of the mail address and teagency responsible fradvocacy of individual established under the for Mentally III Individual established under the formation in the effecting the transfer must update the recipal practicable once to become available.  §483.15(c)(8) Notice In the case of facility the administrator of the written notification protection of the State Survey A State Long-Term Cart the facility, and the rewell as the plan for the relocation of the residual the residual control of the residual control	ss (mailing and email) and the Office of the State budsman; by residents with intellectual isabilities or related and and email address and the agency responsible for dvocacy of individuals with illities established under Part and Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and ty residents with a mental sabilities, the mailing and elephone number of the or the protection and als with a mental disorder er Protection and Advocacy luals Act.	F	523			

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		0:	C 2/09/2023	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 623	Continued From page 39		F 62	23			
F 623	Based on record rev Ombudsman, resider failed to notify the res party (RP) in writing of transfer/discharge to send a copy of the di Ombudsman for 3 of reviewed for hospitali #50).  Findings included:  1. Resident #44 was 11/22/22.  The admission Minim assessment dated 12 Resident #44's cogni The nurse's note date revealed that Reside hospital and was adm resident was readmit 11/27/22.  Review of the nurse's 11:20 AM revealed th transferred to the hos 11/30/22. The reside facility on 12/5/22.	iew and interview with the ints and staff, the facility sident and or responsible of the reason for the the hospital and failed to scharge notice to the 3 sampled residents ization (Residents #44, #5 & admitted to the facility on hum Data Set (MDS) 2/11/22 indicated that tion was intact.  Bed 11/23/22 at 4:48 PM and the facility on the facility of	F 62	The statements made on this place correction are not an admission of not constitute an agreement with alleged deficiencies.  To remain in compliance with all and state regulations the facility or will take the actions set forth in plan of correction. The plan of constitutes the facility allegatic compliance such that all alleged deficiencies cited have been or vicorrected by the dates indicated. F623  1. Corrective action for resident( affected by the alleged deficient.  Residents discharged to the host the month of September 2022-Decent 2022 were included on the disch listing report and faxed to the Ombudsman by the Social Work 01/26/2023. On 02/28/2023, writedischarge notices were sent to a residents by the Administrator as their own responsible party. Residents was sent written notices for 11/21 and 11/30/2022. Resident #5 was written notice for 11/21/2022. Resident #5 was sent written notices for 11/20/2022.  2. Corrective action for residents.	to and do the  federal has taken in this orrection on of  will be  (s) practice: pital for ecember arge er on tten II they are sident #44 3/2022 as sent a esident 9/23/2022		
	Resident #44 was interviewed on 1/24/23 at 10:15 AM. He reported that he did not remember receiving a letter from the facility when he was discharged to the hospital in November 2022.			potential to be affected by the all deficient practice.	eged		
	2. Resident 5 was ad 10/27/22.	mitted to the facility on		On 01/26/2023, the list of resider discharged to the hospital was reby the Administrator for the mont September 2022 through December 2029.	eviewed hs of		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45500	D WING				С
		345532	B. WING _			02	/09/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
I IBERTY (	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		31	10 COMMERCE DRIVE		
LIDLIKIT	SOMMONS NOS AND N	EIAB OTK OF ELE GOOK!		S	ANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From pag	e 40	F	623			
	The quarterly Minimu	ım Data Set (MDS)			to monitor that all residents who had be	een	
	assessment dated 11	1/4/22 indicated that			discharged that month, were present o	n	
	Resident #5's cogniti	on was intact.			the report that was faxed to the		
	_				ombudsman on 01/26/2023 by the soc	ial	
	The nurse's note date	ed 9/23/22 at 4:29 AM			worker. Results: There were no reside	ents	
	revealed that Reside	nt #5 was transferred to the			that were left off the list that was sent of	on	
	hospital and was adr	nitted on 9/23/22. The			01/26/2023. The social worker is		
	resident was readmit	ted to the facility on 9/26/22.			responsible for giving the resident and		
					their responsible party written notices of		
	The nurse's note dated 10/20/22 at 6:26 AM revealed that Resident #5 was transferred to the hospital and was admitted on 10/20/22. The				discharge and for sending all discharge	ed	
					residents to the Ombudsman.		
					0. Management (0tampin altampin alta		
	resident was readmit	ted to the facility on 1/27/22.			<ol><li>Measures /Systemic changes to prevent reoccurrence of alleged deficie</li></ol>	nt	
	Resident #5 was inte	rviewed on 1/24/23 at 10:22			practice:	7111	
	** *	she did not receive any letter			practice.		
		she was discharged to the			On 01/26/2023, the Administrator		
	hospital.	J			educated the Social Worker on the		
	' 				requirement to include all residents		
	The Social Worker (S	SW) was interviewed on			discharged to the hospital on the list of	:	
	1/25/23 at 10:55 AM.	The SW stated that she			discharged residents provided to the		
	started working at the	e facility as social worker on			Ombudsman monthly and on giving the	Э	
		he stated that she was not			resident or their responsible party a no	tice	
		o send a discharge notice to			of discharge in writing. Contact was		
	the Ombudsman who				made to the local ombudsman and she		
		o stated that she was not			stated that the discharge report from P		
		o inform the resident and or			Click Care was sufficient for the month	ly	
		ne reason for the discharge			report and this is all that she required		
		as discharged to the hospital. body had informed her that			once at the end of the month.		
		Ombudsman of discharges			Monitoring Procedure to ensure that	+	
	` , ,	in writing when discharged to			the plan of correction is effective and the		
	the hospital) were he				specific deficiency cited remains correction		
	noopital) word no	. respondibilities.			and/or in compliance with regulatory		
	Nurse #6 was intervi	ewed on 1/25/23 at 11:40			requirements.		
		when a resident was			'		
		ed to the hospital, she			The Administrator will monitor complian	nce	
	notified the RP by ca				utilizing the F623 Quality Assurance To		
					for compliance with inclusion of resider		

Facility ID: 980156

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 /09/2023
NAME OF P	ROVIDER OR SUPPLIER	1		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 02	103/2023
					0 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY			ANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623		ng (DON)#1 was interviewed	F 6	623	discharged to the hospital and faxing of the Discharged Resident Report month		
	notified the resident a a resident was dischadded that she had b while now and she had	23 at 11:45 AM. She stated that nursing the resident and or the RP verbally when at was discharged to the hospital. She at she had been the unit manager for a w and she had not notified the resident e RP in writing when the resident was			to the Ombudsman. This will be monitored monthly x 4 months. Repor will be presented to the weekly Quality Assurance committee by the Administr to ensure corrective action is initiated a appropriate. Compliance will be monitored and the ongoing auditing	ts ator	
	The Ombudsman was interviewed on 1/25/23 at 3:05 PM. She stated that recently she had not received any list of discharges from the facility. She reported that the last time she received a list of discharges was on 6/6/22.				program reviewed at the weekly Qualit Assurance Meeting. The weekly QA Meeting is attended by the Administrat Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Manager, Health Information Manager	or,	
	interviewed on 1/26/2 Administrator stated responsible for notify discharges monthly a	that the Social Worker was ing the Ombudsman of and in notifying the resident ng when a resident was			and the Dietary Manager.  Date of Compliance: 03/17/2023		
	3. Resident #50 was transferred to the hos complaints of chest p	· ·					
	documentation regar and the Resident #50	al record did not include any ding the notice of a bed hold did not return to the facility from the hospital with					
	Business Office Man responsibility of the f	/23 at 10:50 AM with the ager. She stated it was the acility Social Worker to send man a list of the hospital ges.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			C <b>2/09/2023</b>
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 0.	2/03/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 623	AM with the Social V started working at the she was not aware to regional Ombudsma and discharges. The would call the family following day after a the bed hold policy aneed to send out a lestating the reason for An interview was con AM with Nurse #6. Sonurse and had worke approximately 2 more transferred a resider call the RP and explain the reason to resident. She stated RP/resident had to be reason for a hospital An interview was con AM with Director of Note that the floor nurse in verbally that the Phybe sent to the hospit reason for a hospital A telephone interview at 3:05 PM with the stated the last time is stated the last time is stated.	mpleted on 1/25/23 at 10:55  Worker. She stated she e facility on 10/31/22 and that hat she had to send the n a list of hospital transfers SW also stated that she or responsible party (RP) the hospital transfer to discuss and she was not aware of the etter to the RP/resident r a hospital transfer.  mpleted on 1/25/23 at 11:40 he stated she was an agency ed at the facility for hths. She stated when she at to the hospital, she would ain the reason or she would of an alert and oriented she was not aware that the lie informed in writing of the	F 6	23		
	Permitting Residents CFR(s): 483.15(e)(1		F 6	26		3/17/23

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345532	B. WING		C 02/09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 02/03/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 626	Continued From pag	e 43	F 62	16	
	§483.15(e)(1) Permit facility. A facility must establ on permitting resider after they are hospitatherapeutic leave. The following. (i) A resident, whose leave exceeds the bestate plan, returns to room if available or in availability of a bed in resident- (A) Requires the servand (B) Is eligible for Med services or Medicaid nursing facility service (ii) If the facility that of who was transferred returning to the facility more requirements of paradischarges.  §483.15(e)(2) Reading distinct part. When the returns is a composite §483.5), the resident to an available bed in composite distinct part to an available bed in the time of return, the option to return to availability of a bed to This REQUIREMENT by:	ish and follow a written policy at the toreturn to the facility alized or placed on the policy must provide for the control period under the period under		The statements made on this plan of	
	Manager, Ombudsm			correction are not an admission to an	

PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			1	09/2023
NAME OF PR	ROVIDER OR SUPPLIER		l .	S	TREET ADDRESS, CITY, STATE, ZIP CODE	, <u>v=</u> ,	30/2020
LIBERTY (	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY			10 COMMERCE DRIVE ANFORD, NC 27332		
	OUR MAN EN COT	ATEMENT OF DEFINITION			·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 626	Continued From page	<u>.</u> 44	F (	626			
	return to the facility for transfer to the hospital reviewed for hospital medically stable to refacility refused to read resident remained in where she expired. Be person concept a resident for an acute of to their home at the fact the hospital. Refuse return and the resider at the hospital following a reasonable person psychosocial outcome.	rrent Administrator failed to permit a resident to illowing a facility-initiated al for 1 of 1 resident transfer. Resident #106 was turn on 10/03/22 when the			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 sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.  F626  1. Corrective action for resident(s) affected by the alleged deficient practic.  The facility failed to permit a resident to return to the facility following a facility-initiated transfer to the hospital. Resident expired during hospital stay.	ken on ee:	
	The findings included				<ol><li>Corrective action for residents with t potential to be affected by the alleged deficient practice.</li></ol>	he	
	01/25/21.  Financial ledger docurevealed the following				On 02/23/2023, the administrator and corporate clinical nurse completed a 10% audit of all upcoming discharges and the past 4 months to ensure the reside was allowed to come back to the facility	l nt	
	(BOM) switched Resi private pay.	siness Office Manager dent #106's payor source as			Measures /Systemic changes to prevent reoccurrence of alleged deficie practice:	nt	
		ous two months was			Regional Clinical Nurse gave education the Administrator, Business Office Manager, and Social Services Director Code of Federal Regulations 483.15, Section E, Paragraphs 1 and 2. All		

Facility ID: 980156

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING			1	С
NAME OF B	20,4252.02.0122.152	343332	B. WING _	0.7.0		02	/09/2023
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NSG AND	REHAB CTR OF LEE COUNTY			COMMERCE DRIVE		
				SAN	NFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 626	Continued From page	age 45	F 6	626			
		BOM received another check funds. She spoke with			training was completed by 02/24/2023		
		which the resident provided her		.	4. Monitoring Procedure to ensure tha	ıt	
		However, the credit card was			the plan of correction is effective and t		
	expired. The BOM	told Resident #106 "I did			specific deficiency cited remains corre		
		we were probably going to			and/or in compliance with regulatory		
		Day discharge notice. She			requirements.		
		od, but has no one to care for					
	her, and she canno	ot care for herself."			Administrator and/or designee are		
	The care plan und	atad an 09/10/22 identified the			responsible for implementing the acceptable plan of correction. On		
		ated on 08/10/22 identified the ident #106 preference for			2/24/23, the Administrator or designee	will	
		emain at the facility for long			monitor compliance utilizing F-tag 626		
		uded Resident #106 would a			Permitting Residents to Return to Faci		
		stment to life at the facility for			QA tool. Observation will include revie	•	
		acility would continue to meet			all discharges for 5 residents daily x 4		
		90 days. Interventions			then weekly x 3, and then monthly x 2.		
	included the activit	ies department to provide			The ongoing auditing program reviewe	d at	
		meaningful to her; family			the monthly Quality Assurance Meeting		
		from home that would help her			until deemed as no longer necessary f	or	
	adjustment; and hat team quarterly.	ad care plan meetings with the			compliance with reporting abuse and neglect.		
	indicated on 08/24 Resident #106 abo	ocumentation for Resident #106 /22 the BOM went to see out payment. Resident #106			Date of Compliance: 03/17/2023		
	bank, but had not i	red another debit card from her received it. The BOM indicated					
		er until Monday morning					
	-	I am going to proceed with a					
		notice. I have attempted to help veral occasions, and to no					
	avail."	verai occasionis, and to no					
		sing Home Notice of					
		e form dated 09/01/22					
		cheduled discharge date of					
		e, after reasonable and to pay for (or to have paid					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTE	RUCTION		SURVEY PLETED
		345532	B. WING				C / <b>09/2023</b>
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	•	310 COM	NDDRESS, CITY, STATE, ZIP CODE  MERCE DRIVE  RD, NC 27332	1 02	3372023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROVIDENCE)  DEFICIENCY)		) BE	(X5) COMPLETION DATE
F 626	The Former Administ signed the form on 0 discharge was to be Review of the Hearin 09/01/22 documente of 10/01/22, was unso There was no evident discharge planning for Review of the Skilled Home to Hospital Traat 11:15 AM indicated transferred to the host values.  The quarterly Minimum 09/27/22, indicated Format was intact, and she remore staff members as well as extensive members staff for be was not coded as had The discharge MDS Resident #106's return anticipated.  A review of the Hospital Transferred to the host values.	ledicaid) a stay at this facility. trator (Administrator #2) 9/01/22 that documented the Resident #106's home.  In Request form dated discharged signed by Resident #106.  In Resident #106.  In Nursing Facility/Nursing ansfer Form dated 09/29/22 discident #106 was spital due to abnormal lab  In Data Set (MDS) dated Resident #106's cognition required total assist of 2 or for transfers and toilet use assistance of 2 or more staff discident with a dressing. She ving behaviors or delusions.  Indicated 09/29/22 indicated ring to the facility was  In the facility was  In Case Manager and the amount of a they entered a facility to the lages with the facility to 26 was able to return. The	F	526			
		ger was notified by phone by strator #2 that Resident #106					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345532	B. WING			C 02/09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP 0 310 COMMERCE DRIVE SANFORD, NC 27332		02/03/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 626	"owes us over \$45,00 told us we can't take discharge notice was and she did not apper 10/01/22." The Hosp Resident #106 had be to return and facility stell her. She's at your the facility indicated in Medicaid application doesn't meet the critic house."  A review of the hospit 10/26/22 indicated Ron 09/29/22 from the hemoglobin levels. In Department, her blocklevels were low. The and she received 3 uright for discharge on 10/0 would not be accepted due to reported debts subsequently prolong 10/24 where the Lee Social Services assist had no available farm hospitalization, she cacidosis and went intrequired cardiopulmo 20 minutes. The courcalled and Resident Rot Resuscitate (DN cardiac arrest again and An interview with the 01/24/23 at 9:46 AM notified Resident #10 told in the called and Resident #10 told in the called R	on and our corporate office her back 30 day given to patient on 09/01/22 and her notice was due on ital Case Manager asked if een notified of being unable staff stated "no, you have to rhospital." The note revealed they had not started a because "we know she eria because she has a tal discharge summary dated esident #106 was admitted facility due to a drop in the Emergency of pressure and potassium low potassium was treated, inits of blood. She was stable 13/22, but "unfortunately she ed back at Liberty Commons so Her hospitalization was ged awaiting court hearing on County DSS [Department of umed guardianship since she	F	526		

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING				09/2023	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		31	TREET ADDRESS, CITY, STATE, ZIP CODE 10 COMMERCE DRIVE ANFORD, NC 27332	, , , , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
F 626	thousands of dollars. being at the hospital of death. Resident #106 act on her behalf; the emergency court app submitted. Resident # admitted to another fathe same day a court assigned on 10/26/22. The Business Office of interviewed on 01/24/21 indicated Resident #7 facility for skilled Meditality	"Resident #106 ended up for almost a month until her is did not have next of kin to refore, an application for an ointed guardian was #106 was unable to be acility because she expired appointed guardian was 2."  Manager (BOM) was 2."  Manager (BOM) was 2."  Manager (BOM) was 4."  Manager (BOM) was 6."  Manager (BOM) was 6."  Manager (BOM) was 7."  Manager (BOM) was 8."  Manager (BOM) was 8."  Manager (BOM) was 9."  Manager (BOM) was	F	626	DEFICIENCY)			
	the facility's address a could be sent to the facility's address a could be sent to the facility and possible to pay and the sent to the facility's corporate off discharge for non-pay 30-day discharge to facility's address.	from her home address to so the debit card and checks acility. She stated she did #106 ever spoke to her bank to card or checks, and she at #106 with contacting the felt like Resident #106 was dent #106 not having checks er. She was instructed by the ice to issue a 30-day ment. She explained the Resident #106, and she is the She stated Resident #106						

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING				09/ <b>2023</b>
NAME OF P	ROVIDER OR SUPPLIER		1	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2020
LIBERTY	COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY			COMMERCE DRIVE NFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROFILE DEFICIENCY)			(X5) COMPLETION DATE
F 626	did not discuss safe of issue date of the 30-c with the scheduled di She indicated Reside the hospital on 09/29 Administrator #2 told Planner Resident #10 facility because a 30-issued, and they coul Administrator #2 was 2:01 PM by telephone spoke with Resident regarding non-payme "several excuses" as Resident #106 had a 09/29/22 and was seevaluation. She indicathe corporate office thaccept Resident #106 non-payment and the 30-day discharge not discharge planning was Resident #106 was generally at 2:30 Findicated while Resident #106 was generally at 2:30 Findicated while Resident while Resident was 30-day discharge stated they do not pay while residents were stated the facility mad 30-day notice, but he involved in the decision with the stated the stated the stated the facility mad 30-day notice, but he involved in the decision with the stated the facility mad 30-day notice, but he involved in the decision with the stated the facility mad 30-day notice, but he involved in the decision with the decision with the decision with the stated the facility mad 30-day notice, but he involved in the decision with the deci	discharge planning. The day discharge was 09/01/22 scharge date to be 10/01/22. Scharge date do be 10/01/22. Scharge date do be stated the Hospital Discharge do could not return to the day discharge notice was do not take her back.  Interviewed on 01/24/23 at the scheme date was indicated the BOM #106 several times and but the resident had to why she could not pay, change of condition on the tothe hospital for lated she was instructed by the had already issued a lice. She did not know if safe as initiated and stated oing to return to her home.  With the Regional Director of the was conducted. He lent #106 was at the hospital, notice had expired. He luse the discharge notice in the hospital. He further de the decision to issue a became aware and was on. It is the facility's re safe discharge planning,	F	626			
	The Ombudsman wa	s interviewed by telephone					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		C <b>02/09/2023</b>	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	02/09/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 626	on 01/25/23 at 3:01 F not aware of the circu #106's discharge, but her discharge. She in requirement, some fa 30-day discharge not She further stated the readmitted Resident a discharge notice shot Resident #106.  The current Administr interviewed on 01/26/ he had only been at t stated his understand issued a 30-day disch went to the hospital of felt the facility gave si #106 regarding the pe non-payment. He stat #106 a 30, 60, and 90 the 30-day discharge the discharge was sa being admitted to the discharge planning w Resident #106 was so Accuracy of Assessm CFR(s): 483.20(g)  §483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by: Based on record revifacility failed to code (MDS) assessments a	M. She indicated she was imstances of Resident knew she was notified of dicated while it is not a cilities involve her when a ice was given to residents. It facility should have facility for 2 weeks. He facility for 2 weeks. He facility for 2 weeks. He fing was Resident #106 was farge notice on 09/01/22 and in 09/29/22. He indicated he facility gave Resident for the facility gave facility for the facility gave facility for the facility gave facility facility gave facility for the facility gave facility	F 62		ind do	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING _				09/ <b>2023</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	03/2020
					10 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY	SANFORD, NC 27332				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 641	341   Continued From page 51		F6	341			
		& nutrition (Resident #12) for lents whose MDS were			To remain in compliance with all Feder and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of		
	Findings included:				Correction constitutes the facility ☐s allegation of compliance such that all		
		admitted to the facility on			alleged deficiencies cited have been or	ſ	
	9/22/22 with multiple retention.	diagnoses including urinary			will be corrected by the date or dates indicated.		
	indicated that Reside urinary catheter and v	ssessment dated 1/8/23 nt # 45 had an indwelling was always incontinent of			F641 ACCURACY OF ASSESSMENTS	3	
	bladder.				Corrective action for resident(s)     affected by the alleged deficient practic	æ:	
	Resident #45 had a padmission (9/22/22) f	hysician's order on or an indwelling urinary			Resident # 45: Resident Minimum Data	a	
	catheter for urinary re	tention.			Set (MDS) assessment (Quarterly Assessment,) with Assessment		
		interviewed on 1/26/23 at Nurse reviewed Resident			/Reference Date (ARD) [01/08/2023] w modified.	as	
	#45's doctor's orders	and verified that the for an indwelling urinary			Resident # 46: Resident Minimum Data Set (MDS) assessment (Admission	<b>a</b>	
	catheter on admission	n and had the urinary			Assessment,) with Assessment		
		ng on the date of the MDS			/Reference Date (ARD) [12/14/2022] w modified.		
	,	3. She indicated that she			Resident # 12: Resident Minimum Data	<b>a</b>	
		esident #45 as "not rated" for of "always incontinent"			Set (MDS) assessment (Admission Assessment,) with Assessment		
		lling urinary catheter had			/Reference Date (ARD) [01/09/2023] w	126	
	been present during t	•			modified.	40	
	interviewed on 1/26/2	hat he expected the MDS			Corrective action for residents with potential to be affected by the alleged deficient practice.		
	2. Resident # 46 was	admitted to the facility on			All current residents who have indwelling urinary catheters, all current resident with have a wound infection, and all current	/ho	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		E SURVEY IPLETED
		245520	B. WING			С
		345532	D. WING _		· ·	2/09/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NSG AND F	REHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE		
		(2, 13 G.), (3. 2.2.2 G.), (1)		SANFORD, NC 27332		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	Continued From pag	ge 52	F 64	41		
	pressure ulcers.	e diagnoses including		residents who have elected ho services have the potential to by the alleged practice. On 2/2	pe affected 22/2023, an	
	12/7/22 included cip	rs for Resident #46 dated rofloxacin 500 milligrams rs for an E. coli wound		audit was completed by Mini D (MDS) Nurse Consultant to rev Minimum Data Set (MDS) asset the last 3 months to ensure the	riew all essments in at all current	
		n order dated 12/8/22 for ntibiotic) 500 mgs - apply to pically daily.		residents who have indwelling catheters, have Section H0300 Continence coded accurately. total number of 3 current reside indwelling urinary catheters, 3	o: Urinary Out of a ents with	
	Records (MARs) rev received ciprofloxac wound infection duri	2 Medication Administration realed that Resident #46 had in and metronidazole for a ng the assessment period (7 ling on the date of the MDS 4/22.		MDS assessments were modifined reflect accurate data for section Urinary continence due to inact On 2/22/2023, an audit was combini Data Set (MDS) Nurse Coreview all Minimum Data Set (I	ied to n H0300: curacy. mpleted by onsultant to	
	The admission MDS indicated that Resid pressure ulcer that vand had received ar assessment did not	s assessment dated 12/14/22 ent #46 had a stage IV was present on admission a antibiotic medication. The indicate that Resident #46 on during the assessment		assessments in the last 3 mon- ensure that all current resident a wound infection identified in a look back period and whose di- status is active in the last 7 day ARD have section I2500: wour (other than foot) coded accurate all the current residents, no res	ths to s who have the 60day agnosis ys of the nd infection tely. Out of sident is	
	10:42 AM. The MDS #46's orders and the verified that the resireceived antibiotics metronidazole) for a assessment period the date of the MDS She stated that she	s interviewed on 1/26/23 at S Nurse reviewed Resident December 2022 MARs and dent was admitted and had (ciprofloxacin and wound infection during the (7 sequential days ending on assessment) of 12/14/22. should have noted the wound hission MDS assessment.		receiving antibiotic treatment for infection. Section 12500: Wou (other than foot) is coded acculourrent residents. On 2/22/20 was completed by Mini Data Section Nurse Consultant to review all Data Set (MDS) assessments in months to ensure that all curre who have elected hospice services whose weight was taken more 30days prior to the ARD of the	nd infection rately for 23, an audit et (MDS) Minimum in the last 3 nt residents vices and	
		d the Nurse Consultant were		assessment have section K020 Weight coded accurately. Out		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING				C 09/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	00/2020
				3	10 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 641	Continued From page		F	641			
	interviewed on 1/26/2				hospice residents, 3 assessments for 3		
		that he expected the MDS			hospice residents were modified to refl		
	assessments to be a				accurate data for section K0200B: Wei		
		originally admitted to the			due to inaccuracy. This was completed	d	
	, -	His diagnoses included			on 02/22/2023.		
	•	e malnutrition, history of a			2 Magauras /Systemia shangas to		
	stroke and diabetes t	ype 2.			<ol><li>Measures /Systemic changes to prevent reoccurrence of alleged deficie</li></ol>	nt	
	A quarterly Minimum	Data Set (MDS)			practice:	111	
		9/23 indicated Resident			practice.		
		ed as 141 pounds as well as			On 02/23/2023, The Registered Nurse		
	weight loss present.				(RN) Minimum Data Set (MDS)		
					Coordinator and MDS Support nurse a	nd	
	Resident #12's weigh	nt data was reviewed and			any other Interdisciplinary team member	er	
	revealed his last reco	orded weight was 140.8			that participates in the MDS assessme	nt	
		7/26/22. No weights had			process was in serviced /educated by t	:he	
	been noted as measu				Director of Nursing. The education		
		k period (specific time			focused on: The facility must ensure th		
		n included in the MDS			each assessment accurately reflects the	e	
	ending on the assess	sment date).			resident⊡s status. Section H0300:	. :£	
	On 1/24/23 at 2:00 P	M. an intension was			Urinary Continence. Code 9, not rated during the 7-day look-back period the	: 11	
	conducted with the D				resident had an indwelling bladder		
		ssessment dated 1/9/23 as			catheter, condom catheter, ostomy, or	no	
		ta for Resident #12. The			urine output (e.g., is on chronic dialysis		
		cated the weight had been			with no urine output) for the entire 7 da		
		weight data should have			Section I2500: wound infection (other t		
	been entered.	-			foot). There are two look-back periods	for	
					this section: Diagnosis identification (S	tep	
		vith the Administrator #1 on			1) is a 60-day look-back period.		
		he indicated it was his			Diagnosis status: Active or Inactive (St		
	•	DS assessment to be coded			2) is a 7-day look-back period (except		
	accurately.				Item I2300 UTI, which does not use the		
					active 7-day look-back period). Identify		
					diagnoses: The disease conditions in the		
					section require a physician-documente diagnosis (or by a nurse practitioner,	u	
					physician assistant, or clinical nurse		
					specialist if allowable under state		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED			
		345532	B. WING		C			
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE  310 COMMERCE DRIVE  SANFORD, NC 27332				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOL  CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION			
F 641	Continued From pag	e 54	F 64	licensure laws) in the last 60 days. Determine whether diagnoses are Once a diagnosis is identified, it medetermined if the diagnosis is active. Active diagnoses are diagnoses the a direct relationship to the resident current functional, cognitive, or most behavior status, medical treatment nursing monitoring, or risk of death the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident current status, or do not drive the resident plan of care during the look-back period, as these would be considered inactive diagnoses. Chefollowing information sources in the medical record for the last 7 days to identify active diagnoses: transfer documents, physician progress not recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor sorder consults and official diagnostic repand other sources as available. If resident is receiving antibiotic treat for a wound infection, we shall cod Section 12500 wound infection. Section 12500 wound infection. Section 12500 wound infection. Section 12500 wound infection we shall cod section weight consistently over the accordance with facility policy and procedure, which should reflect curstandards of practice (shoes off, etc.) For subsequent assessments, che medical record and enter the weight within 30 days of the ARD of this assessment. If the last recorded weight in 30 days of the ARD of this assessment. If the last recorded weight in the last recorded weight in the last recorded weight in 30 days of the ARD of this assessment. If the last recorded weight in the last recorded weight in 30 days of the ARD of this assessment. If the last recorded weight in 30 days of the ARD of this assessment.	active: ust be e. at have □s od or s, during t  t  s 7-day be neck the e c o tes,  orts, a timent e ection the days. time in  rrent tc.). ck the nt taken			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		C <b>02/09/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LIDEDTY	COMMONO NOO AND DI	THAN OTO OF LEE COUNTY		310 COMMERCE DRIVE		
LIBERTT	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (XE COMPLIANCE CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 641	Continued From page	e 55	F 64	was taken more than 30 days prior to ARD of this assessment or previous weight is not available, weigh the res again. If the resident weight was to more than once during the preceding month, record the most recent weight a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-inform code (-) and document rationale on the resident medical record. This in service was completed by 02/23/2022. Any Registered Nurse (RN) and or Licensed Practical Nurse (LPN) Supp Minimum Data Set (MDS) Coordinate and any other Interdisciplinary team member that participates in the MDS assessment process who did not recein-service training will not be allowed work until training is completed. This information has been integrated into standard orientation training and in the required in-service refresher courses all employees and will be reviewed by Quality Assurance Process to verify the change has been sustained.  4. Monitoring Procedure to ensure the plan of correction is effective and specific deficiency cited remains corrand/or in compliance with regulatory requirements.  To ensure compliance, The Director of Nursing and/or Administrator will reviresident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following the resident electronic medical records.	dent aken  If  ation ae  B.  ort rs  eive to he e for the nat that ected  f ew 5	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345532	B. WING _			l	09/2023
	ROVIDER OR SUPPLIER	HAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332			03/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	÷ 56	F	641	assessments Admission, Annual or Quarterly Assessment to ensure that Section H0300: Urinary Continence, Section I2500: wound infection (other t foot) and section K0200B: Weight are coded accurately. This will be done on weekly basis for 4 weeks then monthly 3 months. The results of this audit will reviewed at the weekly QA Team Meeti Reports will be presented to the weekly QA Committee by the Director of Nursi and/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. Weekl QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Informatic Management), Dietary Manager, Wour Nurse.	for be ing. / ng prs will r the	
F 656 SS=D	CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fac- implement a compreh- care plan for each res- resident rights set for §483.10(c)(3), that in- objectives and timefra	ensive Care Plans cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and	F	656	Date of Compliance: 03/17/2023		3/17/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		C 02/09/2023	
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 02/03/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION	
F 656	assessment. The codescribe the followi (i) The services that or maintain the resist physical, mental, arrequired under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, incluteratment under §4 (iii) Any specialized rehabilitative service provide as a resulter recommendations. findings of the PAS. rationale in the resident's represent (A) The resident's registered outcomes. (B) The resident's putture discharge. Fawhether the resider community was associal contact agence entities, for this pur (C) Discharge plans plan, as appropriate requirements set for section. §483.21(b)(3) The section. §483.21(b)(3) The section. This REQUIREMENTS	tified in the comprehensive omprehensive care plan must ang - t are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required (3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse (83.10(c)(6)). services or specialized es the nursing facility will of PASARR  If a facility disagrees with the ARR, it must indicate its dent's medical record. With the resident and the tative(s)-loals for admission and preference and potential for acilities must document and the sessed and any referrals to lies and/or other appropriate	F 65	The statements made on this Plan o	f	

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 _				09/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIDEDTY				3	10 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY		S	ANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page 58		F	656			
F 656			F	Correction are not an admission not constitute an agreement wire alleged deficiencies.  To remain in compliance with a and State Regulations the facility taken or will take the actions set this Plan of Correction. The Plat Correction constitutes the facility allegation of compliance such the alleged deficiencies cited have will be corrected by the date or indicated.  F656 Develop/Implement Compliance Plan  1. Corrective action for resident affected by the alleged deficient Resident #3: Care plan reviewed revised on 01/26/2023 by interested in the province of the plant that includes supplement oxygen therapy. Resident #16 reviewed and revised on 01/26 interdisciplinary team. Resident comprehensive care plan that in actual pressure ulcer.  2. Corrective action for resident potential to be affected by the adeficient practice.		al n ive ee: ary	
	nasal cannula was in  An additional observa of Resident #3 reveal	supplemental oxygen via use.  Ition on 01/25/23 at 9:13 AM ed resident to continue to gen via nasal cannula.			supplemental oxygen and who have actual pressure ulcers/injury have the potential to be affected by the alleged practice. On 2/22/2023, an audit was completed by Mini Data Set (MDS) Nur Consultant to review all current residen		

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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 _				09/ <b>2023</b>
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	, <u>v=</u>	
				31	10 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			ANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
F 656	During an interview of the MDS Nurse reveated plan should have been was order. Not having plan was an oversight.  An interview with the 01/26/23 at 8:55 AM was responsible for unclinical team has a midiscusses new orders #3's new oxygen order discussed, and the Middle taken note to create at the taken note to	n 01/26/23 at 10:21 AM with aled an oxygen therapy care in initiated when the oxygen g an oxygen therapy care t.  Director of Nursing #1 on revealed the MDS Nurse pdating care plans. The orning meeting that is. In the meeting Resident er would have been DS Nurse should have a care plan for oxygen  with Administrator #1 on he indicated Resident #3 imprehensive care for therapy and care plans en there were new orders admitted on 7/24/19 with sof Dementia, Congestive Kidney Disease, Coronary steoporosis.		656	with orders for supplemental oxygen therapy. Out of a total number 11 residents with supplemental oxygen therapy, 5 did not have oxygen therapy, 5 did not have oxygen therapy care plan. All current residents with supplemental oxygen therapy have an oxygen therapy care plan in place. Thi was completed on 02/22/2023. On 2/22/2023, an audit was completed by Mini Data Set (MDS) Nurse Consultant review all current residents with pressu ulcers/injury. Out of a total number 11 residents with actual pressure ulcers, 0 did not have actual pressure ulcer/injur plan. All current residents with actual pressure ulcer, have an actual pressure ulcer care plan in place. This was completed on 02/22/2023.  3. Measures /Systemic changes to prevent reoccurrence of alleged deficie practice:  On 02/22/2023, The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment	s to re y e	July
	last revised on 10/6/2 ulcers but was not ca	re planned on 9/17/19 and If for a risk of pressure re planned for the presence ulcer that developed on			process was in serviced /educated by t Director of Nursing. The education focused on: The facility must develop a implement a comprehensive person-centered care plan for each resident, consistent with the resident		
		m Data Set (MDS) dated e was coded for one stage 4			rights set forth and that includes measurable objectives and timeframes meet a resident s medical, nursing an mental psychosocial needs that are identified in the comprehensive		

Facility ID: 980156

PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING				09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332			03/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 656	An interview was cor AM with the MDS Nu Consultant. She stat oversight, but Reside care planned for the Senior Nurse Consul were received, the ex	enpleted on 1/26/23 at 10:21 erse and the Senior Nurse end she felt it was an ent #16 should have been actual pressure ulcer. The tant stated when new orders expectation was the new every day to ensure the	F	plases or properties of properties or proper	esessment. The comprehensive care an must describe the following: the ervices that are to be furnished to atta maintain the resident shighest acticable physical, mental, and sychosocial wellbeing; and any service at would otherwise be required but a sot provided due to the resident stercise of rights, including the right to fuse treatment; and any specialized ervices or specialized rehabilitative ervices the nursing facility will provide result of PASARR recommendations and after consultation with the resident of the resident so are residents goals for admission and esired outcomes, the resident seference and potential for future scharge, and discharge plans. A sumprehensive person centered care pust be reviewed and implemented for sidents with supplemental oxygen erapy and with actual pressure cers/injury. This in service was sampleted by 02/22/2023. Any MDS are (full time, part time, and PRN) are ember of the interdisciplinary team were donot receive in-service training will not eallowed to work until training is sampleted. This information has been the tegrated into the standard orientation arining and in the required in-service fresher courses for all employees and the reviewed by the Quality Assurar roces to verify that the change has been sustained.  Monitoring Procedure to ensure that e plan of correction is effective and the	eas re o e as rt on plan r all	

Facility ID: 980156

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 <b>09/2023</b>
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		<u>  02/</u>	09/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page 61		F 65		specific deficiency cited remains correct and/or in compliance with regulatory requirements.  To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will observe 5 residents with supplemental oxygen therapy and actual pressure ulcers/injury to ensure that call plan is implemented. This will be done weekly basis for 4 weeks then monthly 3 months. The results of this audit will reviewed at the weekly QA Team Meeting Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinate to ensure corrective action initiated as appropriate. Any immediate concerns to be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Informatic Management), Dietary Manager, Woun		
F 657 SS=D	be-	(i)-(iii)	Fe	657	Date of Compliance: 03/17/2023		3/17/23

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 02/09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	02/03/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 657	includes but is not lin (A) The attending phy (B) A registered nurs resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practive resident and the An explanation must medical record if the and their resident reprotent practicable for the resident's care plan. (F) Other appropriate disciplines as determor as requested by the (iii) Reviewed and reviewed	ssessment.  terdisciplinary team, that nited to ysician.  e with responsibility for the  d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident oresentative is determined dedevelopment of the  e staff or professionals in ined by the resident's needs are resident. Fised by the interdisciplinary resment, including both the quarterly review  f is not met as evidenced fiew and staff interview, the w and revise the care plan in itus (Resident #45) and dent #12) for 2 of 20 sampled fier plans were reviewed.  stadmitted to the facility on diagnoses including of the prostate.  bysician's order dated	F 65	The statements made on this Plat Correction are not an admission to not constitute an agreement with talleged deficiencies. To remain in compliance with all Federal and Se Regulations the facility has taken take the actions set forth in this Plate Correction. The Plan of Correction constitutes the facility's allegation compliance such that all alleged deficiencies cited have been or with corrected by the date or dates individually and Revision and Revision compliance Plan Timing and Revision.	tate or will an of n of II be icated.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		345532	B. WING _			02/	09/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONE NEC AND DE	THAP CTP OF LEE COUNTY		3	10 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		S	SANFORD, NC 27332		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOUL		E	(X5) COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
F 657	Continued From page	e 63	F 6	357			
	(CPR)/Full code.				Corrective Action:		
	,				Resident #45: Care plan reviewed and		
	Resident #45's advar	nce directives dated 9/22/22			revised on 01/26/2023 by interdisciplin		
	listed as Full code.				team. Resident does not have a care p	lan	
					for DNR.		
	Resident #45's care p	olan dated 10/13/22 was			Resident #12: Care plan reviewed and		
	reviewed. The care p	olan problem for the code			revised on 01/26/2023 by interdisciplin	ary	
	status was "I have a l	Do Not Resuscitate (DNR)			team. Resident does not have a care p	lan	
		wishes for healthcare should			for Dialysis		
	I become unable to m	nake decision for myself".			Identification of other residents who ma	ау	
					be involved with this practice:		
	The Minimum Data S	•			All current residents with advance		
		23 at 10:42 AM. The MDS			directives/code status and who receive		
		dent #45's orders and			dialysis have the potential to be affected	ed .	
		nd verified that the resident's			by the alleged practice.	_	
		code. She stated that the			On 2/22/2023 an audit was completed		
	-	forth on the resident's code			Mini Data Set (MDS) Nurse Consultan		
		that she did not have			review all current residents with Do No		
		it's advance directive, it was			Resuscitate orders. Out of a total numl	ber	
	I -	office, and she missed the			21 residents with Do Not Resuscitate		
	order for the Full code	e.			orders, 2 did not have do not resuscita care plan. All current residents with do		
	Administrator #1 and	the Nurse Consultant were			resuscitate orders have a care plan in		
	interviewed on 1/26/2	23 at 12:54 PM. The			place. This was completed on 02/22/20	)23.	
	Administrator stated t	that he expected the care			On 2/22/2023 an audit was completed	by	
	plan to be reviewed a	and revised as needed.			Mini Data Set (MDS) Nurse Consultant	t to	
	2. Resident #12 was	originally admitted to the			review all current residents on dialysis.		
		lis diagnoses included			Out of a total number 3 residents with		
	diabetes type 2 and h	nistory of a stroke.			dialysis, 0 did not have a dialysis care		
					plan. All current residents with dialysis		
	The medical record for				have an dialysis care plan in place. Th	IS	
		indicate he had received			was completed on 02/22/2023.		
	dialysis since admiss	ion the facility.			Systemic Changes:		
					On 02/23/2023 The Registered Nurse		
		care plan, last reviewed			(RN) Minimum Data Set (MDS)		
	· ·	focus area for risk for			Coordinators and any other		
	I -	opment due to decreased			Interdisciplinary team member that		
		nemiparesis of the left side.			participates in the MDS assessment		
	One of the intervention	ons read "observe my skin			process was in serviced /educated by		

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 02/09/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2020
				3	10 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		s	SANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page		F 6	657			
	Inform nurse if any ar	as upon return from dialysis. reas noted." AM, an interview occurred			Director of Nursing.  The education focused on: The facility must develop, implement, review and revise a comprehensive person-center.	ed	
	reviewing Resident#	ta Set (MDS) nurse. After 12's care plan and medical he had never received			care plan for each resident, consistent with the resident rights set forth and the includes measurable objectives and	at	
		vention was placed on his			timeframes to meet a resident's medica nursing and mental psychosocial need that are identified in the comprehensive	S	
	at 12:51 PM, and indi	was interviewed on 1/26/23 icated it was his expectation e an accurate representation			assessment. The comprehensive care plan must describe the following: the services that are to be furnished to atta		
	of the resident.				or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing; and any service	es	
					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 t residents goals for admission and desi outcomes, the resident's preference ar	red	
					potential for future discharge, and discharge plans. A comprehensive percentered care plan must developed,	son	
					implemented, reviewed and revised up admission, readmission and with any change in condition.	on	
					This in service was completed by 02/22/2023. Any MDS nurse (full time,		
					part time, and PRN) and member of the interdisciplinary team who did not recein-service training will not be allowed to	ve	
					work until training is completed. This		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C	2/2022
NAME OF D	ROVIDER OR SUPPLIER	0 <del>1</del> 0002	5:	STREET ADDRESS, CITY, STATE	ZID CODE	02/09	9/2023
NAME OF T	TOVIDEIT OIT 301 1 EIEIT		310 COMMERCE DRIVE		., ZII CODL		
LIBERTY	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY	SANFORD, NC 27332				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI ID TO THE APPROPRIA ICIENCY)	_	(X5) COMPLETION DATE
F 657 SS=D	CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily I	er Dependent Residents  ent who is unable to carry iving receives the necessary good nutrition, grooming, and	F 6	information has been standard orientation to required in-service ref all employees and will Quality Assurance Prothe change has been Monitoring:  To ensure compliance Nursing and/or Assista Nursing will observe 5 code status and dialysta care plan is reviewed done on weekly basis monthly for 3 months. audit will be reviewed Team Meeting. Report to the weekly QA Combirector of Nursing and (MDS) Coordinators to action initiated as appimmediate concerns which is allowed at the Week Meeting. Weekly QA Combirector of Nursing or appropriate action. Comonitored and ongoin reviewed at the Week Meeting. Weekly QA Combirector of Nursing or appropriate action. Comonitored and ongoin reviewed at the Week Meeting. Weekly QA Combirector of Nurse, Thera Information Managem Manager, Wound Nur Date of Compliance: Co	raining and in the fresher courses for the reviewed by the coess to verify the sustained.  It is a Director of ant Director of	be b	1/17/23

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		C 02/09/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/09/2023
				310 COMMERCE DRIVE	
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.75
F 677	Continued From page	e 66	F 677	7	
	personal and oral hyg This REQUIREMENT by:	giene; is not met as evidenced			
		ns, record reviews, resident		The statements made on this plan of	
		he facility failed to trim and		correction are not an admission to and	do
		dents' nails (Residents #10		not constitute an agreement with the	
		o provide incontinent care of 8 residents reviewed for		alleged deficiencies.  To remain in compliance with all federa	al
	Activities of Daily Livi			and state regulations the facility has ta	
	7 touvilloo of Bally Livi			or will take the actions set forth in this	
	The findings included	:		plan of correction. The plan of correct	ion
				constitutes the facility□s allegation of	
	1. Resident #10 was admitted to the facility on			compliance such that all alleged	
	muscle weakness and	s that included a stroke,		deficiencies cited have been or will be corrected by the dates indicated.	
	muscie weakiless am	d diabetes type 2.		corrected by the dates indicated.	
	A quarterly Minimum			F677	
		7/23 indicted Resident #10			
	had moderately impa			Corrective action for resident(s)	
		of care. She required limited ce from staff for personal		affected by the alleged deficient practi	ce:
	hygiene and bathing			For resident #10, on 01/26/2023 nail c	are
	nygione and battling	idoko.		was provided and documented by the	
	A review of Resident	#10's active care plan, last		nurse. For resident #12, on 1/26/2023	
		luded a focus area for ADL		nail care was provided and documente	
	self-care performance	e deficit. One of the		by the hall nurse. For resident # 46, o	
		d to check nail length and		01/24/2023 incontinent care was provi	
		essary. Report any changes		and documented by the Certified Nurs	ing
	to the nurse.			Assistant.	
	A review of Resident notes from 11/1/22 to refusals of nail care d			2. Corrective action for residents with potential to be affected by the alleged deficient practice.	the
	An observation occur	red of Resident #10 on		Beginning on 02/24/2023, the nurse	
		hile she was lying in the		manager began auditing all current	
		ed with short fingernails to		residents for the need of nail care. Th	is
	both hands; however	, they had a dark substance		audit will be completed by 03/06/2023.	
	under them and the ri	ight first fingernail was		Nail care was provided to those reside	nts

Facility ID: 980156

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			1	09/ <b>2023</b>
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	03/2020
					10 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			SANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE
F 677	Continued From page	e 67	F 6	677			
	AM while lying in bed	served on 1/24/23 at 8:38 . Her nails to both hands			identified in need of nail care. For curr residents, the Certified Nursing Assistants□ were educated by the nurs manager on 02/24/2023 that nail care in the provided during daily activities of the	se s to	
		from previous observation.  AM, Resident #10 was			be provided during daily activities of da living care and whenever necessary ar documented when completed. The nu	nd	
	observed sitting on th				is to notified if the resident refuses. The		
		ands remain with a dark			will be completed by 03/06/2023.		
	substance under them as well as the right first fingernail was jagged.				Beginning on 02/24/2023, the nurse		
					manager began auditing all resident⊡s that required incontinent care. This au		
	On 1/25/23 at 11:30 A	AM, an interview occurred			was completed on 03/06/2023. Reside	ents	
	with Nurse Aide (NA)	#2 who was familiar with			requiring incontinent care during the au	ıdit	
	Resident #10. She st	tated she was not assigned			incontinent care was provided. For		
		nil care should be rendered			current residents, the Certified Nursing		
		during personal care if the			Assistants were educated by the nurse		
		ne was unable to state why			manager on 02/24/2023 that incontiner		
	her nail care had not	been completed.			care is to be provided every 2 hours ar when ever necessary. This is to be	nd	
		ed on 1/25/23 at 3:28 PM			documented when completed and the		
		ssigned to care for Resident			nurse notified if the resident refuses. T	he	
		wers and personal care			will be completed 03/06/2023.		
		ed. During an observation of			3. Measures /Systemic changes to		
		nails, the NA confirmed the			prevent reoccurrence of alleged deficie	ent	
		as jagged and both hands			practice:		
		inder the nails. She added			0 00/00/0000 // 5: / 51/		
		he need during Resident			On 02/23/2023, the Director of Nursing		
	#10's morning care.				and/or RN Manager began education to		
	The Director of Nursi	ng #1 was interviewed on			all full time, part time, and PRN Nurses and CNA□s on the following: nail care	•	
		and stated she was not			should be performed daily with		
		for nail care from Resident			baths/showers and as needed, incontir	nent	
		was needed. She added that			care is to be provided every 2 hours or		
		gernails to be observed on			needed. Refusal of any care by the	us	
		ing personal care with nail			resident is to be documented and the		
	care rendered as nee	<del>-</del> ·			nurse notified. This information has be	en	
	Sale religioned as fice				integrated into the standard orientation		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345532	B. WING				09/2023
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	03/2023
					10 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			ANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page 68		F	677			
	10/11/21 with diagnos affecting the left side A review of Resident	#12's active care plan, last			training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Qua Assurance process to verify that the change has been sustained. The facili specific in-service will be provided to al agency Nurses and CNA  service	ty	
	reviewed 11/22/22, included a focus area for ADL self-care performance deficit related to hemiplegia. One of the interventions included to check nail length and trim and clean as necessary. Report any changes to the nurse.				residents care in the facility. As of 3/17/2023 any nursing staff who does receive scheduled in-service training w not be allowed to work until training has	ill	
	had moderately impa extensive assistance hygiene tasks.	9/23 indicated Resident #12 ired cognition and required from staff for personal			4. Monitoring Procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements.	nat	
	A review of Resident notes from 11/1/22 to refusals of nail care d				The Director of Nursing and/or designe will monitor compliance utilizing the F6 Quality Assurance Tool weekly for 4		
	1/23/23 at 10:00 AM was observed to have hands with a dark sul	red of Resident #12 on while he was lying in bed. He long fingernails to both ostance under them.  ne didn't like his nails as long			weeks then monthly x 3 months or until resolved. The Director of Nursing will reare compliance and timely incontinent care. Reports will be presented to the weekly Quality Assurance committee be the Director of Nurses to ensure corrective action is initiated as	nail	
	AM while lying in bed remain unchanged fro	served on 1/24/23 at 9:00 . Fingernails to both hands om the previous observation.			appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed no	t	
	observed lying in bed	AM, Resident #12 was . Fingernails to both hands rk substance underneath			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	the S	
	On 1/25/23 at 11:30 A	AM, an interview occurred			Manager.		

Facility ID: 980156

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			1	C 09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		31	TREET ADDRESS, CITY, STATE, ZIP CODE O COMMERCE DRIVE ANFORD, NC 27332	1 02/	03/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	Resident #12. She se to care for him, but non shower days and need was present. Shis nail care had not NA #1 was interview and stated she was a #12. She explained completed during she when there was a ne Resident #12's fingel were long with a dark stated she had not not resident #12's morn. The Director of Nursi 1/26/23 at 10:00 AM aware of any refusals #12 or that nail care she would expect fins shower days and dur care rendered as need 3. Resident #46 was 12/7/22 with multiple pressure ulcer. The Set (MDS) assessment that Resident #46 had that was present on a incontinent of bowel extensive assistance.	#2 who was familiar with tated she was not assigned ail care should be rendered during personal care if the he was unable to state why been completed.  ed on 1/25/23 at 3:28 PM assigned to care for Resident nail care should be owers and personal care ed. During an observation of mails, the NA confirmed they a substance under them and oticed the need during ing care.  Ing #1 was interviewed on and stated she was not is for nail care from Resident was needed. She added that gernails to be observed on ing personal care with nail eded.  Is admitted to the facility on diagnoses including admission Minimum Data ent dated 12/14/22 indicated do a stage IV pressure ulcer admission, was always and bladder and he needed with personal hygiene. The indicated that he did not have	F	577	Date of Compliance: 03/17/2023		
	bladder. The goal w	incontinent of bowel and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345532	B. WING			C 2/09/2023
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 3	2/03/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 677	677 Continued From page 70		F 67	77		
	throughout shift for i	luded to check frequently ncontinence and "I wear at all times and need ncontinent care".				
	AM during a dressin Nurse repositioned there were 3 cloth p resident. The Wour pad was soaked with change, Nurse Aide provide the incontine	bserved on 1/24/23 at 9:45 g change. When the Wound the resident to his left side, ads observed underneath the ad Nurse verified that the top th urine. After the dressing (NA) #6 was observed to tent care. The resident's also observed soaked with				
	She stated that she #46. She reported the unable to provide insince the resident with the night shift. Note that the night shift is care was not provide entire shift. Note the resident for but the resident was that she had not information.	was assigned to Resident nat the night shift NA was continent care to the resident as combative. She stated A did not specify if incontinent ed on their last round or the idicated that she tried to or incontinence this morning, a combative. She indicated ormed the nurse that the tive. The NA did not explain rm the nurse.				
	interviewed on 1/24/ that NA #6 did not in was combative and Nurse #4 reported th Resident #46 to be of She stated that she	to Resident #46, was 23 at 10:15 AM. She stated aform her that Resident #46 refused incontinence care. hat she had not known combative nor refused care. expected the NAs to notify resident refused care or was				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	(X3) DATE SURVEY COMPLETED		
		345532	B. WING		C <b>02/09/2023</b>	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 02:03:2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 684 SS=D	that she had not know combative during care expected NAs to notificate resident was combative expected incontinent least every 2 hours an Administrator #1 and interviewed on 1/26/2 Administrator stated to check and to provide every 2 hours and as nurses when a residerefused care. He also the NA to leave the resideresident expected in the NA to leave the resident expected in the NA to leave the NA to l	ng (DON) #1 was 3 at 9:31 AM. She stated on Resident #46 to be e. She indicated that she by the nurses when a ove or refused care. She e checks/care provided at and as needed.  the Nurse Consultant were 3 at 12:54 PM. The hat he expected NAs to incontinence care at least needed and to inform the ont was combative and o indicated that he expected esident and to come back and to try other options to	F 68	77	3/17/23	
	applies to all treatment facility residents. Bas assessment of a resident residents receive accordance with profepractice, the comprehate plan, and the resident REQUIREMENT by:  Based on record revious Wound Physician interests.	ndamental principle that int and care provided to ed on the comprehensive dent, the facility must ensure iteratment and care in essional standards of itensive person-centered sidents' choices. It is not met as evidenced ew, observations, staff and erviews, the facility failed to its ordered by the Wound		The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		C 02/09/2023	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/03/2023	
TO UNIC OF TH	TO VIDER OR GOLF EIER			310 COMMERCE DRIVE		
LIBERTY (	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332		
				SANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475	
F 684	Continued From page	e 72	F 684	4		
	extremity (Resident # reviewed for well-beir	10) for 1 of 3 residents ng.		To remain in compliance with all federa and state regulations the facility has ta or will take the actions set forth in this		
	The findings included:  Resident #10 was admitted to the facility on 7/8/20 with diagnoses that included a stroke, diabetes type 2 with Peripheral Arterial Disease.			plan of correction. The plan of correction constitutes the facility ☐s allegation of	on	
				compliance such that all alleged		
				deficiencies cited have been or will be		
				corrected by the dates indicated. F684		
	Review of the Wound	l Physician's report titled		Corrective action for resident(s)		
	"Wound Evaluation and Management Summary" dated 12/6/22 revealed the right first toe wound measured 2 centimeters (cm) in length and 2.5			affected by the alleged deficient practic	ce:	
				On 02/24/2023, the wound treatment		
		er was to apply Skin Prep to		nurse completed a wound assessment	on	
	the area every shift.	,		Resident #10 to ensure there were no		
				identified change of condition to the		
	Review of the Wound	l Physician's report titled		wound. On 02/24/2023, the Director o	f	
	"Wound Evaluation a	nd Management Summary"		Nursing reviewed resident #10 Treatm	ent	
	dated 12/27/22 revea	lled the right first toe wound		Administration Record to ensure that		
	measured 3.5 cm in l	ength and 2.5 cm in width.		resident wound care on the Treatment		
	The order was to app	ly Skin Prep to the area		Administration Record was transcribed		
	every shift.			correctly. On 2/24/2023, the Director	of	
				Nurses/RN Manager audited resident	#10	
		Treatment Administration		treatment orders for the last 7 days to		
		ed an order to apply Skin		assure treatments were documented a	s	
	Prep to the right first	toe every shift for wound.		administered.		
	A review of the quarte	erly Minimum Data Set		2. Corrective action for residents with	the	
	(MDS) assessment d	ated 1/7/23, indicated		potential to be affected by the alleged		
	Resident #10 had mo	derately impaired cognition		deficient practice.		
	and displayed no beh	naviors or refusal of care				
	_	period. She was coded with		All residents with wound care orders h		
	diabetic foot ulcers ar	•		the potential to be affected by the alleg		
		ne bed/chair and application		deficient practice. On 02/24/2023, the		
	of dressings to the fe	et.		Director of Nursing/RN manager review		
				all current wound care orders to ensur		
	A review of Resident			they were transcribed accurately on th		
		ealed an order, dated 1/8/23,		Treatment Administration Record. This		
	to cleanse the right fi	rst toe with wound cleanser		was completed on 0/24/2023. The res	ults	

Facility ID: 980156

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING				C 09/2023	
NAME OF P	ROVIDER OR SUPPLIER		<del> </del>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	09/2023	
	101.52.1.01.100.1.2.2.1				10 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			ANFORD, NC 27332			
040.15	CLIMMADY CT	ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<			(X5) COMPLETION DATE	
F 684	684 Continued From page 73		F 6	84				
	and apply Betadine every shift for wound care.				included: no other issues identified. C 02/24/2023, the Director of Nurses/RN			
		d Physician's report titled nd Management Summary"			Manager reviewed the last 7 days of ordered wound treatments for			
	dated 1/10/23 revealed	ed the right first toe wound			documentation of completion on the			
	measured 1 cm in length and 2.2 cm in width.				treatment administration record. The			
	The order read to app 30 days.	Betadine once a day for			results included: no other issues identified.			
	Review of the active	care plan, last reviewed			3. Measures/Systemic changes to			
	1/12/23, revealed a focus area for having a diabetic ulcer related to diabetes, lack of sensation to the affected area, poor glycemic				prevent reoccurrence of alleged deficie	ent		
					practice:			
		insufficiency to the right first			On 2/24/2023 the Nurse Consultant			
	toe and left and right				Oprovided in-service education to			
		reat the wound as per facility			management nurses (Director of Nursi			
	protocol.				RN Manage, minimum data set nurse a	and		
	A massiasse of the 10/asse	al Disconsissionale manage to the al			Administrator) and beginning on			
		d Physician's report titled nd Management Summary"			2/24/2023 the Director of Nurses/RN Manager began education with all			
		ed the right first toe wound			licensed nurses, to include agency.			
		ength and 2.4 cm in width.			Topics included: Treatment Process,			
		oly Betadine once a day for			Orders are to be transcriber timely and			
	23 days.	,			accurately to the Treatment Administra			
					Record, Daily clinical review of all New			
	A review of the Janua	ary 2023 TAR for Resident			Wound Care orders to ensure they are			
	#10, did not reveal a	change in the treatment			transcribed correctly to the Treatment			
	order as recommende	ed on 1/10/23 by the Wound			Administration			
	Physician.				Record/Medication/Treatment			
					Administration, A second Nurse review	'S		
		ng progress notes from			the New wound Care orders are	rrectly, Administered		
	12/1/22 to 1/25/23 reversely refusals of wound car	vealed no documented			transcriber correctly, Administered			
	relusais of Wound Cal	e ioi Resident #10.			treatments are to be documented			
	   On 1/24/23 at 8⋅38 ∧	M, wound care observation			following completion of the ordered treatment, If a treatment is missed the			
		he Wound Physician and the			MD/RP are to be notified and a treatme	≏nt		
		Vound Nurse was observed			error report completed, Documentation			
		wrap from Resident #10's			administered treatments are to be	J1		
		ness or odor present. The			reviewed in the Daily Clinical Meeting.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(	С	
		345532	B. WING _			02/	09/2023	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
LIDEDTV	COMMONS NEC AND	DELIAD CTD OF LEE COLINTY		31	0 COMMERCE DRIVE			
LIDERIT	COMMONS NSG AND	REHAB CTR OF LEE COUNTY		SA	ANFORD, NC 27332			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 684	Continued From p	age 74	F	684				
	Wound Physician	measured the end of the right			This information has been integrated in	ıto		
	first toe at 1.3 cm	in length and 2 cm in width.			the standard orientation training and in	the		
	The Wound Nurse	cleansed the area, applied			required in-service refresher courses for	or		
	Betadine, and wra	pped the foot with gauze.			all nurses and management nurses as			
					identified above and will be reviewed b	y		
		was interviewed on 1/25/23 at			the Quality Assurance process to verify			
		ed that she rounded weekly			that the change has been sustained. A	lny		
		hysician and ensured the orders			applicable staff who does not receive			
		ne "Wound Evaluation and			in-service education by 3/17/2023, will	not		
	_	nmary". This summary was			be allowed to work until training been			
		cility within 24 hours after the			completed.			
	_	s visit. She reviewed Resident						
		cian Orders as well as the			4. Monitoring Procedure to ensure tha			
		n and Management Summary" /10/23. The Wound Nurse			the plan of correction is effective and the			
					specific deficiency cited remains correct	ilea		
		ect order was present for the nd and felt it was an oversight.			and/or in compliance with regulatory requirements.			
	right hist toe woul	id and left it was all oversight.			requirements.			
	A phone interview	was conducted with the Wound			The Director of Nursing or designee wi	II		
		/23 at 2:15 PM. She explained			monitor the transcription of new wound			
	1 -	ility once a week to assess and			care orders on the Medication/Treatme			
		for residents that were on her			documentation during clinical meeting	to		
	caseload. The Wo	ound Nurse rounded with her			ensure timely accurate transcription.			
	where he relayed	the measurements as well as			second Nurse is to verify the transcript	ion		
	any changes to th	e treatment orders. She stated			of the new order is accurately transcrib	ed.		
	she thought the nu	urse was reviewing the			The F 684 Quality Assurance tool will be	е		
	treatment orders f	or accuracy from week to week			completed daily for 4 weeks then mont	•		
	•	facility to follow her			for 3months or until resolved. Reports	will		
		unless the Medical Director			be presented to the weekly Quality			
	_	ie Wound Physician stated			Assurance committee by the Administr	ator		
		been no negative outcomes to			to ensure corrective action initiated as			
		atments according to the			appropriate. Compliance will be monito			
	December 2022 T	AR.			and ongoing auditing program reviewe			
	The Direct Co.				the weekly Quality Assurance Meeting			
		ursing #1 was interviewed on			The weekly Quality Assurance Meeting			
		M and stated she would have			attended by the Administrator, Director	of		
	l .	and Nurse to review and revise			Nursing, MDS Coordinator, Therapy,			
	the wound orders				Health Information Manager, and the			
	recommendations	by the Wound Physician.		- 1	Dietary Manager.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345532	B. WING			C 02/09/2023	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		02/00/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	Continued From page 75 F 684		4				
F 686 SS=K	Treatment/Svcs to Pr CFR(s): 483.25(b)(1)	revent/Heal Pressure Ulcer (i)(ii)	F 68	Date of Compliance: 03/17/2023	3	3/17/23	
	resident, the facility r (i) A resident receive professional standard pressure ulcers and of ulcers unless the ind demonstrates that the (ii) A resident with professional standard promote healing, pre new ulcers from deverance healing, pre new ulcers f	ehensive assessment of a must ensure that- is care, consistent with a fixed practice, to prevent adoes not develop pressure vidual's clinical condition and sesure ulcers receives and services, consistent adards of practice, to went infection and prevent aloping.  To is not met as evidenced a fiew, observation and pedic Physician Assistant and Physician Assistant and Physician, Medical and Physician (DON) #2, and Physician (NP) #2 and and to prevent the		The statements made on this p correction are not an admission not constitute an agreement wit alleged deficiencies.  To remain in compliance with al and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility □s allegat compliance such that all alleged deficiencies cited have been or corrected by the dates indicated F686  1. For resident #16, a correcti was obtained on 2/02/2023 and residents #12, #45 and #46 corraction was obtained on 02/24/2	to and do h the  I federal h has taken in this correction ion of d will be d.  I federal h has taken in this correction ion of d will for for rective		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVI COMPLETED	
	0.45500	D WING		С	
	345532	B. WING _		02/09/20	023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY COMMONS NSG AND	REHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE		
EIDERTT COMMICTO NOC AND	TREMADON OF LEE GOOK!!		SANFORD, NC 27332		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COM	(X5) IPLETION DATE
An unstageable prefull-thickness skin extent of tissue date be confirmed becard obscured by eschasional (yellow tissing granulation tissue) which lumpy, pink connective tissue; edges of a wound/performed. The fawound after 1/17/24 (deep wound read bone) pressure ultiple failed to provide the Resident #45 and mattress was function manufacturer's insignaturer's insi	unstageable pressure ulcer. essure ulcer means a and tissue loss in which the mage within the ulcer cannot nuse the wound bed is ar (dry, dark scab of dead skin), ue that is stingy and thick) and (part of the healing process in tissue containing new and capillaries form around the b. Treatments were not acility failed to assess the 23 and it re-opened as a stage aching the muscle, ligaments of the on 1/24/23. The facility also the eatments as ordered for ensure the alternating air tioning and set according to tructions for Resident #12 and as deficient practice affected 4 of ts reviewed for pressure ulcers	F 6	Resident #16 received a total body assessment on 02/02/2023 by the Director of Nursing (DON). The total skin assessment revealed that Resignal and a treatment wound on the left calf and a treatment was in place the being managed by the treatment in the staff nurse according to the physician sorder.  On 02/03/2023, the Interim Directon Nurses reviewed Resident #16 so and care plan to ensure preventation measures were currently in place to prevent new skin issues and worse current wounds.  On 01/27/2023, the nursing team of the resident sweight and adjusted alternating pressure reducing air mosetting accordingly to assure each set correctly for resident #12 and #12 On 01/24/2023, the assigned nurse completed the ordered treatment for resident #45.  Corrective action for residents the potential to be affected by the adeficient practice.  All residents have the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice by completing total body sessessments on all current resident 02/03/23. This audit was complete reviewing 100% of current resident identify any residents with new prewounds or skin integrity alterations results included:	nterim I body dent I lateral at was arse or  of rders e ning of erified the attress were H6.  r with lleged e actice. of ents is sin ss on d by st to essure	

Facility ID: 980156

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _				C ( <b>09/2023</b>	
NAME OF PR	ROVIDER OR SUPPLIER	I	<del></del>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2020	
				3	310 COMMERCE DRIVE			
LIBERTY (	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From page	e 77	F 6	386				
	The findings included				Director of Nurses assessed and audit 100% of all current pressure wounds to assure current wound measurements	)		
		admitted on 7/24/19 with s of dementia, congestive			were completed. The results included: On 2/3/2023, the nurse consultant aud			
	_	kidney disease, coronary			100% of all residents with identified	ileu		
	artery disease and os				pressure wounds to assure a current			
	,	•			treatment order was correct and in place	ce		
	Resident #16 was care planned on 9/17/19 for a				on the electronic treatment record. The	е		
	-	s. This care plan was the			results included:			
		ng the survey. Interventions			On 2/3/2023 the Interim DON complete			
		equent position changes and			100% audit of all resident Braden score			
	-	uction and comfort, float her			for risk for pressure ulcers. The results included:			
		e reducing mattress on the ence care as needed and			On 2/03/2023, 100% of residents with			
		mediately of any redness,			pressure wounds or at risk for pressure	<u>د</u>		
	open areas or irritation				ulcers were audited by the Minimum D			
	'				Set nurse to ensure preventative			
					measures were currently in place to			
	The quarterly Minimu	m Data Set (MDS) dated			prevent new skin breakdown and addre	ess		
	6/28/22 indicated Res	sident #16 had severe			the current pressure wound. The resul	ts		
	cognitive impairment,				included:			
		nobility, transfers and			On 03/01/2023, the nursing team audit	ed		
		e was assessed as having			all residents with ordered alternating			
		ght gain and no pressure			pressure reducing air mattresses to			
	ulcers.				assure that the mattress was at the	_		
	A nursing note dated	9/17/22 at 5:20 DM road			correct setting based on the resident weight. Results: As of 03/01/2023 all	5		
		8/17/22 at 5:20 PM read d from the emergency room			residents with ordered alternating			
		left leg immobilizer due to a			pressure reducing air mattresses were	in		
	_	re with orders to wear the			compliance.			
		was evaluated on 9/6/22 by			On 03/01/2023 the Director of Nurses			
		ian and to check her skin			educated the wound nurse on the			
	daily to her left lower				expectation that alternating pressure			
	presence of the leg in	nmobilizer.			reducing mattresses will be set following	-		
					the manufacturer recommends and the	<del>)</del>		
	The electronic medica	• •			resident□s weight.			
		d not include any evidence eft lower leg had any skin			On 03/01/2023, the DON/RN Manager audited administered documented wou			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _				C <b>09/2023</b>
NAME OF PR	ROVIDER OR SUPPLIER		•	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	, , ,	00.2020
				31	0 COMMERCE DRIVE		
LIBERTY (	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		S	ANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page concerns.  An orthopedic PA not Resident #16 was to breakdown due to the Resident #16's Auguincluded an order dat to check her skin for immobilizer use on e Resident #16's Augutreatment administratistaff initials indicating leg under her immobilizer use on et a 2:50 PM with the Vishe thought she recalled yield and the orthopedic Physic orders.  An orthopedic PA not was an observed abrileg. The orthopedic of to pad the area under wound management.	e 78  e dated 8/22/22 read have daily checks for skin e leg immobilizer.  st 2022 Physician orders ted 8/23/22 that read for staff breakdown daily due to	F 6	686		ys.  s  to  at / of ned /e  de	
	9:00 AM with the Orti 9/6/22, he observed a lower leg and wrote of pad the area for prote wound provider for w	nopedic PA. He stated on an area to Resident #16's left on his consult note orders to ection and to consult the			followed. On 02/02/2023, the Interim Director of Nurses/Quality Assurance Nurse Consultant/Senior Regional Staff Education Specialist began in-service of 100% of all licensed nurses, full time, ptime, as needed nurses, including ager	of eart	
	, tolophone line we	THAS COMPLETED ON ZIZIZO AL			and, as necessarial ses, including agei	. Uy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _				C <b>09/2023</b>	
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	03/2023	
				3	310 COMMERCE DRIVE			
LIBERTY (	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From page	e 79	F 6	386				
	· -	und Nurse. She stated she			to include: The Skin			
		Resident #16's 9/6/22			Assessment/Pressure Ulcer Assessme	nt		
	appointment for wour				Process to include how to identify when			
	• •				skin or wound assessment is due to be			
	A form titled "Review	to Ensure Quality Pressure			completed in the electronic health reco	rd.		
	Injury related to Leg I	mmobilizer" dated 9/16/22			Identification of New Orders and Provis	sion		
	read wound care orde	ers given at the orthopedic			of Ordered Treatments.			
	office visit on 9/6/22 v	were not implemented. The			Wound/Skin/Treatment/Order			
form was initiated by DON #2. The form read				Documentation Process. The Post Foll				
		Resident #16 back from her			Up of Appointment Orders Process and	Ł		
		ent on 9/6/22 and she placed			the Order Clarification Process.			
	the consult note with wound care orders in the				Documentation and notification of the			
		to be scanned into the			Administrator/Director of Nurses if a	_		
		cord (EMR). She stated she			treatment cannot be completed for any			
		not recognize that the note entered into the EMR and			reason.	,		
	implemented.	entered into the EMR and			On 02/02/23 education was initiated by the Quality Assurance Nurse Consultar			
	implemented.				for 100% of all licensed nurses, includi			
	The facility was unab	le to provide any contact			agency nurses, on the Nurse Practice	•		
		#14 who was no longer an			and North Carolina Board of Nursing	101		
	agency nurse for the				Position statement on Wound Care.			
	5 ,	,			In addition, on 02/02/23, the Quality			
	A telephone interview	was completed on 2/1/23 at			Assurance Nurse Consultants/ Senior			
	4:50 PM with DON #2	2. She stated nobody knew			Regional Staff Education Specialist be	gan		
	about the area discov	ered at the 9/6/22			direct observation, with return			
	orthopedic appointme	ent until on 9/13/22 when a			demonstration, of how to complete a sl	kin		
		Wound Nurse that there			assessment/wound assessment utilizing			
		from Resident #16's leg			competency check list of the steps of the			
	immobilizer who cons				skin/wound/order/treatment process ar			
	_	ty at the time. She stated			the nurses were instructed to identify o			
		it was determined that			the skin assessment, for residents with			
		plement the wound care			immobilizers/braces, the condition of the			
	orders from the 9/6/2	z orthopedic consult.			skin under or surrounding the immobili	zer		
	The Contember TAD	royaalad ataff initials			or brace. Including notification of the			
	The September TAR				physician and wound nurse for further			
		16's left lower leg under her			assessment and treatment orders for a			
		et from 9/7/22 through			new or worsening changes to the skin.			
	9/12/22.				On 2/2/2023, the Interim Director of Nurses/Quality Assurance Nurse			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG	` '	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		C	200	
NAME OF D	DOMED OF SHEET	343532	D. WING_	OTDEET ADDRESS SITV STATE 71D SODE	02/09/20	)23	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LIBERTY	COMMONS NSG AND	REHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE			
				SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE CON	(X5) MPLETION DATE	
F 686	Continued From p	age 80	F 6	86			
	There were no nu medical record fronursing note date. Resident #16's skirritation to her leg. The daily skin chee 9/6/22 through 9/7 telephone intervie 1:27 PM with Nursoff on 9/7/22 and skin check under immobilizer when interview was conwith Nurse #8. Sh she assessed the immobilizer on 9/8 she did not see ar any open areas, s Charge Nurse or I A weekly skin ass #3 dated 9/9/22 in	rsing notes in the electronic om 9/8/22 through 9/12/22 and a d 9/13/22 at 12:21 PM read in was being monitored for  cks under her immobilizer from 12/22 indicated no concerns. A www.s. completed on 2/2/23 at see #13. She stated she initialed 19/12/22 that she completed the Resident #16's left leg she did not do it. A telephone on 19/12/23 at 1:40 PM e stated she initialed off that skin under Resident #16's leg 19/12/29 and 9/11/29 but only open areas. If she had seen the would have notified the MD #2.		Consultant/Senior Regional Stateducation Specialist began education Specialist began education Aides and agency Nursing Assistants on observir resident skin when providin timely notification of the nurse noted areas of alterations in skin The Certified Nursing Assistant included: what skin integrity cout to be reported to the nurse. The changes such as odor from a wound/swelling/increased redness/pain/drainage from we site/new areas of redness or nurse areas of redness or nurse Consultants began educations in the woor nurse assigned is to comple weekly pressure ulcers assess rounding with the wound doctor nurse is responsible to look at	ucation of c, Certified ng the g care and regarding kin integrity. t education concerns are his includes  bund ew skin  rance cation of all ncy on the und nurse bete the coment after or. The the User		
	completed on 2/2/ She was unable to	elephone interview was 23 at 2:37 PM with Nurse #3. b recall completing Resident assessment on 9/9/22 but		Defined Assessment in the ele medical record in order to com weekly skin assessment timely are to be transcribed by the nu	plete the v. All orders		
	stated she must n Resident #16's lef	ot have seen an open area to t lower leg.		receives the order. If the nurse clarification of the order, the nu contact the physician for clarity	needs urse is to of the		
	2:50 PM with the sassess the area ureported that there immobilizer.	riew was completed on 2/2/23 at Wound Nurse. She did not ntil 9/13/22 when it was e was drainage noted on her leg		order. During morning clinical orders are to be reviewed to e clarity. All Staff would be expedaily monitoring of the high-ris Certified Nursing Assistants are noted skin integrity alterations nurse.	nsure ected to do k skin area. e to report		
		assess Resident #16 for an		As of 2/5/2023, no Licensed N	urses or		

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CENTER	3 FOR MEDICARE &	WEDICAID SERVICES			OND N	<u> </u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			B 14//140			С	
		345532	B. WING		02	/09/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LIBERTY	COMMONS NSG AND R	REHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE			
				SANFORD, NC 27332			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI		(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)	'PROPRIATE	DATE	
F 686	Continued From pag	je 81	F 686				
	_	e to her left lateral calf on		Certified Nursing Assistants will	work		
		ment revealed Resident #16		without the education/training a			
	had an unstageable	pressure ulcer to her left		competency check off list compl			
		erate serosanguinous		is to include agency and new sta			
	(consisting of both b	lood and serous fluid)		Interim Director of Nurses and			
	drainage at least 7 d	lays in duration. The note		Administrator are responsible to	ensure all		
	described the wound	d as measuring 10		staff are educated as well as to			
		5 cm with 5% of thick		monitoring and tracking of susta			
		otic tissue (eschar) 80% thick		compliance for staff that still req			
		necrotic tissue (slough) and		education to include newly hired			
	_	ue. There was no pain		nurses, Certified Nursing Assist	ants and		
		pressure ulcer. The note read		agency.			
		n performed an in-house		After 2/05/23 the Interim Directo			
		ment (removal of dead,		Nursing will be responsible to en	-		
	_	d tissue) of the area with e left lateral calf with wound		new Licensed Nurses, agency a			
		amicin (antibiotic) ointment		Certified Nursing Assistances at educated on the applicable police			
		g agent) and to cover it with a		procedures related to skin/wour			
		dressing made from salts of		and the serious complications the			
		from seaweed) dressing and		occur for failing to identify and to	-		
	wrap with gauze eve	,		wound in a timely manner to inc			
	map mar gaazo ovo	ny day.		completion and documentation			
				wound treatments and appropria			
	Resident #16's cumu	ulative Physician orders		monitoring the functioning/setting	•		
		Physician's new wound care		ordered specialty mattresses.	· ·		
	orders were written of	on 9/13/22.					
				4. Quality Assurance monitori	ng		
	A telephone interviev	w was completed on 2/3/23 at		procedure.			
	8:15 AM with the Wo	ound Physician. She recalled					
		r the beginning of cellulitis so		Utilizing the F686 Quality Assura			
	· •	ed the Gentamycin ointment.		Tool, the Director of Nurses or d			
		identified on 9/13/22 to		will monitor the post appointmen			
		ateral calf was avoidable and		process/treatment administratio			
	-	re ulcer could lead to		documentation process and the			
	· ·	ole osteomyelitis (bone		mattress process for compliance			
	infection).			4 weeks then monthly x 3 month			
				resolved. Appointment follow up			
		w was completed on 2/2/23 at		monitored as part of the Daily C			
	4:41 PM with MD #2	. He stated he thought he		Meeting. Reports will be preser	ited to the		

Facility ID: 980156

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 _				09/ <b>2023</b>
NAME OF P	ROVIDER OR SUPPLIER	l	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	, <u>v</u>	30,2020
				31	10 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			ANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<b>`</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Physician on 9/13/22 pressure ulcer. He star pressure ulcer that de immobilizer was avoid that was not treated viead to infection, sepsible osteomyelitis. A grievance dated 9/2/#16's family member lower calf dated 9/20/Wound Nurse and floand verified the treatr. The facility began aud pressure ulcers for do along with re-education treatment orders frequently and Nurse #14 downd care treatment 9/22/22 but the wound provided.  The facility was unablinformation for Nurse completed Resident #16's TARs through October 2022/22/22 the start of the star	one care from the Wound to discuss Resident #16's ated Resident #16's eveloped underneath an dable and any pressure ulcer would deteriorate and could sis (blood infection) and s.  23/22 indicated Resident found a dressing to her left /22. The grievance read the or staff were interviewed ment was ordered for daily. diting of residents with ocumentation of treatments on to the nurses to follow the uency as ordered.  10 Ensure Quality"  2 dated 9/23/22 read Nurse ocumented Resident #16's ts completed on 9/21/22 and d care treatment was not  1e to provide any contact #14 why documented she #16's stating she was an  2 indicated documented to checks under her left leg mmobilizer was	F	686	weekly Quality Assurance committee be the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Informati Manager, and the Dietary Manager  DOC: 03/17/2023	the e	
	A Wound Physician n	ote dated 12/6/22 read					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			02/	09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, Z 310 COMMERCE DRIVE SANFORD, NC 27332	IP CODE	<u> </u>	03/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 686	Resident #16's left la improved measuring with moderate serous granulation and 50%  A Wound Physician r Resident #16's left la deteriorated from her area measured 5.5 c moderate serosangu granulation tissue an Resident #16's new to 12/14/22 were to cleawound cleaner, apply pad or gel derived frocollagen), cover with multilayer, soft, non-vand secure with gauze Resident #16's Dece administration records	teral calf pressure ulcer had 5.3 cm by 1.3 cm x 0.1 cm s drainage with 50% skin.  note dated 12/13/22 read teral calf pressure ulcer had last visit on 12/6/22. The m by 2.0 cm by 0.1 cm with inous drainage with 70% d 30% skin.  reatment orders dated anse her left lateral calf with a Collagen sheet (sheet, om bovine or porcine an ABD (a highly absorbent, woven moisture barrier) pad the wrap every day.	F	686			
	left lateral calf was con 12/29/22 and 12/31/2 An interview on 1/24/2 completed with the Woof wound care document confirmed she was an 12/28/22 but stated son 12/28/22. She standard the MDS Nuthat day and she assed of the dressing chance.  An interview was con AM with the MDS Nuthal 12/28/29.	/23 at 3:00 PM was //ound Nurse about the lack nentation on 12/28/22. She ssigned Resident #16 on the did not do the treatment ted she was on a medication rese took over around noon umed the MDS Nurse would					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			02/0	9/2023	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332			02/0	312023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTIO			(X5) COMPLETION DATE	
F 686	and she did not completesing change. She a Medication Aide (Mprovide treatments to An interview was con AM with Nurse #4. She with Resident #16 on reported she did not treatments. She state those days and she complete Resident #  A telephone interview at 10:25 AM with Nur worked the evening of She stated she was resident #16's press completed to her left 12/31/22.  A Wound Physician refollows. Resident #1 ulcer 114 days in dur to her left lateral calf scabbed. There were Vaseline or equivaler dressing daily for one #16's January 2023 of and read to start the 7 days.  Review of Resident # orders read a new or	plete Resident #16's e stated she was relieved by A), and she could not pressure ulcers.  Inpleted on 1/26/23 at 10:10 The confirmed she worked 12/29/22 and 12/31/22. She complete her wound ad Nurse #3 relieved her on did not ask Nurse #3 to	F	586				
	cover with a dry dres	sing daily through 1/17/23.  Sonal orders for the area after						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C <b>02/09/2023</b>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	02/00/2020	
LIBERTY	COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE			
LIBERTT	COMMONS NOG AND RI	ENABOTE OF LEE COOK!		SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIA CIENCY)		
F 686	Continued From page	e 85	F 6	586			
	documented evidence completed 1/11/23 the no documented evide wound care was com						
	#5 on 2/2/23 11:54 A completing Resident 1/14/23 and 1/15/23 healing stage. She st						
	at 11:40 AM with the completed Resident a but she did not recall but stated it must have	was completed on 1/26/23 Nurse #8. She stated she #16's wound care on 1/16/23 exactly how the area looked re looked healed since she withing unusual that day.					
	12:00 PM to Nurse #	attempted on 2/2/23 at 12 to inquire why she did not ound care on 1/17/23 but the ox was full.					
	was sitting up in her was member stated she ju appointment with her Observed to Residen dressing dated 1/16/2 been changed since There was old bloody drainage observed or dressing. The family the first time she had pressure ulcer dressi	3 at 11:18 AM. Resident #16 wheelchair and her family ust returned from an orthopedic physician. t #16's left lateral calf was a 23. It appeared to have not 1/16/23 for a total of 7 days.					

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345532	B. WING			C <b>2/09/2023</b>		
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		2/09/2023		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 686	Nurse #3 on 1/21/2: concern.  A telephone intervie at 10:05 AM with Nucompleted Residen 1/21/23. She recalle lower calf, but she con the dressing nor Nurse #3 was informassessment on 1/2: #16's left lower calf the Wound Nurse of the ones to assess.  An interview on 1/2: completed with the completed wound rephysician on Tuesd order for the Vaselin after 7 days, there was physician on 1/10/2 for a surveyor obse	assessment completed by 3 noted an existing skin 2 arse #3. She confirmed she to #16's skin assessment dated and seeing a dressing to her left did not notice the date written did she remove it. When med that at the time of her 1/23, the dressing to Resident was 5 days old. She stated r Wound Physician would be	F 68					
	agreed to get surve Physician's assess 1/24/23.  An observation was AM of Resident #16 dressing previously still in place.  An interview was co PM with DON #1. S	yor prior to the Wound ment was completed on conducted on 1/24/23 at 8:35 is left lateral calf. The old described dated 1/16/23 was empleted on 1/24/23 at 2:50 She stated she received a call office on 1/23/23 who						

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 _				09/ <b>2023</b>	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY			EET ADDRESS, CITY, STATE, ZIP CODE COMMERCE DRIVE	, ,,	00.2020	
LIBERTT	COMMONS NSG AND RE	ENAB CIR OF LEE COUNTY		SAN	NFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686		e 87 on Resident #16's left lower peared to be bleeding and	F 6	886				
	that she told the Wou time. She stated she	nd Nurse to assess it at that would ensure the Wound th the surveyor regarding the						
	scheduled wound ass stated it was her expe	sessment on 1/24/23. She ectation that resident wound inistered as ordered and						
		of a newly healed pressure ased likelihood it could						
	after the order for the completed after 7 day	23 at 3:00 PM was  /ound Nurse. She stated  Vaseline dressing was  /s, there were no additional  was resolved by the Wound						
	Physician on 1/10/23 assess Resident #16 Vaseline treatment or stated she assumed	She stated she did not s left lateral leg after her ders were completed. She that the floor nurses would						
	when they completed The Wound Nurse sta the area reported by	their skin assessments.  ated she forgot to assess the orthopedic office on						
	healed pressure ulce now a stage 4 pressu Nurse stated she forg to observe Resident a her next wound treatr	y. She stated the previously rhad reopened and was are ulcer again. The Wound got to get the surveyor earlier #16's left lateral calf and that ment was not until Thursday						
	follows: Resident #16 evaluated for a stage lateral calf that was a	n note dated 1/24/23 read as was assessed and 4 pressure ulcer to her left t least 1 day in duration. It eter (cm) by 1.5 cm x 0.1						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C <b>02/09/202</b> 3	3
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	<u>'</u>	<b>V V V V V V V V V V</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLE DATI	ETION
F 686	debrided, new treatmenthe Wound Physician heal with continued printerventions in 63 data. A telephone interview at 2:15 PM with the V the original onset of trulcer was from her leafter the left femur frat Wound Physician state scabbed area near the leg on 1/10/23 and shave contacted her if appear intact. She state and 90% grant fracility to assess Restard 1/24/23 and noted the re-opened and preset tissue and 90% grant Physician stated it was kin surveillance was She stated Resident have been discovered when the facility note She further stated she was the stated at the facility is started at the facility is She stated she was the st	otic (dead) tissue and cissue. The wound was ent orders were given, and estimated the wound would hysician evaluation and cys.  If was completed on 1/25/23 Wound Physician. She stated the left lateral calf pressure fit leg immobilizer she wore acture in August 2022. The ted there was only a see bottom of her left lateral cale assumed the facility would on 1/17/23 the area did not eated she was asked by the ident #16's left lateral calf on the healed pressure ulcer had inted with 10% of necrotic	F6	386			
	Wound Nurse, and the assessed all pressure	ho told her. She stated the e Wound Physician e ulcers every Tuesday and wrote her own treatment					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345532	B. WING_			C 02/09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		CODE	02/03/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 686	orders. NP #1 stated observe a pressure to requested by a nurse expectation that Restreatments as ordered the area to her left la 1/17/23 when the Valcompleted to ensure or declined since it at as of 1/10/23.  A wound care observed lateral calf was compwith the Wound Nurse tissue to the center of the pressure ulcer extending higher up Physician stated it with Another wound care on 2/2/23 at 10:35 Ald dressing had a small drainage. There was infection. The area wobservation completed Administrator #1 was jeopardy on 2/3/23 at Administrator #1 provallegation for the immediate likely to suffer, a a result of the nonco On 09/06/23 Resider orthopedic appointment the nurse the post visiting to the suffer of the post visiting the post visiting the suffer of the post visiting the pos	she did not routinely alcer unless specifically a. She stated it was her ident #16 receive her d and would have expected teral leg be assessed after seline dressing for 7 day was the wound had not reopened pparently still was scabbed vation of Resident #16's left pleted on 1/26/23 at 9:43 AM are. There was noted necrotic of the lower, smaller section with pink/red tissue on her calf. The Wound as a stage 4 pressure ulcer.  Observation was completed M with Nurse #1. The old amount of serosanguinous no evidence of redness or as improved since previous and on 1/26/23.  In notified of the immediate that 10:00 AM.  Vided the following credible mediate jeopardy removal:  Ints who have suffered, or serious adverse outcome as impliance.  Int #16 returned from an ent and the transporter gave	F	586		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
						С	
		345532	B. WING _			02/09/2023	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
LIDEDTY	COMMONO NOO AND	DELIAD OTD OF LEE COUNTY		310 COMMERCE DRIVE			
LIBERIY	COMMONS NSG AND	REHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 686	New orders were rearea underneath the included that the dechanged daily, and was advised. The mote/order sheet in she had been instrument on 13/23 the Certiful resident's immobilizer with resident went to an new orders were rewound nurse reviewassessment of the placed by the orthowound doctor evaluated areas to the knee. Treatments were calf stage 4 pressures unstageable deep knee based on the assessment and of On 09/15/22 the Dithe Root Cause Amprocess of review the wound occurred arcorrect the occurred on 1/10/23 the wound and docume epithelized and had presented with a set for a Vaseline or end daily x 7days. The the last day of order remained in place in the set of the last day of order remained in place.	eral aspect of the left lower leg. eceived for treatment to the ele immobilizer. The orders ressing and padding must be a wound management consult nurse placed the after-visit the medical records box as ucted to do in the past. On ied Nurse Aide was lifting the zed leg and felt a wet area on the her hand. On 9/13/23 the orthopedic appointment and eceived. On 9/13/2023 the wed the orders and upon resident #16 noted a dressing opedic doctor. On 09/13/22 the uated the left lower leg and left lateral calf and left anterior were initiated to both left lateral are ulcer and to the tissue injury to the left anterior wound physician's rector of Nursing completed ealysis. This is an internal to help determine how the end what could be done to	F	886			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		(X3) DATE SURVEY COMPLETED		
		345532	B. WING				09/ <b>2023</b>
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 02/	03/2023
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY			O COMMERCE DRIVE NFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	· ·			(X5) COMPLETION DATE
F 686	Continued From page	e 91	F	686			
	nurse and a new dres 1/24/23 the wound phand noted that a previous closed on 1/10/23 had calf and orders were. Resident #16 receive assessment on 02/02 Director of Nursing (Eassessment revealed current wound on the treatment was in place by the treatment nurs according to the phys. On 02/03/2023, the Interviewed Resident #2 ensure preventative replace to prevent new of current wounds. On 02/02/2023, the Interviewed Resident #2 ensure preventative replace to prevent new of current wounds. On 02/02/2023, the Interviewed preventative residents to identify a pressure wounds or so On 02/02/2023-02/03. Nurses assessed and pressure wounds to a measurements were On 2/3/2023, the nurse of all residents with it assure a current treatin place on the electron 2/3/2023 the Interviewed residents B pressure ulcers.	ssing was applied. On hysician assessed the area vious stage 4 injury that dependent to the left lateral initiated to the wound. In a total body skin (2/2023 by the Interim (2/2023 by					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L , IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345532	B. WING _			02/	09/2023	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				31	0 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		SA	ANFORD, NC 27332			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI)	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	ıF.	(X5) COMPLETION	
TAG	,	SC IDENTIFYING INFORMATION)	TAG	`	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE	
F 686	Continued From page		F 6	686				
	-	um Data Set nurse to ensure						
	-	es were currently in place to						
	·	akdown and address the						
	current pressure wou							
	Root Cause Analysis	•						
	Administrator, Interim	llowing staff in attendance:						
	Regional Operations	•						
		nsultant and the Medical						
		analysis was done related						
		of daily skin surveillance						
	and thorough skin as							
	changes in skin integ							
		nts for a resident at risk for						
	skin breakdown. Upo	n interview of the nursing						
	staff/agency it was de	etermined that the root cause						
		istration failure to provide						
		d leadership to ensure						
		re in place to: Prevention of						
	avoidable pressure so							
	residents at risk. Prov							
	dressing changes per							
		n assessments. Review						
		reatment from physician						
		entified wounds. Ensure						
		wound care were followed. e entity will take to alter the						
		lure to prevent a serious						
		n occurring or reoccurring						
	and when the action	•						
	On 02/02/2023, the Ir							
	Nurses/Quality Assur							
		gional Staff Education						
	Specialist began in-se	•						
		ime, part time, as needed						
		ncy to include: The Skin						
		e Ülcer Assessment Process						
	to include how to ider	ntify when a skin or wound						
	assessment is due to							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD	NG		، ا	С	
		345532	B. WING			1	09/2023	
NAME OF P	ROVIDER OR SUPPLIER	•		STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
LIBERTY	COMMONS NSG AND	REHAB CTR OF LEE COUNTY			COMMERCE DRIVE			
LIDLIKI	COMMICTO NOC AND	KENAD O'N OF LEE GOOK!!		SAN	IFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Orders and Provisi Wound/Skin/Treati Process. The Post Orders Process an Process. Documer Administrator/Direct cannot be complet On 02/02/23 educ Quality Assurance all licensed nurses the Nurse Practice of Nursing Position In addition, on 02/0 Nurse Consultants Education Speciali with return demons skin assessment/wound/order/t nurses were instru assessment, for reimmobilizers/brace under or surroundi Including notification nurse for further as orders for any new skin.  On 2/2/2023, the In Nurses/Quality Ass Consultant/Senior Specialist began e Assistants, Medica Nursing Assistants skin when providin the nurse regardinskin integrity. The	ecord. Identification of New fon of Ordered Treatments. Identify of Appointment and the Order Clarification of the cor of Nurses if a treatment ed for any reason. In attain a similar of the Nurse Consultants for 100% of a statement on Wound Care. Or North Carolina Board of the Statement on Wound Care. Or North Carolina Staff of Statement on Wound Care. Or Senior Regional Staff of the steps of the reatment process and the corder to identify on the skin sidents with the statement of the physician and wound seessment and treatment or or worsening changes to the other the interim Director of	F	686				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			C 02/09/2023
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		02/03/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL PREGULATORY OR LSC IDENTIFYING INFORMATION) TA		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 686	Continued From pag	ge 94	F 6	86		
	changes such as or wound/swelling/incr from wound site/new skin breakdown. As of 2/02/23 the Qr Consultants begand nurses, including age expectations: the words is to complete the wrassessment after for The nurse is responded to the properties of the nurse is responded to the properties of the nurse is responded to the nurse is to contact the nurse needs of the nurse is to contact the order. During morning are to be reviewed the would be expected the high-risk skin area, are to report noted so nurse.  As of 2/5/2023, no Let Nursing Assistants we do a completed. This is the staff. The Interim Dial Administrator are reare educated as we and tracking of sust still require education clicensed nurses, Ceagency.  After 2/05/23 the Intibe responsible to er Certified Nursing Asthe applicable polici	lor from a leased redness/pain/drainage vareas of redness or new  luality Assurance Nurse leducation of all licensed lency on the following lound nurse or nurse assigned leekly pressure ulcers lunding with the wound doctor.  Is sible to look at the User to in the electronic medical lomplete the weekly skin  All orders are to be lurse who receives the order.  Itarification of the order, the line physician for clarity of the line clinical meeting all orders loo do daily monitoring of the Certified Nursing Assistants licensed Nurses or Certified				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C <b>02/09/2023</b>	
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	•	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 686	Continued From pag	ge 95	F 6	86			
	wound in a timely m Alleged date of imm 02/06/23.  On 2/7/23, the facilit immediate jeopardy multiple staff intervie staff were conducted agency nurses had assessments, treath false documentation reviewing consults for was completed with	failing to identify and treat a anner. ediate jeopardy removal  y's credible allegation for removal was validated by the sews including administrative and revealed the facility and enservices on preventive risk ment guidelines, inaccurate or treatment errors and or new orders. In-servicing the aides-current and agency d reporting any areas of					
	ulcers or at risk for p and reviewed. The in were reviewed for st	of the residents with pressure pressures ulcers were initiated in-servicing sign in sheets aff signatures.  was removed on 2/6/23.					
	10/11/21. His diagno	s admitted to the facility on oses included severe utrition, diabetes type 2 and a to the left side.					
	reviewed 11/22/22, i areas: - Risk for pressure u decreased sensation hemiparesis (paralystincluded a pressure - Currently with a preand at risk for develoulcers due to decreatincontinence- reside	t #12's active care plan, last included the following focus elected development due to in related to left sided isis). The interventions reducing mattress to the bed. The elected development of additional pressure insed ability to re-position and intrefusing repositioning. The elected dir mattress to the bed.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C	
		345532	B. WING _			02/09/2023
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY	1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	Continued From pag	ge 96	F 6	886		
	had moderately imp extensive assistance the 7-day assessme two stage 2 and one as well as having a the bed.	n Data Set (MDS) /9/23 indicated Resident #12 aired cognition, required e and had been bed bound for ent period. He was coded with e unstageable pressure ulcer, pressure reducing device to				
	9/20/22 to 1/17/23 i	revealed wound care was and left hip pressure ulcer.				
	of Resident #12 whi alternating air mattre the foot of the bed, I mattress was lying of	PM, an observation was made le he was lying in the bed. An ess machine was hooked to nowever the connection to the on the floor as well as the ht #12 was lying on a deflated				
	on 1/24/23 at 9:00 A The alternating air n connected to the ma	was made of Resident #12  M while he was lying in bed.  nattress machine was not attress and the power plug or. Resident #12 was lying on g air mattress.				
	alternating air mattre	on of Resident #12 the ess machine was no longer if the bed. The deflated air mained under Resident #12 in				
	Resident #12 occurr and Nurse Aide (NA	PM, an observation of red with the Wound Nurse ) #1. The Wound Nurse ng air mattress machine was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C <b>02/09/2023</b>
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	•	02/03/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 686	no longer in place a Resident #12 was ly mattress overlay in the Wound Nurse both in present at the foot of morning and was no At 3:34 PM on 1/24/ reported the alternal located in a drawer observation occurre mattress machine w overlay underneath plugged into power.  A phone interview o Physician on 1/25/2 would expect the alt connected and func #12 was at high risk a history of pressure hip. 3. Resident #45 was 9/22/22 with multiple malignant neoplasm	t the end of the bed and ring on the deflated air the bed. NA #1 and the recalled the machine being of Resident #12's earlier that of sure what happened to it.  23, the Wound Nurse ting air mattress machine was in Resident #12's room. And d revealing the alternating air ras connected to the mattress Resident #12 as well as	F6	86		
	stage 3 pressure uld admission.  Resident #45's care that he currently had sacrum and left butt pressure ulcers to s remain free from infi included to administ Resident #45 had a	ed that Resident #45 had 2 pers and 1 was present on  plan dated 10/7/22 indicated d pressure ulcers on his ock. The goal was for the how signs of healing and to ection. The approaches er treatment as ordered.  physician's order dated pressure ulcer on the sacrum				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION	_	(X3) DATE COMP	SURVEY LETED
		345532	B. WING _			C 02/09/2023	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, 310 COMMERCE DRIVE SANFORD, NC 2733		1 021	03/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	calcium alginate (a h moderate to heavy d with border gauze dr.)  On 1/24/23 at 9:20 A Nurse was observed She reported that Re on the left buttock ha Wound Nurse was observed ulcer on the wound cleanser, app wound bed and cover dressing. She was not maked to the wound signature was as 1 PM. She review Resident #45's press the order was to appalginate to the wound only applied calcium wound, and she forged She explained that the responsible for the daulcers. She was responsible for the daulcers.	apply Medi honey f necrotic tissue) and then ighly absorbent used for rainage wounds) and cover essing daily.  M, the facility's Wound during the dressing change. sident #45's pressure ulcer d already been healed. The beerved to clean the e resident's sacrum with a lied calcium alginate to the red with a dry gauze ot observed to apply the	F	586			
	1/25/23 at 2:25 PM. #45's pressure ulcer medical condition, bu provide the treatmen ordered.	n was interviewed on She stated that Resident was unavoidable due to his at she expected the nurses to t to his pressure ulcer as the Nurse Consultant were					
	interviewed on 1/26/2						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _				C 09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		31	REET ADDRESS, CITY, STATE, ZIP CODE  O COMMERCE DRIVE  ANFORD, NC 27332	1 02/	03/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	Administrator stated t	e 99 that he expected nursing to pressure ulcers as ordered.	F€	886			
	12/7/22 with multiple pressure ulcer. The a Set (MDS) assessme that Resident #46 had	admission Minimum Data Int dated 12/14/22 indicated d a stage IV pressure ulcer admission and his weight					
	that he currently had sacrum and right hee pressure ulcers to sh	plan dated 12/7/22 indicated pressure ulcers on his I. The goal was for the ow signs of healing and to ction. The approaches to bed.					
		nic weight records revealed reight on 1/12/23 was 184					
	1/23/23 at 9:50 AM a He was on air mattres machine was set betw The air mattress mac	served lying in bed on nd on 1/24/23 at 9:45 AM. ss and the air mattress ween 200-250 pounds (lbs.). hine had setting in lbs. and ding to the resident's weight					
	3:31 PM. She reported responsible for check shift. She stated that should have been set The Wound Nurse incourrent weight was 18	as interviewed on 1/24/23 at ed that nurses were ling the air mattress every. Resident #46's air mattress according to his weight. dicated that Resident #46's 84 lbs., and she checked the s and she verified that it was					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG	(XS	3) DATE SURVEY COMPLETED	
		345532	B. WING			C 02/09/2023	
NAME OF P	ROVIDER OR SUPPLIER	1 111		STREET ADDRESS, CITY, STATE, ZIP COD	<b>!</b>	02/09/2023	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 686	F 686 Continued From page 100		F 6	86			
	set between 200-250 reset the machine between 200-250	lbs. She reported that she tween 150-200 lbs.					
	that she was respons	3 at 3:32 PM. She stated ible for checking the air ng but not for the weight					
	interviewed on 1/26/2 Administrator stated t						
F 688 SS=D	Increase/Prevent Dec CFR(s): 483.25(c)(1)-	crease in ROM/Mobility -(3)	F6	88		3/17/23	
	resident who enters the range of motion does range of motion unless	cility must ensure that a ne facility without limited not experience reduction in as the resident's clinical es that a reduction in range ble; and					
	motion receives appro	ent with limited range of opriate treatment and ange of motion and/or to ase in range of motion.					
	receives appropriate assistance to maintain the maximum practical reduction in mobility is This REQUIREMENT by:	ent with limited mobility services, equipment, and n or improve mobility with able independence unless a s demonstrably unavoidable.					
	Based on record revi	ew, observations, resident,		The statements made on this	plan of		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345532	B. WING	<del></del>	02/09/2023
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 688	failed to schedule a ordered (Resident # reviewed for limited)  The findings included Resident #28 was a 1/20/21 with diagnostroke, osteoarthritist A Nurse Practitioner 9/20/22 indicated refinger and hand combe was found to have the left first finger, rifinger and requeste treatment. The program orthopedic appoint A Modified Quarterly assessment dated #28 was cognitively A review of Residen 9/20/22 to 1/24/23 consult records.  On 1/23/23 at 9:45 with Resident #28 at "a few months back"	ctitioner interviews, the facility in Orthopedic appointment as (28) for 1 of 1 resident range of motion.  Id:  Id:  Id:  Id:  Id:  Id:  Id:  Id	F 68	correction are not an admission not constitute an agreement with alleged deficiencies.  To remain in compliance with all and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility allegat compliance such that all alleged deficiencies cited have been or corrected by the dates indicated F688  1. Corrective action for resident affected by the alleged deficient  For resident #28, an Orthopedic Appointment was scheduled for follow up of the contractures of first finger, and the right hand for fingers. This appointment is on 03/06/2023.  2. Corrective action for resident potential to be affected by the all deficient practice.  Beginning on 02/27/2023, the D manager audited all current resi were recommended for follow up appointments. The findings were there were no other discrepanci regards to follow up appointments.	frederal has taken in this orrection ion of l will be l. t(s) practice: further the left burth/fifth  ts with the lleged  ON/nurse dents who p e that es with
	fingers. Stated he had wanted to be seen by an orthopedic to see what could be done as the contractures are uncomfortable and interfere somewhat with his daily activities. Resident #28 stated he has yet to be seen by an Orthopedic Physician for his finger contractures.			resident that required a follow up appointment has been schedule 02/23/2023.  3. Measures /Systemic changes prevent reoccurrence of alleged practice:	p ed by s to deficient
ORM CMS-256	7(02-99) Previous Versions O	bsolete Event ID: KJ60	)11	Facility ID: 980156	continuation sheet Page 102 of 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C 02/09/2023	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 688	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		F6	TAG CROSS-REFERENCED TO THE APPRO			
	initial consult with an finger contractures. The Director of Nursi 1/26/23 at 10:00 AM	should have already had an Orthopedic Physician for his ang #1 was interviewed on and was unable to state why altation had not been made			the MD/RP notified. The post appointmy visit note will be given to the Director on Nurses for review at the Daily Clinical Meeting to assure all needed follow up has been implemented. The post follow up visit note will be placed in the resident seminary medical record. 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 Certified Nursing Assistant	f  ito the or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
			A. BOILDIN	<u></u>	С		
		345532	B. WING _		02/09/2023		
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I IRFRTY (	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY	310 COMMERCE DRIVE				
LIDEIXIII	SOMMONO NOO AND NE	INAB OTK OF EEE GOOKIT		SANFORD, NC 27332			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE.		
F 689 SS=G		ards/Supervision/Devices	F 6	who provide residents care in the facili As of 3/17/2023 any nursing staff who does not receive scheduled in-service training will not be allowed to work untitraining has been completed.  4. Monitoring Procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements.  The Director of Nurses/RN Manager with monitor compliance utilizing the F688 Quality Assurance Tool weekly x 4 weet then monthly x 3 months or until resolve The Director of Nursing will monitor scheduled follow up appointments to ensure they are scheduled timely. 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 untideemed no longer necessary for compliance with splint application. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Thera Manager, Health Information Manager and the Dietary Manager.  Date of Compliance: March, 17, 2023	t nat cted lill eks ed.		
	§483.25(d) Accidents						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING			C 02/09/2023
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		210312020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	as free of accident h §483.25(d)(2)Each is supervision and ass accidents. This REQUIREMEN by: Based on observati record review, the fa on 8/16/22 for a resi impairment and poor required extensive is mobility and position residents reviewed if rolled from her side left femur fracture. To position while Nursi room to throw dirty is outside the resident included:  Resident #16 was a cumulative diagnose Heart failure, Chron Artery Disease, and The quarterly Minim 6/28/22 indicated Re cognitive impairment assistance with bed personal hygiene.  Resident#16 was ca last revised on 8/16, risk for further falls.	esident environment remains nazards as is possible; and resident receives adequate istance devices to prevent.  IT is not met as evidenced ons, staff interviews and acility failed to prevent a fall ident with cognitive or decision-making skills who staff assistance with bed ning for 1 (Resident #16) of 8 for accidents. Resident #16's onto the floor resulting in a The bed was in the high ng Assistant (NA) #11 left the inens in the laundry bin s's room. The findings	F 68	Past noncompliance: no plan correction required.	of	

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 02/09/2023		
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		310 COMM	DDRESS, CITY, STATE, ZIP CODE  IERCE DRIVE  D, NC 27332	1 02/	03/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Resident #16 was lyi room. The was noted her right upper lateral noted to the inside of stated areas were "it touched. The nurse a #16 onto her back for Resident #16 yelled simmediately reached stated she was not in Medical Director (ME and orders for x-rays given for Tramadol (milligrams (mg) every Review of Resident #medication administrate received pain medicated an order da (narcotic pain reliver) Tramadol and Napro	8/16/22 at 2:45 PM reading in bed upon entry to the dial arge red area noted to all thigh and a red are also finer left knee. Resident #16 chy" when they were attempted to roll Resident ar asses her further when and grimaced in pain then for right thigh. Resident #16 in pain until she was moved.  2) #2 was notified of findings awere given. Orders were narcotic pain reliever) 50 by 8 hours as needed for pain.  2/16's August 2022 action record (MAR) indicated action on 8/16/22 but not on  2/16's August 2022 orders ted 8/18/22 for Percocet by every 6 hours while the exen were discontinued.	F	689	DEPICIENCY)			
	read Resident #16 w noted to right lateral were red blanchable denied any pain, nun and she was able to	e dated 8/17/22 at 10:11 AM as assessed and the area thigh and left medial knee in color. Resident #16 hbness or tingling at this time move her extremities at her ead the facility was waiting for a arrive.						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		345532	B. WING _			C 02/09/2023	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332			03/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	read due to the delay was notified and orde Resident #16 to the h	dated 8/17/22 at 11:06 AM in obtaining x-rays MD #2 ers were given to send cospital for evaluation.	F 6	689			
	of the left knee demo femur fracture, and k to her left leg, Napro anti-inflammatory dru	g) 500 mg twice daily for and to follow up with an					
	read Resident #16 re room (ER) with an im report from the ER no had a fracture to her were orders to follow Physician, leg immob Resident #16 stated when her knees were (There was no docum her pain meds were	dated 8/17/22 at 5:20 PM turned from the emergency mobilizer to her left leg. The arse stated Resident #16 left distal femur and there up with an orthopedic illizer and Naproxen for pain. She only experienced pain emoved. The moved in the process of the process					
	dated 8/16/22 was as	for the past non-compliance s follows: The root cause ned that NA #11 used poor					
	read NA #11 began F PM and was in the ro	he incident was reviewed. It Resident #16's care at 12:30 om for approximately 20 ed the bed to perform care					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C 2/09/2023	
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I IREDTV	COMMONS NSG AND	REHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE			
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F 689	Continued From p	age 107	F 6	889			
	to hip height and the Resident #16 still Resident #16 was collected the linen outside the of the exiting the room whom. Nurse #13 on her back when her right leg and refloor. Nurse #13 in assessment but the and no physical ewith the assistance name unknown) a lift to place Reside #13 called MD #2 orders for inhouse hips and both kne notified. On 8/17/2 was initiated on bowas reported to the did not come on 8 and he gave order ER for an evaluating the ER with a diagree periprosthetic fraction her left leg and order left le	then stripped the bed linen with in the bed. NA #11 stated bying on her back when she into put them in the laundry bin room. She stated as she was when Nurse #13 entered the stated Resident #16 was lying she raised left leg to cross over olled out of the bed onto the inmediately did a head-to-toe here was no complaints of pain widence of an injury. NA #11 e of another agency aide (full ssisted her with the mechanical ent #16 in the bed while Nurse at 2:45 PM, MD #2 gave at 7:00 AM, staff education here and the x-ray provider was ear and the x-ray technician with the x-ray technical with the x-ray technical with the x-ray technical wit					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING				OATE SURVEY OMPLETED		
		345532	B. WING _			C 02/09/2023
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		02/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 689	1:39 PM with Nurse Resident #16's rash her back since NA # stated when she was observed Resident; #11stood at the foot #16 crossed her leg out of the bed. She assessment at that another agency aide a mechanical lift. Shappear to have any not complain of pair re-education at the foot Corrective Action The There was no apparincident at 12:30 PM Resident #16's area and left inner knee. be transferred to the 8/17/22 to rule out a diagnosed with a left care plan was updated were given for grab positioning Resident Identification of Other Identification Identification of Other Identification Identification Identification of Other Identification I	w was completed on 2/7/23 at #13. She stated she got cream and went to apply it to #11 had her in the bed. She liked into the room, she #16 lying in bed while NA of the bed when Resident s at the ankles, and she rolled stated she did a head-to-toe time and then NA #11 with a placed her in the bed using the stated Resident #16 did not evidence of injuries and did that at that time. She recalled time of the incident.  The will be Accomplished:  The time of the was got and the morning on any fractures where she was fit distal femur fracture. The ted on 8/16/22 and orders bars to assist in turning and ti #16 while in bed.	F 6	89		
	audits of all falls that days was completed residents' incidents	t occurred in the previous 14 d to assure that no other				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345532	B. WING				C (09/2023	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		310	REET ADDRESS, CITY, STATE, ZIP CODE  COMMERCE DRIVE  NFORD, NC 27332	1 02/	09/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	There were no other  On 8/18/22, DON #2 all care plans for the with the appropriate in the audit included 51 compliance with the and as of 8/18/22 10 compliance for the new in the bed mobility. Systemic Changes:  DON #2 and DON #7 at that time began example and aides to include at 7:00 AM on bed poprovision of care. Ed completed no later the	and the MDS Nurse audited presence of bed mobility nterventions. The result of of 53 resident were in care planned intervention 0% of all care plans were in eeded level of assistance  who was the RN Supervisor fucation for all licensed nurse agency staff began 8/17/22 positioning, mobility, and safe fucation needed to be an 8/21/22 or the staff allowed to work until the	F	689				
	provision of care wer weeks and monthly for compliance with safe monitoring included of include agency aides weekends. Reports wassurance (QA) com and corrective action	sitioning, mobility and safe e completed weekly for 2 or 3 months for the provision of care. The observations of 4 aides to on various shift to include were present the quality mittee to ensure compliance . A weekly QA meeting would and audit for compliance.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	02/03/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 689	Continued From page	<del>=</del> 110	F 68	9	
	correction was review review of the audit sh and staff interviews. conducted on 2/1/23, staff completing care bed. There were no ostaff left a resident un the high position prior room.  Interviews with the sta 8/16/22 were completing and staff left are sident un the high position prior room.	on process, the plan of yed and verified through eet, the in-service records, Observations were 2/2/23, 2/3/23 and 2/7/23 of on resident while lying in the observed incidents where nattended of left the bed in to leaving the resident's aff involved incident dated ted and with current staff.			
F 690 SS=D	bed mobility and posi The validation proces of compliance of 8/18	es verified the facility's date 5/22. inence, Catheter, UTI	F 69	0	3/17/23
	resident who is continuadmission receives somaintain continence u	cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain.			
	incontinence, based of				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  IG	COMI	E SURVEY PLETED
		345532	B. WING _		1	C / <b>09/2023</b>
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE
F 690	indwelling catheter resident's clinical co catheterization was (ii) A resident who exindwelling catheter is assessed for remas possible unless demonstrates that cand (iii) A resident who receives appropriate prevent urinary traccontinence to the exidence of the exidence	is not catheterized unless the ondition demonstrates that necessary; enters the facility with an or subsequently receives one oval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder entereatment and services to the infections and to restore extent possible.  I resident with fecal do not the resident's essment, the facility must ent who is incontinent of bowel the treatment and services to extent possible.  It is not met as evidenced enterewell the facility failed to the facility failed to the facility failed to the facility on the facility on the diagnoses including urinary catheters and services to the facility on the diagnoses including urinary the facility on the diagnoses including urinary the facility on the diagnoses including urinary catheters.	F 6	The statements made on this p correction are not an admission not constitute an agreement wit alleged deficiencies.  To remain in compliance with al and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility □s allegat compliance such that all alleged deficiencies cited have been or corrected by the dates indicated F690  1. Corrective action for residen	to and do h the  I federal has taken in this orrection ion of i will be i.	
ORM CMS-256	retention. The quart assessment dated	terly Minimum Data Set (MDS) 1/8/23 indicated that Resident ng urinary catheter.	1	corrected by the dates indicated F690  1. Corrective action for resident	i.	Page 112 of 162

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			1	00/2022
NAME OF D	ROVIDER OR SUPPLIER	0.0002	1		TREET ADDRESS, CITY, STATE, ZIP CODE	02/	09/2023
NAME OF T	TOVIDER OR SOLT EIER				10 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			SANFORD, NC 27332		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUNTS TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)			COMPLETION DATE
F 690	Continued From page	e 112	F 6	590			
	Resident #45 had a p	hysician order dated 9/23/22			affected by the alleged deficient practic	e:	
	for a strap free secure	ement device which locks					
	the catheter in place a	and eliminates any chance			For resident #45: a leg band was applied	∍d	
	of a sudden pull and t	to check the device every			on 01/26/23 by the nurse manager. The	е	
	day and to change ev	ery 7 days and as needed.			nurse manager confirmed the task and		
					order for catheter leg band securement	t	
	Resident #45's care p	olan dated 9/29/22 indicated			was in the resident□s medical record.		
		lling urinary catheter due to			This was completed on 01/26/23.		
		e goal was to remain free					
	from catheter related trauma and the approaches				Corrective action for residents with the second contraction of the second contract of	the	
	included a leg band to	o secure the catheter.			potential to be affected by the alleged deficient practice.		
	Resident #45 was into	erviewed on 1/24/23 at 9:18					
		e could not tell whether his			Beginning on 02/27/2023, the nurse		
	catheter was secured	or not since he was			manager audited all current residents v	vith	
	paralyzed from waist	down.			Indwelling Urinary Catheters to ensure securement device was in place. This	а	
	Resident #45 was ob	served in bed on 1/24/23 at			audit was completed as of 02/27/2023.	3	
	9:20 AM during the di				of 3 residents were noted with an		
		provided by the Wound			Indwelling Urinary Catheter tubing		
		was observed to have an			securement device in place. The		
		heter in place and the			resident⊡s care plan has been updated	t	
	catheter tubing was n	ot secured to his thigh.			on 02/27/2023 by the nurse manager.		
	<b>.</b>				Orders were verified to ensure the	ſ	
	Resident # 45 was ag				securement device is in place by the		
		n on 1/24/23 at 2:35 PM.			nurse manager on 02/27/2023.	ĺ	
		esident's urinary catheter and					
	verified that there was	s no securement device.			Measures /Systemic changes to prevent reoccurrence of alleged deficient	nt	
	NA #7 was interviewe	ed on 1/24/23 at 2:36 PM.			practice:	111	
		ansferred the resident from			practice.	ĺ	
	the bed to his wheelc				On 2/27/2023, the Director of Nurses/ I	RN	
	noticed that his cathe	S .			nurse manager began educating all full		
		The NA reported that she			time, part time, and prn nurses and		
	forgot to report it to the	•			CNA□s on the following topics: indwel	lina	
	J 5p				urinary catheter care, preventing traum	-	
	Nurse # 1, assigned t	o Resident #45. was			and ensuring the Indwelling Urinary	,	
		3 at 2:38 PM. She stated			Catheter Tubing securement device is	in	
		uding NAs were responsible			place at all times.		

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		345532	B. WING _			C <b>02/09/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER	l	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	<u></u> )E	02/00/2020	
				310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DATE.		
F 690	Communication page		F 6	90			
	for ensuring the resid secured and if not, Not the nurses. Nurse #1 informed her that Residid not have a secure. The Wound Nurse was 3:28 PM. She stated Resident #45's urinar during the dressing of the Director of Nursii interviewed on 1/26/2 that residents with uritheir catheters secure nursing was responsi securement device was Administrator #1 and interviewed on 1/26/2	ent's urinary catheters were As were expected to inform stated that nobody had sident #45's urinary catheter ement device.  as interviewed on 1/24/23 at that she did not notice that y catheter was not secured hange.  and (DON) #1 was 3 at 9:31 AM. She stated nary catheter should have ded to their thigh/leg and ble for ensuring that the as in place at all times.  the Nurse Consultant were 3 at 12:54 PM. The hat he expected resident's		This information has been into the standard orientation training required in-service refresher of all staff identified above and we reviewed by the Quality Assumprocess to verify that the characteristic will be provided to a Nurses and CNA who give care in the facility. As of 3/17/ nursing staff who does not rescheduled in-service training allowed to work until training allowed to work until training completed.  4. Monitoring Procedure to enthe plan of correction is effect specific deficiency cited remains and/or in compliance with regrequirements.  The Director of Nurses or designating the plan of correction is effect specific deficiency cited remains and/or in compliance with regrequirements.  The Director of Nurses or designating the plan of correction is effect specific deficiency cited remains and/or in compliance with regrequirements.  The Director of Nurses or designating the plan of correction is effect specific deficiency cited remains and/or in compliance utilizing the Quality Assurance Tool weekly then monthly x 3 months or under the plan of corrective and the plan of corrective and the rescaled to the weekly Quality Assurance committee by the Nurses to ensure corrective and initiated as appropriate. Complete monitored and the ongoing program reviewed at the weekly catheter securement. The QA Meeting is attended by the QA Meeting is attended by the plan of corrective and the designation of the weekly guality assurance of the weekly catheter securement. The QA Meeting is attended by the plan of corrective and the ongoing foley catheter securement. The QA Meeting is attended by the plan of corrective and the ongoing foley catheter securement. The QA Meeting is attended by the plan of corrective and the ongoing foley catheter securement. The QA Meeting is attended by the plan of the plan of corrective and the ongoing foley catheter securement.	ing and in a courses for will be rance nge has specific all agency excive will not be has been ensure that tive and the sins correctly latery signee will he F690 ly x 2 weel and the specific action is pliance will be litty. Director of action is pliance will g auditing auditing auditing auditing once with the weekly	the or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED		
		345532	B. WING			C <b>02/09/2023</b>		
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<b>_</b> E	02/03/2023		
I IDEDTY	COMMONS NSC AND DE	HAB CTR OF LEE COUNTY	310 COMMERCE DRIVE					
LIDERITY	COMMONS NSG AND RE	ENAB CIR OF LEE COUNTY		SANFORD, NC 27332				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
F 690	Continued From page	÷ 114	F 69	Administrator, Director of Nur Coordinator, Therapy Manage Information Manager, and the Manager.	er, Health			
F 695 SS=D	Respiratory/Tracheos CFR(s): 483.25(i)	tomy Care and Suctioning	F 69	Date of Compliance: March 1	7, 2023	3/17/23		
	The facility must ensured needs respiratory carcare and tracheal succare, consistent with practice, the compreheare plan, the resider and 483.65 of this sul	nd tracheal suctioning.  ure that a resident who e, including tracheostomy etioning, is provided such professional standards of hensive person-centered hts' goals and preferences,						
	interviews, the facility therapy was provided for 1 of 1 sampled res (Resident #3). Additionally display cautionary signuse for 2 of 2 resident and #10).	ew, observations and staff failed to ensure oxygen as ordered by the physician sidents of oxygen therapy onally, the facility failed to inage indicating oxygen in ts observed (Resident #3		The statements made on this correction are not an admission not constitute an agreement valleged deficiencies.  To remain in compliance with and state regulations the facilior will take the actions set for plan of correction. The plan of constitutes the facility salleged accompliance such that all alleged to the state of the st	on to and do vith the  all federal ity has taken th in this f correction pation of			
	The findings included:  1. Resident #3 was admitted to the facility on 07/02/21 with diagnoses which included a			compliance such that all alleg deficiencies cited have been corrected by the dates indicat	or will be			
	assessment dated 01	ly Minimum Data Set (MDS) /02/23 revealed Resident #3 . She required extensive		Corrective action for reside affected by the alleged deficient For resident #3, on 01/26/23 to 1.	ent practice:			

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		345532	B. WING			1	C 09/2023
NAME OF PI	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	03/2020
				3.	10 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			ANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO			(X5) COMPLETION DATE
F 695	Continued From page	e 115	F	695			
	use. She was not coo	nobility, dressing, and toilet led as utilizing oxygen.			concentrator flow rate was set for 2 lite per minute per the physician orders by assigned nurse. For resident #3, on	the	
	01/13/23 revealed su	3's physician orders dated pplemental oxygen to be er minute via cannula every			01/26/23 the Oxygen in Use signage w placed on the resident s door frame by the assigned nurse. For resident # 10, 01/26/23 the Oxygen in Use signage w placed on the resident s door frame by	y on /as	
	observed lying in the	AM, Resident #3 was bed receiving humidified			the assigned nurse.		
	when viewed horizon	er minute via nasal cannula tally, eye level. There was no oserved on the door, door room.			<ol><li>Corrective action for residents with a potential to be affected by the alleged deficient practice.</li></ol>	ine	
	oxygen at 1.5 liters powhen viewed horizon cautionary signage of frame, or outside the	bed receiving humidified er minute via nasal cannula tally, eye level. There was no oserved on the door, door room.  AM Resident #3 was			On 02/27/2023, the RN manager completed an audit OF all current residents receiving Oxygen Therapy to ensure the Oxygen Concentrator is set the correct flow rate as prescribed by the physician. 5 concentrators needed correction. The Oxygen Concentrators were corrected to the correct setting per physician sorder on 02/27/2023.	at he	
	oxygen at 1.5 liters powhen viewed horizon cautionary signage of frame, or outside the  On 01/24/23 at 2:42 Fobserved lying in the	PM, Resident #3 was bed receiving humidified			On 02/27/2023, the RN manager completed audit of all current residents receiving Oxygen Therapy to ensure th Oxygen In Use signage is displayed outside the resident ☐s room who is receiving oxygen therapy. No other concerns were identified.		
	when viewed horizon	er minute via nasal cannula tally, eye level. There was no oserved on the door, door room.			Measures /Systemic changes to prevent reoccurrence of alleged deficie practice:	∘nt	
		AM, Resident #3 was bed receiving humidified er minute via nasal cannula			On 2/27/2023, the Director of Nurses/ F Manager began education to all full tim part time, and PRN Nurses (including		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
						С		
		345532	B. WING _		02	2/09/2023		
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZI				
				310 COMMERCE DRIVE				
LIBERTY	COMMONS NSG AND	REHAB CTR OF LEE COUNTY		SANFORD, NC 27332				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE		
F 695	Continued From pa	age 116	F 6	695				
	· ·	ontally, eye level. There was no	. ,	agency) on the following	. Oxygen			
		observed on the door, door		Concentrator are to be s				
	frame and outside			ordered by the physician				
				Concentrator Setting will				
	An observation was	s made with Nurse #2 of		nurse every shift to ensu				
	Resident #3's oxyg	en concentrator on 01/25/23 at		receiving the oxygen and	d the correct flow			
	10:12 AM, who sta	ted the oxygen regulator on the		rate, To verify the Setting				
		et at 2 liters when she viewed		must be eye level with th	•			
	it while she stood over the machine. She stated she did not know she needed to view the oxygen regulator on the concentrator at eye level. Then Nurse #2 viewed the oxygen regulator on the			to ensure it is the correct				
				Oxygen in Use Signage	• •			
				outside the resident □s re				
		e level and adjusted the flow to		receiving oxygen therapy	<b>y</b> .			
	1	of oxygen as ordered. Nurse		This information has bee	an integrated into			
		not know why the oxygen		the standard orientation	_			
		at 2.5 liters. She further stated		required in-service refres	-			
	_	been a cautionary signage on		all staff identified above				
	the door for oxyger			reviewed by the Quality	Assurance			
				process to verify that the	change has			
	During an interview	with the Director of Nursing		been sustained. The fac	cility specific			
		08:55 AM, nurses should view		in-service will be provide				
		or on the concentrator at eye		Nurses and CNA□s who	~			
		f it was set at the correct flow		care in the facility. As of				
		ated she expected each		nursing staff who does n				
		administered oxygen to have a on the outside of the door.		scheduled in-service trai				
	cautionary signage	on the outside of the door.		allowed to work until train completed.	ning has been			
		as interviewed on 01/26/23 at						
		d physician orders should be		Monitoring Procedure				
		rect oxygen flow rate and all		the plan of correction is				
		needed to be placed outside		specific deficiency cited				
		n resident who were on		and/or in compliance wit	n regulatory			
	oxygen.	as admitted to the facility on		requirements.				
		ses that included congestive		The Director of Nurses of	or designee will			
	_	and coronary artery disease.		monitor compliance utiliz	~			
	incart ialiare (Or II )	and oblinary artory discuso.		Quality Assurance Tool v				
	A quarterly Minimu	m Data Set (MDS)		weeks then monthly x 3				
		1/7/23 indicated Resident #10		resolved. The Director of				

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		345532	B. WING _			l	09/ <b>2023</b>	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00/2020	
				3.	10 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		S	ANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 695	Continued From page	e 117	F6	95				
		ired cognition (BIMS score as not coded for the resident.			monitor the Oxygen Concentrator flow rate to be accurate and the Oxygen in signage is displayed outside the			
		Physician orders included			resident□s room where oxygen is in us			
	an order dated 1/11/23 for oxygen at 2 liters per nasal cannula as needed for chest pain or				Reports will be presented to the weekly	/		
	nasal cannula as nee shortness of breath.	ded for chest pain or			Quality Assurance committee by the Director of Nurses to ensure corrective			
	SHULLICSS OF DIEALI.				action is initiated as appropriate.			
	Resident #10's active	care plan, last reviewed			Compliance will be monitored and the			
		ocus area for CHF with an			ongoing auditing program reviewed at	the		
	intervention to admini	ister oxygen as ordered by			weekly Quality Assurance Meeting or u	ıntil		
	the Physician.				deemed not necessary for compliance			
					with ADL Care. The weekly QA Meeting			
	A review of the Janua				attended by the Administrator, Director	of		
		d indicated Resident #10			Nursing, MDS Coordinator, Therapy			
	used oxygen at 2 liter 1/12/23 and 1/13/23.	rs via nasal cannula on			Manager, Health Information Manager, and the Dietary Manager.			
	On 1/23/23 at 9:31 Al	M, Resident #10 was . The oxygen concentrator			Date of Compliance: March 17, 2023			
		ut not in use at the time of						
	the observation. Nasa							
		entrator which was plugged						
		gen signage anywhere on						
	the door or door fram							
	1/24/23 at 8:38 AM ar when she felt short of concentrator was at the	served lying in bed on nd stated she wore oxygen f breath. The oxygen he bedside. There was no he door or door frame of her						
	10:12 AM who stated as needed for shortne there was no cautiona door frame and stated	d with Nurse #2 on 1/25/23 at Resident #10 used oxygen ess of breath. She verified ary signage on the door or d there should have been a ent #10's use of oxygen.						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245520	B. WING				С
		345532	B. WING			02/	09/2023
	ROVIDER OR SUPPLIER	HAB CTR OF LEE COUNTY		3	TREET ADDRESS, CITY, STATE, ZIP CODE  10 COMMERCE DRIVE  EANFORD, NC 27332		
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F 695	11:00 AM, from outsid	onducted on 1/25/23 at le of Resident #10's room,	F	695			
F 756	During an interview w #1 on 1/26/23 at 8:55 when a resident was concentrator in their r oxygen in use sign wa door frame. She was not occurred for Resident	e on the door or door frame.  ith the Director of Nursing AM, she indicated that ordered oxygen and had a oom, a red, magnetic as normally placed on the unable to state why this had	F	756			3/17/23
SS=D	§483.45(c) Drug Regi §483.45(c)(1) The dru must be reviewed at I licensed pharmacist.	men Review. ug regimen of each resident east once a month by a view must include a review					
	§483.45(c)(4) The phirregularities to the attractility's medical direct and these reports mu (i) Irregularities including that meets the c (d) of this section for a during this review mu separate, written report attending physician a director and director cominimum, the resident	armacist must report any tending physician and the stor and director of nursing, st be acted upon.  de, but are not limited to, any riteria set forth in paragraph an unnecessary drug.  noted by the pharmacist st be documented on a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			02//	) 09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY			REET ADDRESS, CITY, STATE, ZIP CODE  O COMMERCE DRIVE	1 02/0	J9/2023
LIDEKTT	COMMONS NOS AND RE	THAD OTK OF ELE COOK!!		SA	ANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	resident's medical recirregularity has been action has been taken be no change in the rephysician should doct the resident's medical §483.45(c)(5) The fact maintain policies and drug regimen review limited to, time frames the process and steps when he or she identifications urgent action. This REQUIREMENT by:  Based on record review Nurse Practitioner, are failed to act upon recompositions were reviewed to act upon recompositions. The findings included Resident #12 was ad 10/11/21 with diagnost dementia with mood of the regularity has been actionally as a second record reviewed to act upon recompositions.	resician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in I record.  Cility must develop and procedures for the monthly that include, but are not is for the different steps in its the pharmacist must take fies an irregularity that in to protect the resident.  The is not met as evidenced rew, Consultant Pharmacist, and staff interviews, the facility ommendations made by the st for 1 of 6 residents whose iewed (Resident #12).	F	756	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 tak or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility a sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	l ken	
	an order dated 12/16, medication) 0.5 millig mouth every four hou	physician orders revealed //22 for Ativan (an antianxiety rams (mg) one tablet by rs as needed for anxiety, f breath. The order was order from Nurse			Corrective action for resident(s) affected by the alleged deficient practice.  For resident# 12, on 02/09/2023 the physician order was updated to include 14 day stop date and appropriate clinic indications for use of the psychotropic.	a	

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SIRECT LODRESS, CITY, STATE, JP CODE   316 COMMERCE DRIVE   SAMPORD, NC 27332			345532	B. WING		0.	_
IDENTITY COMMONS NSG AND REHAB CTR OF LEE COUNTY   SAMFORD, NC 27332     IDENTITY   SUMMARY STATEMENT OF DEPICIENCIES   FACE DEPICIENCY MUST SE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REEFRENCED TO THE APROPRIATE OF TAG     F756   Continued From page 120   F756   A review of Resident #12's December 2022   Medication Administration Record (MAR) revealed he received the as needed Ativan on 12/16/22, 12/18/22, 12/12/22, 12/26/22 and 12/31/22.   A Pharmacy Medication Regimen Review progress note dated 12/27/22 indicated recommendations were left in a report to the facility. The report indicated a stop date was needed for the as needed Ativan or 478/23.   A review of Resident #12's January 2023 MAR revealed he received a dose of the as needed Ativan on 19/23.   A review of Resident #12's January 2023 MAR revealed he received a dose of the as needed Ativan on 19/23.   A review of Resident #12 and stated she had requested a stop date for the as needed Ativan on 12/27/22.   The Pharmacist continued the practitioners for follow-up if the recommendations were sent to the Director of Nursing (DON) via email and the DON would provide to the practitioners for follow-up if the recommendations were sent to the Director of Nursing (DON) via email and the DON would provide to the practitioners for follow-up if the recommendations were sent to the Director of Nursing (DON) via email and the DON would provide to the practitioners for follow-up if the recommendations were sent to the Director of Nursing (DON) via email and the DON would provide to the practitioners for follow-up if the recommendations were sent to the Director of Nursing (DON) via email and the DON would provide to the practitioners for follow-up if the recommendations were sent to the Director of Nursing (DON) via email and the DON would provide to the practitioners for follow-up if the recommendations were sent to the Director of Nursing (DON) via email and the DON would provide to	NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	2/09/2023
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		345532	B. WING _			l	09/ <b>2023</b>
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LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			NFORD, NC 27332		
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F 756	Continued From page	e 121	F 7	756			
F 756	Administrator for almothe facility acquired a January 2023. He felt related to the reason a stop date had not be	ost three weeks. In addition, new Medical Director in t the changeover in staff why the recommendation for een addressed. tempts were made to the	F	756	are uploaded to the individual resident documents once all steps in the proces have been completed, and psychotrop medications should be reviewed in dail clinical to ensure that all PRN Psychotropic medications have a 14 dastop date. PRN orders for psychotropic drugs are limited to 14 days and cannobe renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Thinformation has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training who to be allowed to work until training has been completed by 3/17/2023.  4. Monitoring Procedure to ensure that 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 F756 Quality Assurance Tool for compliance with the Drug Regimen Review Proces weekly x 2 weeks then monthly x 3 moor until resolved. The Director of Nursir will monitor for follow through of physic review and that all orders received are	ic y ay c t is e or ot ill s t at the	
					initiated. Reports will be presented to t weekly Quality Assurance committee b		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		SURVEY PLETED
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F 756 F 758 SS=E	Free from Unnec Psy CFR(s): 483.45(c)(3)(	chotropic Meds/PRN Use		the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be mor and the ongoing auditing program reviewed at the weekly Quality Assu Meeting. The weekly QA Meeting is attended by the Administrator, Direct Nursing, MDS Coordinator, Therapy Manager, Health Information Managand the Dietary Manager.  Date of Compliance: 03/17/2023	rance tor of	3/17/23
	affects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a compreheresident, the facility manual sychotropic drugs and unless the medication specific condition as of in the clinical record;  §483.45(e)(2) Reside	hotropic drug is any drug that associated with mental for. These drugs include, drugs in the following  ensive assessment of a must ensure that ints who have not used for not given these drugs in sinecessary to treat a diagnosed and documented  ints who use psychotropic I dose reductions, and				

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F 758	Continued From page	e 123	F 7	58			
	contraindicated, in ar drugs;	n effort to discontinue these					
	unless that medicatio	ursuant to a PRN order on is necessary to treat a condition that is documented					
	are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the PI beyond 14 days, he of	RN order to be extended or she should document their ent's medical record and					
	drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of	rders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication.  is not met as evidenced					
	Psychiatric Nurse Pa #2, Director of Nursin Director (MD) #2 inte record review, the fac gradual dose reduction antipsychotic last incu #29). The facility also as needed (PRN) psy medications had a ste Resident #12) for 3 o	riewed for unnecessary		The statements made on this procurrection are not an admission not constitute an agreement wire alleged deficiencies.  To remain in compliance with a and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility sallegar compliance such that all alleged deficiencies cited have been or corrected by the dates indicated F758  The facility failed to attempt a general series.	n to and of th the Il federal y has take in this correction tion of d will be d.	en	

PRINTED: 04/26/2023 FORM APPROVED OMB NO. 0938-0391

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NAME OF PE	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/03/2023
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LIBERTY	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY		SANFORD, NC 27332	
	OUR MAR DV OT	ATTIMENT OF REFIGIENCIES		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 758	Continued From page	e 124	F 758	8	
	1. Resident #29 was readmitted on 5/2/22 of dementia with mod with anxiety, and Pari Review of the cumula indicated she was ad (an antipsychotic medincreased to 10 mg d no documented evide Abilify 10 mg dose from the conducted on Resident #29 was carevised on 5/9/21 for medication for anxiety Interventions included review her psychotropiand as needed for poreductions.  Review of Resident #0 orders included an orders included an orders included an orders included an orders included and incomplete the continue Abilify (antip daily for depression procession of the annual Minimum indicated Resident #2 exhibited no mood diswas coded for taking Area Assessment was	admitted on 4/17/19 and with cumulative diagnoses d disturbance, dementia kinson's Disease.  Itive orders for Resident #29 mitted on 4/17/19 on Abilify dication) 5 mg daily and aily on 4/21/21. There was ence of a GDR attempt of the om 4/21/21 through the 1/26/23.  It planned 2/3/21 and the use of an antipsychotic y and Parkinson's Disease. If consulting Pharmacist to bic medications quarterly ssible changes or  29's January 2023 Physician der dated 5/27/22 to sychotic) 10 milligrams (mg) the psychological services.  Data Set dated 1/17/23 are years of the psychological services.  Data Set dated 1/17/23 are years of the psychological services.  Data Set dated 1/17/23 are years of the psychological services and antipsychotic and a Care is completed for ion use and addressed the possible GDR of her		dose reduction of a prescribed antipsychotic drug for resident #29 and failed to ensure orders for as needed (PRN) psychotropic (antianxiety) medications had a stop date for resident s #45 and #12.  1. Corrective action for resident(s) affected by the alleged deficient practic For resident # 29, the clinical indication the Abilify is depression.  On 02/27/2023, the Director of Nursing followed up with the psychiatric nurse practitioner and medical director to discuss pharmacy recommendations for gradual drug reduction of Abilify for resident #29. The plan for gradual drug reduction and clarifications were documented in the resident schart by the provider on 03/01/2023.  For resident #12, a hospice resident now with order for as needed (PRN) psychotropic medication without a stop date of 14 days. On 01/25/2023 the Director of Nursing notified the medical provider for clarification orders with corrective actions completed on 02/27/2023.  For resident # 45, a hospice resident noted with order for as needed (PRN) psychotropic medication without a stop date of 14 days. On 02/09/2023, the Director of Nursing notified the medical provider for clarifications orders with corrective actions completed on 02/27/2023.	ce: ofor g or ug oted
	Review of a Consulta Regimen Review rep Nursing (DON #2) da			Corrective action for residents with the potential to be affected by the alleg.	

Facility ID: 980156

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		PLETED
		345532	B. WING _			l	C ( <b>09/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3′	10 COMMERCE DRIVE		
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(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 758	' '		F	758			
	recommended to atte				deficient practice.		
	, , ,	esident #29's Abilify to			On 02/27/2023, the pharmacy consulta		
	ensure the lowest po	ssible dose was effective			began review of all current residents of		
					anti-psychotic medications for appropri		
	Davison of a Nata to	\			clinical indication and potential for grad		
	Review of a Note to A	recommendation from the			drug reductions. Any concerns noted to be reviewed with the MD for changes.	VIII	
		st dated 1/25/22 read			This process will be completed by		
		escribed Abilify 10 mgs and			02/27/2023. Results included: no other	r	
		nsidered to ensure she was			concerns.	•	
	on the lowest possible						
	1	e recommendation read her			On 02/27/2023, the Director of Nursing		
	behaviors were stable	e but her Abiify was not			began audit of the past 30-day pharma		
	addressed but did ha	ve a GDR completed for 2			recommendations to ensure all reques	ted	
	1	depressants. This note was			clarifications and follow up concerns ha	ave	
	signed by MD #2 on	3/1/22.			been addressed with the medical		
					provider. This process was completed	on	
	Review of Resident #				02/27/2023.		
		's (MAR) for February 2022			Results included: no other concerns.		
	received her Abilify d	indicated Resident #29			On 02/27/2023, the Director of Nursing began auditing all as needed (PRN)		
	received her Ability d	ally as ordered.			psychotropic medications to ensure 14		
	Review of a Consulta	ant Pharmacist's Medication			day stop date. This process was		
	I .	ort sent to DON #2 dated			completed on 02/27/2023. Results		
		sultant Pharmacist was			included: no other concerns.		
	unable to locate the r	equest from last month for					
	MD #2 to review Res	ident #29's psychotropic			3. Measures /Systemic changes to		
	medications for a GD	R.			prevent reoccurrence of alleged deficiently practice:	ent	
	Review of a Consulta	nt Pharmacist's Medication			Beginning on 2/23/2023 the nurse		
		ort sent to DON #2 dated			consultant began educating the Directo	or	
	I .	iewed the psychiatric NP			of Nursing, Minimum Data Set Nurse,		
		nd it again made no mention			Administrator, RN Unit Manager on the		
	that Resident #29 wa	•			pharmacy consultant report process ar	ıd	
	recommendations for	a GDR of Ability.			Residents right to be Free from	,	
	Davieus et a manal : (	wie NID www.www.w.c.			unnecessary psychotropic medications		
		ric NP progress note dated			PRN use. Education by the Director of		
	that Resident #29 wa	e any documented evidence			Nurses/RN Unit Manager was started of 2/24/2023 with all licensed nurses on	ווע	
	LINGLI NOUNGELIL #40 WC	io produibou / willy.	1		, <i>_,_</i> ,,_,,_,, with an ilochood fluides off		1

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 _			l	C 09/2023
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	03/2023
					10 COMMERCE DRIVE		
LIBERTY (	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			ANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	e 126	F	758	residents right to be Free from		
	_	nt Pharmacist's Medication ort sent to the DON #2 dated acility to ensure the			unnecessary psychotropic medications PRN use.	1	
	psychiatric NP was a	ware the Resident #29 was ere was no mention of it in			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	
		ic NP progress note dated any documented evidence s prescribed Abilify.			reviewed by the Quality Assurance process to verify that the change has been sustained. As of 3/17/2023, any staff who does not receive scheduled		
	_	nt Pharmacist's Medication ort sent to DON #2 dated acility to ensure the			in-service training will not be allowed to work until training has been completed		
		ware the Resident #29 was ere was no mention of it in niatric NP note.			4. Monitoring Procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory	nat	
	Consultant Pharmaci	recommendation from the			requirements.  The Director of Nurses or designee wil monitor compliance utilizing the F758  Quality Assurance Tool weekly x 4 weekl		
	a GDR should be con on the lowest possible	sidered to ensure she was			then monthly x 3 months. The Director Nursing will monitor pharmacy consulta recommendations to ensure timely follo	of ant	
	psychiatric NP.	eviewed by MD #2 or the			up and clarification and Daily Clinical review of all as needed (PRN) psychotropic medications to ensure 14		
	9/14/22 read a GDR of failed and no other do note about the Abilify				day stop date period has been entered Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate.	/	
	Regimen Review rep	nt Pharmacist's Medication ort sent to DON #2 dated ity needed to evaluate if ting Abilify.			Compliance will be monitored and the ongoing auditing program reviewed at weekly Quality Assurance Meeting untideemed no longer necessary for compliance unnecessary medications a	I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 758 Continued From page	127	F 7	'58			
Review of a Note to At Physician/Prescriber of Consultant Pharmacist Resident #29 was press a GDR should be conson the lowest possible documentation on the NP #2 disagreed becaresponse to the current not indicated and would #29's function or cause note was signed by the A telephone interview at 11:22 AM with NP # recall addressing the A Physician/Prescriber of Consultant Pharmacist documented on the rewas not indicated due impairment to Resident psychiatric instability, the Review of a psychiatric 10/26/22 read a GDR of had failed, and Reside medication regimen we noted. There was no of in the note about the A Review of a Consultant Regimen Review report 10/28/22 read for the find signed all GDR request medications since the Medicaid Services (CM).	tending ecommendation from the t dated 9/26/22 read scribed Abilify 10 mgs and sidered to ensure she was effective dose. The recommendation indicated use she has had a good at treatment. A GDR was and likely impair Resident e psychiatric instability. This e NP #2 on 10/3/22.  was completed on 1/26/23 2. She stated she don't attending ecommendation from the t dated 9/26/22 but if she commendation that a GDR to the risk of further at #29's function or cause that was she intended.  C NP progress note dated of Resident #29's Abilify and #29 was tolerating her cell with no side effects ther documented evidence abilify.  At Pharmacist's Medication rt sent to DON #2 dated acility to ensure the MD	F 7	758	psychotropic medications. The weekly Meeting is attended by the Administrate Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.  Date of Compliance: 03/17/2023		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			1	C <b>09/2023</b>
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	,	310 CO	MMERCE DRIVE  DRD, NC 27332	, 02.	<u> </u>
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F 758	11/23/22 read a GDF had failed, and Resid medication regimen noted. There was not in the note about the Review of a Consult. Regimen Review rep 12/27/22 read the fa Resident #29 was ta Review of a Note to Physician/Prescriber Consultant Pharmac Resident #29 had susome of her medications listed for The recommendation decrease her Amlod. An interview and obswith Resident #29 or was dressed for the on the side of her be appeared to have a was exhibited by her constantly moving. Shaving any concerns by the facility and on as trouble sleeping a Observations were constantly worked.	tric NP progress note dated R of Resident #29's Abilify dent #29 was tolerating her well with no side effects other documented evidence Abilify.  ant Pharmacist's Medication port sent to DON #2 dated cility needed to evaluate if king Abilify.  Attending recommendation from the ist dated 12/27/22, read istained recent falls and ions may have the possibility increased fall risk. These review included her Abilify. In read NP #1 only agreed to ipine (lowers blood pressure).  Servation were completed in 1/23/23 at 9:20 AM. She day, well-groomed and sitting id. She was pleasant, flat affect and restlessness if fidgeting, her hands were the stated she was not a regarding the care provided ally voiced some anxiety such and concentrating.	F	758			
		w was completed on 1/25/23 Consultant Pharmacist. She					

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	
		345532	B. WING			1	C 09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		310 COM	ADDRESS, CITY, STATE, ZIP CODE IMERCE DRIVE RD, NC 27332	1 02/	00/2020
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F 758	aware Resident #29 1/25/22, 2/24/22, 3/1 9/26/22, 10/28/22 and were issues with the recommendations and she documented the monthly Medication F was sent to DON #2.  A telephone interview at 1:43 PM with NP # the pharmacy recommendations and she was Resident #29's alleged because she could one refusals by the MD # On 1/25/23 at 11:00 / completed with Medical Assistant (NA) #2 and the observed behavior was impatience, restigned.	I GDR attempts or ng if the psychiatric NP was was prescribed Abilify on 1/22, 5/27/22, 7/26/22, d 12/27/22. She stated there facility responding to ad clarifications. She stated issue numerous times in her Regimen Review report that was completed on 1/25/23 at 1. She recalled reviewing mendation on 12/27/22 at 29 sustaining some falls but orking at the facility for a few not thoroughly up to date on ad failed GDR attempts and Find evidence of GDR 2 and NP #2  AM interviews were cation Aide (MA) #1, Nursing d Nurse #2. They reported ors Resident #29 exhibited	F	758	DEFICIENCY)		
	AM with NP #2. She psychiatric NP would recommendation reg was uncertain as to vanytime in 2022. She have had a GDR attedetermine if the dose effective due to the a	act on pharmacy arding psychotropics and why that did not occur stated Resident #29 should					

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 _			1	C /09/2023	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		310	EET ADDRESS, CITY, STATE, ZIP CODE  COMMERCE DRIVE  NFORD, NC 27332	1 02/	03/2023	
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F 758	' •		F7	758				
	of any GDR refusals, Resident #29.	attempts for failures by						
	at 12:24 PM with the she spoke to staff, the medical record on he stated according to the should have been an Resident #29 refused decrease her Abilify. was alert and orienter party therefore that stated the psychiatric NP stated documented anywhere why there was no evil her behalf. She stated	re in her notes but that was dence of a GDR attempt on d it was her understanding he MD and NP #2 were						
	with DON #1 who wa until 1/13/23. She sta with reviewing the ph Pharmacist's Medicat reports, but she could	_						
	4:28 PM with DON #2 working as the DON receiving a report frommonth, but she would Nurse Supervisor or a in reviewing and comrecommendations. SI	was completed on 2/1/23 at 2. She stated her last day was 1/13/23. She verified in the pharmacy every I enlist the assistance of the another administrative nurse pleting any needed ne stated she did not go a recommendations were						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345532	B. WING		C 02/09/2023	
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 02/00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPORTICIENCY)	D BE COMPLETION	
F 758	Continued From part A telephone intervie 4:41 PM with MD # impression that Reserviewed for a poss NP and a GDR attent attempted in 2022.  2. Resident #12 was 10/11/21 with diagn dementia, congestion obstructive pulmons:  A review of the actinan order dated 12/1 medication) 0.5 mill mouth every four heagitation, shortness:  The December 202 Record (MAR) indicated in the continues.  A quarterly Minimum assessment dated in ad moderately impression interview.	ge 131  ew was completed on 2/2/23 at 2. He stated he was under the sident #29's Abilify was being sible GDR by the psychiatric mpt should have been  s admitted to the facility on oses that included vascular we heart failure and chronic ary disease.  We physician orders revealed 6/22 for Ativan (an antianxiety igrams (mg) one tablet by ours as needed for anxiety, a of breath.  2 Medication Administration cated Resident #12 had aded dosage of Ativan five	F 75	DEFICIENCY)		
	The January 2023 I had received the as time.  A phone interview we Practitioner #4 on 1	MAR indicated Resident #12 needed dosage of Ativan one was held with Nurse /25/23 at 2:30 PM, who stated he regulation that required all				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	ON (X3) DATE COMF	
	345532	B. WING _			C <b>02/09/2023</b>
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PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE
were exempt from On 1/25/23 at 2:3 occurred with Nuverbal order on a aware there was psychotropic me oversight to not I when the order with the order was	n but thought Hospice residents in the regulation.  33 PM, a phone interview urse #9, who transcribed the 12/16/22. She stated she was a time limited duration for dications and felt it was an have inquired about a stop date was received on 12/16/22.  Sursing (DON) #1 was /26/23 at 10:00 AM and stated all as needed psychotropic uired time limited duration even if itiec care, to allow for the need for the medication of if hight be needed. DON #1 stated is responsibility to obtain a stop der was received for an as	F 7	58		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  3		PLETED
		345532	B. WING	<del></del>		C /09/2023
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			•	STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	, , , , ,	
PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 758	12/6, 12/8, 12/9, 12 12/15, 12/16, 12/19 12/24, 12/25, 12/26 MARs for January 2 had received the Lo 1/8, 1/10, 1/11, 1/12 1/20 and 1/24/23.  Nurse #7 was intern She verified that Re care of hospice. Sh the order for the PR electronic medical r #45. She indicated stop date is needed psychotropic medic  The Director of Nursinterviewed on 1/26 that PRN orders for should have a stop that she was not su 14 days applied to r  Administrator #1 an interviewed on 1/26 Administrator stated psychotropic medic date of 14 days. Food Procurement, CFR(s): 483.60(i)(1  §483.60(i) Food saf The facility must -	/10, 12/11, 12/13, 12/14, , 12/20, 12/21, 12/22, 12/23, , 12/28, and 12/29/22. The //23 revealed that the resident //24 rezepam on 1/2, 1/3, 1/4, 1/7, //2, 1/13, 1/14, 1/16, 1/17, 1/18, //2 rewed on 1/25/23 at 9:44 AM. //2 rewed on	F 75			3/17/23

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345532	B. WING		C		
NAME OF P	ROVIDER OR SUPPLIER	0.000_		STREET ADDRESS, CITY, STATE, ZIP CODE	02/09/2023		
				310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 812	from local producers, and local laws or regu (ii) This provision doe	ood items obtained directly subject to applicable State ulations. s not prohibit or prevent	F 81	2			
	gardens, subject to co safe growing and food (iii) This provision doe	roduce grown in facility compliance with applicable d-handling practices. es not preclude residents s not procured by the facility.					
	serve food in accorda	prepare, distribute and ince with professional rvice safety. is not met as evidenced					
	facility failed to air dry prior to stacking toge of 44 insulated plate	n and staff interview, the the insulated plate bases ther and ready for use for 44 pases observed. This intial for cross contamination dents.		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	al ken		
	On 1/24/23 at 11:30 A conducted prior to the were 44 insulated pla	AM, tour of the kitchen was e tray line observation. There te bases observed that were		constitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	511		
	area. When separate The Dietary Manager observed the wet inst	ready for use at the tray line d, the plate bases were wet. (DM) was informed and ulated plate bases. The DM bye the insulated plate		F812 1. Corrective action for resident(s) affected by the alleged deficient praction	ce:		
	started drying them w On 1/24/23 at 11:50 A	AM, the DM was interviewed.		On 1/24/2023 Dietary Service Director washed, sanitized, air-dried and prope stacked bases on storage rack when completely dried.			
	She stated that she edried and not to stack reported that some of			Corrective action for residents with potential to be affected by the alleged	the		

Facility ID: 980156

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345532	B. WING _		_	C 02/0	9/2023
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				310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 812	Continued From page 135 insulated plate bases were wet this morning since they were late in washing the dishes and there was not enough time to air dry them before lunch. She reported that 1 dietary aide was sent home and 1 dietary aide came in at 9 AM this morning.  The Administrator and the Nurse Consultant were interviewed on 1/26/23 at 12:54 PM. The Administrator stated that he expected the dishes to be air dried and not to stack them when wet.		F8	deficient practice.  All residents have the potential to be affected by the alleged deficient practice. On 1/24/2023, the Dietary Service Director completed a kitchen walk through to ensure all pots, pans, and small wares had been properly cleaned and stored.  3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:  In-service education was provided to all full time, part time, and as needed staff. Topics included: proper washing, sanitizing, and drying procedures, wet nesting definition and prevention, and		ugh res ent ent	
				was inserviced by to 02/28/2023. Dietal begun on 2/28/202 Services Director. If are not inserviced the is completed.  This information has the standard orient required in-service all staff and will be Assurance process change has been service the plan of corrections.	If dietary employees by 03/03/2023 they to work until education as been integrated in refresher courses for reviewed by the Questo verify that the	ce s will on nto the or ality	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			l	C /09/2023	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		31	REET ADDRESS, CITY, STATE, ZIP CODE  O COMMERCE DRIVE  ANFORD, NC 27332	, <u> </u>	00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 812	Continued From page 136		F 812		and/or in compliance with regulatory requirements.  The Dietary Service Director and/or designee will monitor procedures for proper storage procedures weekly x 4 weeks, then monthly x 3 months, using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that all items are washed, sanitized, dried, and stored properly. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance we be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Therapy, Health Information Manager, and the Dietary Manager	o / on ill		
	enables it to use its re efficiently to attain or practicable physical, well-being of each res This REQUIREMENT by: Based on record rev	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial	F8	335	Date of Compliance: 03/17/2023  The statements made on this plan of correction are not an admission to and	do	3/17/23	
		failed to have effective			not constitute an agreement with the			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE COMP	SURVEY
			7 BOILDI	_		1 ,	c
		345532	B. WING _				/09/2023
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	021	03/2023
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F 835	Continued From page	e 137	F	335			
		revent, identify, assess,			alleged deficiencies.		
		sidents with and at risk for			To remain in compliance with all federa	1	
	_	failure resulted in Resident			and state regulations the facility has tal		
	-	oidable abrasion under her			or will take the actions set forth in this	1011	
		entified on 09/06/22 at an			plan of correction. The plan of correction	n	
		sit. The abrasion went			constitutes the facility□s allegation of		
	untreated and area d				compliance such that all alleged		
	unstageable pressure	e ulcer (Full-thickness skin			deficiencies cited have been or will be		
		ich the extent of tissue			corrected by the dates indicated.		
	damage within the ul-	cer cannot be confirmed					
	because the wound b	ed is obscured by slough or			F 835		
	eschar) on 9/13/22. 1	Γhe Wound Physician			<ol> <li>How corrective action will be</li> </ol>		
		6's avoidable pressure ulcer			accomplished for those residents found	I to	
		der for 7 days of dressing			have been affected by the deficient		
		the healed area. The lack			practice:		
		r 1/10/23 resulted in the					
	_	ng consulted on 1/24/23			Resident #16 received a total body skir		
		the area had reopened into			assessment on 02/02/2023 by the Intel		
		cer (deep wound reaching			Director of Nursing (DON). The total bo	-	
	_	s of bone) on 1/24/23. This			skin assessment revealed that Resider #16 had a current wound on the left lat		
		nts reviewed for pressure ). The facility also failed to			calf and a treatment was in place that		
		petic ulcer as ordered by the			being managed by the treatment nurse		
		1 of 3 residents reviewed for			the staff nurse according to the	Oi	
		being (Resident #10).			physician □s order. On 02/03/2023, the	ڋ	
		20g (. 100.100 , 10).			Interim Director of Nurses reviewed		
	Immediate jeopardy l	pegan on 9/6/22 when the			Resident #16□s orders and care plan t	0	
	facility administration	~			ensure preventative measures were		
		dentify and prevent further			currently in place to prevent new skin		
	deterioration of an ab	rasion on Resident #16's left			issues and worsening of current wound	s.	
	lateral calf underneat	h her leg immobilizer.					
		was removed on 2/7/23			2. How the facility will identify other		
		ided and implement an			residents having the potential to be		
	-	allegation for immediate			affected by the same deficient practice	:	
		e facility remains out of					
		r scope and severity of E (no			All residents have the potential to be		
		potential for more than			affected by the alleged deficient practic	e.	
		not immediate jeopardy) to			On 02/02/2023, the Interim Director of		
	ensure the facility cor	mpletes all staff training and			Nurses began identification of resident	s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING				C	
NAME OF D	ROVIDER OR SUPPLIER	343332	1 5: 11:110 _	CTD	REET ADDRESS, CITY, STATE, ZIP CODE	02	/09/2023	
NAME OF PI	ROVIDER OR SUPPLIER							
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY			COMMERCE DRIVE			
				SA	NFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		BE .	(X5) COMPLETION DATE	
F 835	Continued From pag	e 138	F 8	35				
	ensure monitoring sy effective. Examples scope and severity of the findings included Cross Reference to: F 684: Based on recestaff and Wound Physician to extremity (Resident Freviewed for well-being F 686: Based on receinterviews with Orthodox	estems put into place are #2, #3 and #4 were cited at f "E".  d:  ord review, observations, esician interviews, the facility and care as ordered by the a diabetic ulcer on the lower #10) for 1 of 3 residents ing.  ord review, observation and epedic Physician Assistant			that were potentially impacted by this practice by completing total body skin assessments on all current residents of 02/03/23. This audit was completed be reviewing 100% of current residents to identify any residents with new pressure wounds or skin integrity alterations. To results included: no other issues identified. On 02/02/2023- 02/03/23, interim Director of Nurses assessed a audited 100% of all current pressure wounds to assure current wound measurements were completed. The results included: no other issues identified. On 2/3/2023, the nurse consultant audited 100% of all resider with identified pressure wounds to assure wounds to assure with identified pressure wounds to assure which identified pressure which identified pressure wounds to assure which identified pressure which identified pressure wounds to assure which identified pressure which identified identified pressure which identified pressure which identified id	y o re he he nd		
	Director (MD) #2, Dir Administrator #2, Nu family, the facility fail development of a pre Resident #16's skin of following a fractured leg just above the kn checks under the imit At the first orthopedic abrasion was identification and physician. The order Skin checks continue the identification of the deteriorated to an under An unstageable present full-thickness skin and extent of tissue dama be confirmed because obscured by slough of tissue). Treatments we	essure ulcer, protect under an immobilizer used distal femur (the area of the ee joint), perform skin mobilizer and assess skin. c follow up appointment, an ed. Orders were given to consult with a wound rs were not implemented. ed not to be done following ne pressure ulcer. The area stageable pressure ulcer. sure ulcer means a d tissue loss in which the age within the ulcer cannot			with identified pressure wounds to assa a current treatment order was correct in place on the electronic treatment record. The results included: no other issues identified. On 2/3/2023 the Interpretation DON completed a 100% audit of all resident Braden scores for risk for pressure ulcers. The results included: other issues identified. On 2/03/2023 100% of residents with pressure wour or at risk for pressure ulcers were audity the Minimum Data Set nurse to enspreyentative measures were currently place to prevent new skin breakdown address the current pressure wound. results included: no other issues identified.  3. Address what measures will be purplace or systematic changes made to ensure that the deficient practice will recoccur:	and erim no ids ited sure in and The		

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION  . BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING_			1	C / <b>09/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER	2.000		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	09/2023	
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	OLIMAN DV OT	ATTIMENT OF REFIGIENCIES			, T		T	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 835	Continued From page	e 139	F 8	335				
	and it re-opened as a	stage 4(deep wound			On 02/24/2023, the Interim Director of			
	reaching the muscle,	ligaments of bone) pressure			Nurses (DON), RN Unit Manager, LPN			
	ulcer on 1/24/23. The	facility also failed to provide			Support Nurse, and MDS Nurse were			
		d for Resident #45 and			educated by the Quality Assurance Nu			
	ensure the alternating				Consultant on the importance for ensu	ring		
		ccording to manufacturer's			that all wounds were assessed on a			
		ent #12 and Resident #46.			regular basis, referrals to the attending			
		e affected 4 of 4 sampled			physician and/or wound physician, and	i		
	#45 and #46).	r pressure ulcers (#16, #12,			efficient oversight of the program.			
	An interview was com	npleted on 2/3/23 at 10:00			4. Monitoring Procedure to ensure that the plan of correction is effective and the			
		r #1. He stated the facility's			specific deficiency cited remains correction			
		ed a problem with pressure			and/or in compliance with regulatory	nou		
		ne first part of January 2023			requirements:			
		oportunity to address the						
	concerns.	. ,			The Administrator and/or designee will			
	An interview was com	pleted on 2/7/23 at 10:00			monitor compliance utilizing the F835			
		ursing (DON) #1. She stated			Quality Assurance Tool weekly x 4 wee	∗ks		
		ON on 1/13/23 was not			then monthly x 3 months. The			
		with skin surveillance and			Administrator and/or designee will mor	ıitor		
		cers until it was brought to			for compliance with F686 Preventing,			
	her attention on 1/23/				Treating Pressure Ulcers. Reports will	be		
	orthopedic Physician	notified of the immediate			presented to the weekly Quality Assurance committee by the Administr	otor		
	jeopardy on 2/3/23 at				and/or designee to ensure corrective	ator		
	jeopaidy 011 2/5/25 at	10.00 AW.			action is initiated as appropriate.			
	Administrator #1 prov	rided the following credible			Compliance will be monitored and the			
		nediate jeopardy removal:			ongoing auditing program reviewed at	the		
	0	, ,			weekly Quality Assurance Meeting. Th			
	Identify those recipier	nts who have suffered, or			weekly QA Meeting is attended by the			
	are likely to suffer, a	serious adverse outcome as			Administrator, Director of Nursing, MD	S		
	a result of the noncor	npliance			Nurse, Therapy Manager, Unit Suppor			
					Nurses, Health Information Manager, a	ınd		
		rovide leadership and			the Dietary Manager.			
		nt effective systems to			B			
	identify changes in sk				Date of Compliance: 03/17/2023			
	thorough skin assess as ordered, and mana	ments, provide treatments age pressures ulcers.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345532	B. WING				C	
NAME OF PE	ROVIDER OR SUPPLIER	0.0002	1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	02/	09/2023	
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(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 835	Continued From page	e 140	F 8	335				
	In September of 2022	2, the facility identified a care						
	concern involving Re	sident # 16. The resident						
	had an orthopedic ap	pointment 9/6/2023 and the						
		d care to be provided to an						
		ted under the immobilizer.						
		care, which allowed the						
		to a lack of monitoring. The						
		oot cause analysis with input						
		ector as to the cause of the						
	-	ited a plan of correction						
		cation, looking under the umentation of skin checks.						
		ng was responsible for						
		f correction and reporting						
	progress to the Quali							
		ound physician assessed						
		ound was resolved, and						
		a protective dressing. On						
		dent to have a dressing						
	dated 01/16/23 to the	left lateral leg with dried						
		. The wound physician						
		on 1/24/2023 and provided a						
	diagnosis of a stage I	V presser ulcer.						
	It was determined that							
	response initiated in							
	regards to the wound							
		g, was completed by the						
		on 9/28/2022. However,						
		ent had not continued or						
	been integrated into t processes. Monitorin							
		ig of pressure dicers, ion of risk, providing wound				ſ		
	•	anges per physician orders,				ſ		
		skin assessments, review of				ſ		
		om physician referrals				ſ		
	regarding identified w					ĺ		
		or wound care were followed				ſ		
		peen audited or reported on						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345532	B. WING			1	C 09/2023	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		COMMERCE DRIVE	1 02/	03/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE	
F 835	Continued From page	e 141	F	335				
	during daily clinical m All residents have the the deficient practice	e potential to be affected by						
	process or system fare adverse outcome from when the action will be as a part of the root Corporate Chief Clinic Clinical Services, Nu Director of Operation conducted a review of daily clinical and wout treatment. Based on determined that reed process was needed Interim Director of Nu conducted of the tool alerts with the Admin Director of Nursing. Consultant provided This included the need Interim Director of Nurprovided by the corporation of the work provided by the corporation o	cause analysis, the cal Officer, Director of rese Consultant, Regional s, and Administrator on 2/3/2023 of the policies for and prevention and this review, it was ucation on the daily clinical for the Administrator and ursing. A review was and work process for istrator and the Interim The Regional Clinical this education on 2/3/2023. And for the Administrator and ursing to use the tools orate team for this process. A pocess for alerts in the clinical included. No changes were seen. The facility failed to through with the policies ions Director and the Quality insultant will monitor ongoing ling this daily clinical meeting in of six months. Operations and Quality insultant determined on ininistrative team completed sponse initiated in						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345532	B. WING _				09/ <b>2023</b>	
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F 835	integrated into the question of risk, and ressing changes per conducting thorough needed treatments for regarding identified with physician orders for a consistently been audily clinical meeting On 2/3/2023, the Integration of the clinical which including staying events that require of addressed. The Quaracter of the clinical review mattended by the Administration with the Administration with the clinical review mattended by the Administration with the Administration with the Administration with the Administration of the Administration with	rality assurance processes. re ulcer prevention, providing wound care and r physician orders, skin assessment, review of om physician referrals rounds, and ensuring wound care had not dited or reported on during s. erim Director of Nursing and ducated on the need to review meeting objectives ng focused on adverse ngoing monitoring have been ality Assurance (QA) Nurse d this education on 2/3/2023. eeting is a meeting held at eek. This meeting is inistrator, Interim Director of se, MDS Nurse, Dietary vices Director and Activities meeting, the team reviews	F 8					
	needed treatments fr regarding identified w physician order for w will be annotated on for this meeting and w Director to review an be taken to the mont meeting to ensure co policy. Additionally, on 2/3/2 Consultant reeducate	skin assessment, review of om physician referrals vounds, and ensuring ound care. This information a form created specifically will be given to the Medical d initial. Then this form will hly Quality Assurance intinual compliance with						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345532	B. WING				09/2023
NAME OF P	ROVIDER OR SUPPLIER	0.0002			STREET ADDRESS, CITY, STATE, ZIP CODE	02/	09/2023
TO THE OT THE	NOVIDER OR GOLL EIER				110 COMMERCE DRIVE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	the previous daily clir Director of Nursing w	al meeting all orders since nical meeting. The Interim ill print the order listing	F	835			
	clinical meeting form. date identified, then t	e and attach it to the daily If a dressing has a stop					
	enter an additional or remove the dressing	der for the next day to and initial next to the					
	Inter-Disciplinary Tea	dentifying it as corrected. m (IDT,) consisting of ırsing, MDS Nurse, Director					
	of Rehabilitation, Die	tary Manager, RN Unit rse, and Administrator, in					
	daily clinical meeting	should review the alerts related to existing pressure					
	ulcers. If an alert for	an existing pressure ulcer is					
		terim Director of Nursing,					
		S Nurse should review the					
		nt and chart to ensure that					
		previously assessed, is					
	, ,	ound Physician, and has a					
		ne IDT was educated on					
		lurse Consultant on the new					
	electronic medical re	will create an alert on the					
		that the IDT reviews as part					
		eeting whenever a nurse					
	-	existing wound on the skin					
		ssessment. The Interim					
		dits on 2/6/23 that focus on				ĺ	
		the nurses accurately					
		wound assessments and					
		assure compliance on all				ſ	
	shifts to include week					ĺ	
	On 2/3/2023, the Reg	gional Director of Operations				ſ	
	_	onsultant were onsite to				ſ	
		of the Interim Director of					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345532	B. WING		C 02/09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE  310 COMMERCE DRIVE  SANFORD, NC 27332	02/09/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 835	Nursing and Administimplementation of this credible allegation resupervision will continuous to ensure completion that the daily clinical identification of adverreview by the IDT. The Operations and the Cattend the monthly Questings either in pethat compliance is between adverse events are comonthly QA.  Alleged date of immeto 2/07/23.  On 02/07/23, the facil Immediate Jeopardy was validated by the creditable allegation fremoval was validated Director of Nursing (Director of Nursing (Dir	crator to ensure s credible allegation and the lated to F686. This have with weekly monitoring of the plans of correction, process is occurring, timely rise events, and completed he Regional Director of the A Nurse Consultant will have usuality Assurance Committee rison or remotely to ensure hing monitored and that honsistently reviewed during diate jeopardy removal  lity's credible allegation for hinemoval effective 02/07/23 following: The facility's for immediate jeopardy d by Administrator #1 and hon in and in-serviced on 2/3/23 hince Nurse Consultant. hed but there were no	F 835		
F 842 SS=D	Resident Records - Id	vas removed on 2/7/23. dentifiable Information 483.70(i)(1)-(5)	F 842		3/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345532	B. WING		C 02/09/2023	
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	02/03/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 842	Continued From pa	ge 145	F 84	12		
	(i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use of except to the extensito do so.  §483.70(i) Medical §483.70(i)(1) In accordessional standar must maintain medical that are- (i) Complete; (ii) Accurately docu (iii) Readily accessi (iv) Systematically of §483.70(i)(2) The fact all information contained are gardless of the forecords, except who (i) To the individual, representative when (ii) Required by Law (iii) For treatment, poperations, as permit with 45 CFR 164.50 (iv) For public healt neglect, or domestic activities, judicial ar law enforcement put	release information that is to an agent only in contract under which the agent or disclose the information the facility itself is permitted  records. cordance with accepted ords and practices, the facility ords and practices, the f				
	activities, judicial ar law enforcement pu purposes, research medical examiners,	nd administrative proceedings,				

		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		C 02/09/2023	
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	02/03/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 842	Continued From page by and in compliance §483.70(i)(3) The fact record information agunauthorized use.  §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 years legal age under State §483.70(i)(5) The medii) Sufficient informatif (ii) A record of the restiii) The comprehensing provided; (iv) The results of any and resident review edeterminations conductively Physician's, nurse professional's progresional's progresional's progresional services reports as retained to the complex of the resting to the complex of the complex of the resting to the complex of the compl	with 45 CFR 164.512.  ility must safeguard medical ainst loss, destruction, or  records must be retained  required by State law; or e date of discharge when in the interest of the interest o	F 842	DEFICIENCY)	ALE	
	facility failed to maint	iew and staff interviews, the ain accurate medical records iewed for diabetic wound		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 ta	al	
	Resident #10 was ad 7/8/20 with diagnoses	mitted to the facility on sthat included a stroke, peripheral artery disease.		or will take the actions set forth in this plan of correction. The plan of correctic constitutes the facility allegation of compliance such that all alleged deficiencies cited have been or will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			l	09/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, <u> </u>	00/2020
					10 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			ANFORD, NC 27332		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	e 147	F8	342			
	Resident #10's Decer	mber 2022 physician orders			corrected by the dates indicated.		
		n Prep to the right first toe			F842		
	every shift for wound.				1. Plan for correcting specific deficience	ÿ.	
	•				The process that led to deficiency cited		
	The December 2022	Treatment Administration			The facility failed to maintain accurate		
	Record (TAR) was re-	viewed and revealed the			medical records for resident #10.		
	right first toe wound o	care had not been			On 02/24/2023, the treatment nurse		
		leted or refused by the			completed a wound assessment on		
		ng shift on 12/8/22, the night			Resident #10 to ensure no identified		
	shift on 12/8/22 and t	he day shift on 12/14/22.			change of condition.		
	A	D ( 0 ( (MD0)			On 02/24/2023, the Director of Nursing		
	A quarterly Minimum	• •			reviewed resident #10 Treatment	. 1	
		7/23 indicated Resident #10			Administration record to ensure resider	ıτ	
		ired cognition, displayed no n of care, and was coded			was receiving ordered care and notification to medical provider and RP	of	
	with diabetic foot ulce				any identified concerns.	Oi	
	with diabetic foot dice				Corrective action for residents with	he	
	Review of the Januar	y 2023 physician orders			potential to be affected by the alleged		
	included the following				deficient practice.		
		23 to cleanse the right first			All residents with ordered wound		
		er and apply Betadine every			treatment have the potential to be affect	ted	
	shift for wound care.				by the alleged deficient practice.		
		/23 to cleanse the left heel			On 02/27/2023, the Director of Nursing	)	
		apply Santyl and protective			began auditing the past 14 days of		
	dressing every day.				Treatment Administration Records to		
		/23 to cleanse the right heel			ensure treatments were appropriately		
		apply Santyl and protective			documented as completed by the		
	dressing every day.				assigned nurse. This was completed of	n	
	The January 2023 TA	R was reviewed and			02/27/2023. The results included: no other concerns/issues.		
	_	t toe and bilateral heel			On 02/27/2023, the Director of Nursing		
	wound care had not b				began assessment of current residents		
		by the resident for the day			with missed treatment documentation t		
		he evening shift on 1/21/23.			ensure no changes in wound status. T		
		<b>5</b> ==			was completed on 02/27/2023. The		
	Review of the nursing	g progress notes from			results included: no other		
		d not reveal any refusals of			concerns/issues.		
	wound care by Resid	ent #10.					
					3. Systemic changes:		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING			l	C 09/2023
NAME OF PI	ROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	03/2020
					10 COMMERCE DRIVE		
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY				ANFORD, NC 27332			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	e 148	F	842			
	On 1/25/23 at 9:54 Al	M, an interview occurred			On 02/27/2023, the Director of Nursing		
	with Nurse #1 who wa	as assigned to care for			began an in-service education to all full		
		day shift of 1/19/23. She			time, part time, and as needed RN, LPI	٧,	
	reviewed the TAR sho				Treatment aide, and wound nurse		
		ound care or refusal by			(including agency). Topics included:		
		ted that she completed the			Examples of Potential Treatment Errors	S:	
		ed but got busy and forgot to			" Omission of treatment  " Treatment administered without a		
	sign the treatments o	ii as completed.			physician's order		
	A phone interview wa	s completed with Nurse #9			" Wrong treatment or medication		
	-	M. She was assigned to care			ordered with treatment is incorrect		
		he night shift of 12/8/22 and			" Wrong Route Administered		
	had not initialed the w	vound care as completed or			" Wrong Time administered		
	refused by the reside	nt. Nurse #9 stated she			" Wrong dose of medication delivered	ed	
		care as ordered but forgot			with ordered treatment		
	to sign the TAR.				" Failure to document that the		
					treatment was administered		
		ned to care for Resident #10			On 00/07/2002 the Nivers Consultant		
		of 12/8/22 and had not vound care completed or			On 02/27/2023, the Nurse Consultant provided an in-service education to		
		#10. Nurse #10 was unable			management nurses (Director of nursir	na	
	to be interviewed.	710. Nuise #10 was unable			support nurse, MDS nurse and	ıg,	
	to be interviewed.				Administrator). Topics included:		
	Multiple phone call at	tempts were made for Nurse			" Daily clinical review of Treatment		
	#11 but were unsucce	essful. Nurse #11 was			Administration Record /		
	assigned to Resident	#10 on 1/21/23 and had not			Medication/Treatment Administration A	udit	
	initialed the evening s				report for missed documentation to		
	completed or refused	by the resident.			ensure timely follow up and immediate		
					corrective actions.		
		was interviewed on 1/26/23			This information has been integrated in		
		cated it was his expectation			the standard orientation training and in		
	or the nursing staff to	completed wound care as			required in-service refresher courses for all nurses and management nurses as	)I	
	completed or refused				identified above and will be reviewed b	v	
	oompicica or reluseu	by the resident.			the Quality Assurance process to verify		
					that the change has been sustained. A		
					applicable staff who does not receive		
					inservice education by 3/17/2023,will n	ot	
					be allowed to work until training been		

OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345532	B. WING _				C 09/2023	
	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332			03/2023	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x			(X5) COMPLETION DATE	
Continued From page	e 149	F	342	the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements.  The Director of Nursing or designee will monitor the completion of Medication/Treatment documentation daily Monday   Friday during daily clin to ensure timely corrective actions and follow up. The F 842 Quality Assurance tool will be completed weekly for 2 weet then monthly for 3months or until resolved. Reports will be presented to weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager.	nat cted  II  ical e ks the y		
CFR(s): 483.75(c)(d) §483.75(c) Program monitoring. A facility must establi policies and procedu collections systems,	(e)(g)(2)(i)(ii)  feedback, data systems and  sh and implement written res for feedback, data and monitoring, including	F	367	Date of compliance. 03/17/2023		3/17/23	
	QAPI/QAA Improvem CFR(s): 483.75(c) Program monitoring. A facility must establi policies and procedur collections systems, a adverse event monitoring.	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 149  QAPI/QAA Improvement Activities  CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)  §483.75(c) Program feedback, data systems and	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 149  Continued From page 149  F & SAB3.75(c) (d)(e)(g)(2)(i)(ii)  §483.75(c) Program feedback, data systems and monitoring.  A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and	GAPI/QAA Improvement Activities CFR(s): 483.75(c) (d)(e)(g)(2)(i)(ii)  §483.75(c) Program feedback, data systems and monitoring. A BUILDING B. WING  SIMMARY STATEMENT OF LEE COUNTY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 842  Continued From page 149  F 842  GAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)  §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and	ROWIDER OR SUPPLIER  345532  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE  SAMPORD, NC 27332  SUMMARY STATEMENT OF DEFICIENCES (EACH DEPOCEMENCE) PRECIDED BY PILL REGULATORY OR USE DENTIFYING INFORMATION)  Continued From page 149  F 842  Completed.  4. Monitoring Procedure to ensure that the plan of correction is effective and the plan of correction of Medication/Treatment documentation daily Monday □ Friday during daily clin to ensure timely corrective actions and follow up. The F 842 Quality Assurance tool will be completed weekly for 2 wee them monthly for 3 months or until resolved. Reports will be presented to weekly Quality Assurance committee be the Administrator to ensure corrective action initiated as appropriate. Compliance will be monthly for 3 months or until resolved. Reports will be presented to weekly Quality Assurance Meeting. The Weekly Quality Assurance Meeting. The Weekly Quality Assurance Meeting is attended by the Administrator, Director Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager.  CAPI/QAA Improvement Activities  CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)  §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring, including adverse event monitoring, The policies and	ROWIDER OR SUPPLIER  345532  ROWIDER OR SUPPLIER  COMMONS NSG AND REHAB CTR OF LEE COUNTY  SUMMARY STATEMENT OF DEFICIENCIES  (EACH OFFICIENCY MUST SE PRECEDED BY YPUL REGULATORY OR I.SC IDENTIFYING INFORMATION)  Continued From page 149  F 842  Completed.  4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in completion of Medication/Treatment documentation daily Monday in Friday during daily clinical to ensure time to ensure that the normal procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in completion of Medication/Treatment documentation daily Monday in Friday during daily clinical to ensure timely corrective actions and follow up. The F 842 Quality Assurance tool will be completed weekly for 2 weeks then monthly for 3 months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate.  Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager.  Date of compliance: 03/17/2023  F 867  CAPI/QAA Improvement Activities  CFR(s): 483.75(c)(d)(e)(g)(2)(0)(ii)  §483.75(c) Program feedback, data systems and monitoring. The policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED			
		345532	B. WING _			C <b>02/09/2023</b>	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP ( 310 COMMERCE DRIVE SANFORD, NC 27332	CODE	02/03/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 867	systems to obtain and from direct care staff, resident representation information will be used are high risk, high voopportunities for improved by the systems to identify, conformation from all donot limited to the facility systems to identify, conformation from all donot limited to the facility and evaluation of per including the method development, monitoon systematically identification and yet and use data adverse events in the facility will use the data prevent adverse events in the facility will use the data and the systematically identification and yet and use data adverse events in the facility will use the data and yet and use the data and yet an	maintenance of effective duse of feedback and input other staff, residents, and wes, including how such ed to identify problems that lume, or problem-prone, and rovement.  maintenance of effective ollect, and use data and epartments, including but lity assessment required at ding how such information op and monitor performance  development, monitoring, formance indicators, ology and frequency for such ring, and evaluation.  adverse event monitoring, so by which the facility will y, report, track, investigate, a and information relating to efacility, including how the state to develop activities to ints.  systematic analysis and  cility must take actions e improvement and, after actions, measure its success,	F	867			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345532	B. WING		C 02/09/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 02/03/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 867	determine underlying impacting larger syste (ii) How they will deve will be designed to ef level to prevent quality safety problems; and (iii) How the facility wo fits performance improvement that improvement with the facility wo fits performance improvement with the facility wo fits performance, and with the facility with the facility.  §483.75(e)(2) Performance facility.  §483.75(e)(3) As par improvement activitied distinct performance number and frequence number and frequen	cility will develop and ddressing: a systematic approach to causes of problems ems; elop corrective actions that fect change at the systems by of care, quality of life, or ill monitor the effectiveness provement activities to ments are sustained.  activities.  cility must set priorities for its ement activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care.	F 86	57	

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		IPLE CONSTRUCTION  IG	· /	(X3) DATE SURVEY COMPLETED		
		345532	B. WING _		,	C 02/09/2023		
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	, ,	02/03/2023		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPLICATION OF THE APPLICA	OULD BE	(X5) COMPLETION DATE		
F 867	assessment require Improvement project annually a project the problem-prone area collection and analy (c) and (d) of this see §483.75(g) Quality a §483.75(g) Quality a §483.75(g)(2) The construction of the second	as reflected in the facility d at §483.70(e). Its must include at least nat focuses on high risk or is identified through the data sis described in paragraphs action.  Assessment and assurance.  Assessment and	F8	on this plan of correction are no admission to and do not constitu agreement with the alleged defice. To remain in compliance with all and state regulations the facility or will take the actions set forth in plan of correction. The plan of coconstitutes the facility of allegatic compliance such that all alleged deficiencies cited have been or work corrected by the dates indicated.	te an siencies.  federal has taken n this prrection on of			

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X: A. BUILDING		(X3) DATE SURVEY COMPLETED		
			A. BOILDIN		l c
		345532	B. WING		02/09/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/03/2023
				310 COMMERCE DRIVE	
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332	
				·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCE)	D BE COMPLETION
F 867	Continued From page	153	F8	967	
1 001					
		transfer/discharge (F623),		F867	
	accuracy of assessme			1 Corrective action for resident(s)	
		omprehensive care plan		Corrective action for resident(s)     effected by the alleged deficient pro-	otion:
	, , ,	ing and revision (F657), ng (ADL) care provided for		affected by the alleged deficient pra On 2/9/23, the facility ☐s Quality	Alice.
	_	(F677), quality of care		Assessment and Assurance (QAA)	
	(F684), treatment/ser			committee failed to maintain implem	ented
	pressure ulcers (F686			procedures and monitor intervention	
	hazards/supervision/d			committee put into place following the	
	-	and resident records		recertification and complaint investig	
	, ,	on (842) and were recited on		(CI) survey conducted on 2/17/22. T	
		tion and CI survey of 2/9/23.		was for 11deficiencies that were cite	
		additionally failed to maintain		the areas of self-determination (F56	1),
	implemented procedu			notice requirements before	
	interventions the com	mittee put into place		transfer/discharge (F623), accuracy	of
	following the recertific	cation and CI survey		assessments (F641), develop/imple	nent
	conducted on 2/6/20.	This was evident for 6		comprehensive care plan (F656), ca	re
	deficiencies that were	e cited in the areas of		plan timing and revision (F657), Acti	vities
	increase/prevent deci			of daily Living (ADL) care provided f	
	motion/mobility (F688	· ·		dependent residents (F677), quality	of
	incontinence, cathete			care (F684),treatment/services to	
		omy care and suctioning		prevent/heal pressure ulcers (F686)	
	, ,	review, report irregularities		of accident hazards/supervision/dev	
		ecessary psychotropic		(F689),administration (F835) and re	
	medications/PRN use			records -identifiable information (842	·
		repare/serve-sanitary (F812)		were recited on the current recertific	ation
	-	recertification and CI survey		and CI survey of 2/9/23. The QAA	4
		on the current recertification		committee additionally failed to mair	
	_	23. The duplicate citation		implemented procedures and monitorinterventions the committee put into	
	_	urveys of record shows a s inability to sustain effective		following the recertification and CI s	-
	QAA program.	s maximy to sustain ellective		conducted on 2/6/20. This was evidence	-
	w va program.			6 deficiencies that were cited in the	
	Findings included:			of increase/prevent decrease in range	
	a.i.go iiloidaca.			motion/mobility (F688), bowel/bladd	' I I
	This tag is cross refer	renced to:		incontinence, catheter, UTI	.
				(F690),respiratory/tracheostomy car	e and
	F561 - Based on reco	ord review, observation and		suctioning (F695), drug regimen rev	
		erviews, the facility failed to		report irregularities (F756), free from	

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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 02/09/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	103/2020
					10 COMMERCE DRIVE		
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY		EHAB CTR OF LEE COUNTY			SANFORD, NC 27332		
(X4) ID PREFIX TAG			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 867	Continued From page	e 154	F 8	367			
	#10) for 1 of 1 reside	oice for showers (Resident nt reviewed for choices.			unnecessary psychotropic medications/PRN use (F758), and food procurement,	i	
	During the recertificat	<u>-</u>			store/prepare/serve-sanitary(F812)	<b></b>	
		iled to honor resident's owers and shampoos for 3			originally cited on the recertification an		
	of 4 residents reviewe	·			CI survey on 2/6/20 and recited on the current recertification and CI survey of		
	or 4 residents review	ed for endices.			2/9/23. The duplicate citation during th		
	F623 - Based on reco	ord review and interview with			federal surveys of record shows a patt		
		idents and staff, the facility			of the facility's inability to sustain effect		
	failed to notify the res	ident and or responsible			QAA program.		
	party (RP) in writing o	of the reason for the					
		the hospital and failed to			2. Corrective action for residents with	the	
	send a copy of the dis				potential to be affected by the alleged		
	Ombudsman for 3 of				deficient practice:	_	
	•	zation (Residents #44, #5 &			" Corrective action has been taken	ior	
	#50).				the identified concerns in the areas of:		
	During the receptificat	tion and Claumov of			self-determination (F561)  " Corrective action has been taken."	for	
	During the recertificat	iled to notify the responsible			the identified concerns in the areas of:		
	party (RP) in writing of				Safe/Clean/Comfortable /Homelike		
	ı. , , ,	oital for 4 of 5 residents			Environment (F584.)		
	reviewed for hospitali				" Corrective action has been taken	for	
					the identified concerns in the areas of:		
	F641 - Based on reco	ord review and staff			notice requirements before		
	interview, the facility	failed to code the Minimum			transfer/discharge (F623)		
	Data Set (MDS) asse	ssments accurately in the			" Corrective action has been taken	for	
	areas of bladder inco	ntinence (Resident #45),			the identified concerns in the areas of:		
	pressure ulcer (Resid	lent #46) & nutrition			accuracy of assessments (F641)		
	'	of 20 sampled residents			" Corrective action has been taken		
	whose MDS were rev	riewed.			the identified concerns in the areas of:		
					develop/implement comprehensive car	е	
	During the recertificat				plan (F656)		
	2/17/22, the facility fa				" Corrective action has been taken the identified concerns in the group of:		
		ely in the areas of nutrition,			the identified concerns in the areas of:		
		us, accidents, pressure agement for 7 of 22 residents			care plan timing and revision (F657)  " Corrective action has been taken."	for	
	reviewed.	igenient for 7 of 22 residents			the identified concerns in the areas of:		
	i evieweu.				Activities of daily Living (ADL) care		

Facility ID: 980156

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION SUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _				09/ <b>2023</b>	
NAME OF P	ROVIDER OR SUPPLIER		-	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		00/2020	
				31	0 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			ANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 867	Continued From page	e 155	F 8	367				
F 867	F656 - Based on obst staff interviews, the faimplement a comprehemeasurable objective areas of oxygen thera of 20 sampled resident Resident #16) review plans.  During the recertificat 2/17/22, the facility faintervention after a fareviewed.  F657 - Based on receinterview, the facility fainterview, the facility fainterview, the facility fainterview, the facility facare plan in the a (Resident #45) and pfor 2 of 20 sampled rewere reviewed.  During the recertificat 2/17/22, the facility facare plan in the areas pressure ulcers for 2  F677 - Based on obstresident and staff intertim and clean dependence (Residents #10 & #12 incontinent care (Resident resident compared to the facility facare plan in the areas pressure ulcers for 2	ervations, record review and acility failed to develop and hensive care plan with and interventions in the apy and pressure ulcers for 2 ants (Resident #3 and ed for comprehensive care dion and CI survey of iled to implement care plan ll for 1 of 22 residents  and review and staff failed to review and revise reas of code status ressure ulcer (Resident #12) esidents whose care plans  and CI survey of iled to review and revise rescure ulcer (Resident #12) esidents whose care plans  and CI survey of iled to review and revise the sof medications and of 22 residents reviewed.  Bervation, record review and reviews, the facility failed to dent residents' nails and failed to provide ident #46) for 3 of 8 ar Activities of daily living	F8	867	provided for dependent residents (F67" Corrective action has been taken if the identified concerns in the areas of: quality of care (F684)  "Corrective action has been taken if the identified concerns in the areas of: treatment/services to prevent/heal pressure ulcers (F686)  "Corrective action has been taken if the identified concerns in the areas of: increase/prevent decrease in range of motion/mobility (F688)  "Corrective action has been taken if the identified concerns in the areas of: free of accident hazards/supervision/devices (F689),  "Corrective action has been taken if the identified concerns in the areas of: bowel/bladder incontinence, catheter, (F690)  "Corrective action has been taken if the identified concerns in the areas of: respiratory/tracheostomy care and suctioning (F695)  "Corrective action has been taken if the identified concerns in the areas of: drug regimen review, report irregularitie (F756)  "Corrective action has been taken if the identified concerns in the areas of: free from unnecessary psychotropic medications/PRN use (F758)  "Corrective action has been taken if the identified concerns in the areas of: free from unnecessary psychotropic medications/PRN use (F758)  "Corrective action has been taken if the identified concerns in the areas of: free from unnecessary psychotropic medications/PRN use (F758)  "Corrective action has been taken if the identified concerns in the areas of: free from unnecessary psychotropic medications/PRN use (F758)  "Corrective action has been taken if the identified concerns in the areas of: food procurement,	or or or JTI or or		
	2/17/22, the facility fa	iled to provide nail care to for 5 of 8 residents reviewed			store/prepare/serve-sanitary(F812)  " Corrective action has been taken the identified concerns in the areas of: administration (F835)	or		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		A. BUILI		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED  C 02/09/2023	
NAME OF T	NOVIDEN ON 3011 LIEN							
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY					0 COMMERCE DRIVE			
				S	ANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 867	Continued From pag	e 156	F 8	367				
	staff and Wound Phy failed to provide wou Wound Physician to	ord review, observation and sician interviews, the facility and care as ordered by the a diabetic ulcer on the lower \$\frac{1}{2}(1)\$ for 1 of 3 residents and.			" Corrective action has been taken the identified concerns in the areas of: resident records -identifiable informatio (842)  The Quality Assurance Performance Improvement (QAPI) committee held a	on		
	2/17/22, the facility fa skin coverings as ord treatment to a surgic	tion and CI survey of billed to provide the protective lered and failed to provide all wound as recommended bian for 2 of 22 residents ang.			meeting on 02/09/2023 to review the deficiencies from the January 23 □ February 9, 2023 annual recertification survey, CI survey, and reviewed the citations.  On 02/09/2023, the RDO and Regiona Clinical Consultant in-serviced the facil	I		
	F686 - Based on record review, observation and interviews with Orthopedic Physician Assistant (PA), Wound Nurse, Wound Physician, Medical Director (MD) #2, Director of Nursing (DON) #2, Administrator #2, Nurse Practitioner (NP) #2 and family, the facility failed to prevent the development of a pressure ulcer, protect Resident #16's skin under an immobilizer used following a fractured distal femur (the area of the leg just above the knee joint), perform skin checks under the immobilizer and assess skin. At the first orthopedic follow up appointment, an abrasion was identified. Orders were given to pad an abrasion and consult with a wound physician. The orders were not implemented. Skin checks continued not to be done following the identification of the pressure ulcer. The area deteriorated to an unstageable pressure ulcer. An unstageable pressure ulcer means a full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by eschar (dry, dark scab of dead skin), slough (yellow tissue that is stingy and thick) and granulation tissue (part of the healing process in				administrator and the Quality Assurance Committee on the appropriate function of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficienci 3. Measures/Systemic changes to prevent reoccurrence of alleged deficience: Education:	ing se es.		
					On 2/22/23, the administrator complete in-servicing with the QAPI team memb that include the Administrator, Director Nurses, Minimum Data Set Coordinator Therapy Manager, Health Information Manager, and the Dietary Manager, on the appropriate functioning of the QAP Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies.  This in-service was incorporated in the new employee facility orientation for th QAPI Committee team members identified above.  This will be reviewed by the Quality	ers of r, I		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED  C 02/09/2023	
NAME OF PROVIDER OR SUPPLIER			<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	10312023	
					10 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332				
(X4) ID PREFIX TAG			ID PREFIX TAG				(X5) COMPLETION DATE	
F 867	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			3367		led by t nat tor be tthe sing ng tor		
	motion.  F689 - Based on obs and record review, th fall on 8/16/22 for a re	ident reviewed for range of ervations, staff interviews e facility failed to prevent a esident with cognitive decision-making skills who			Date of Compliance: 03/17/2023			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILD		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345532	B. WING			C 02/09/2023	
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	·	5210312023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 867	Continued From page 158 required extensive staff assistance with bed mobility and positioning for 1 (Resident #16) of 8 residents reviewed for accidents. Resident #16 rolled from her side onto the floor resulting in a left femur fracture. The bed was in the high position while Nursing Assistant (NA) #11 left the room to throw dirty linens in the laundry bin outside the resident's room.  During the recertification and CI survey of 2/17/22, the facility failed to prevent repeated falls by not providing effective interventions after each fall for 1 of 4 residents reviewed for accidents. The Resident sustained fracture of fingers on 9/10/21 and left and right hip fracture on 9/24/21 after the fall.  F690 - Based on record review, observation and resident and staff interview, the facility failed to secure a urinary catheter to prevent tension or accidental removal for 1 of 2 sampled residents reviewed with indwelling urinary catheters (Resident #45).		F 80	67			
	the facility failed to	ation and CI survey of 2/6/20, secure the indwelling urinary esident reviewed for urinary					
	staff interviews, the oxygen therapy was physician for 1 of 1 therapy (Resident # failed to display cau	cord review, observations and facility failed to ensure sprovided as ordered by the sampled residents of oxygen 3). Additionally, the facility tionary signage indicating of 2 residents observed 10).					

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 02/09/2023		
NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY				STREET ADDRESS, CITY, STATE, ZI 310 COMMERCE DRIVE SANFORD, NC 27332	P CODE	02/09/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 867	Continued From page 159		F 8	367			
	the facility failed to a	tion and CI survey of 2/6/20, dminister continuous oxygen red rate for 2 of 2 residents ory care.					
	Pharmacist, Nurse Printerviews, the facility recommendations matching Pharmacist for 2 of 6	rfailed to act upon the ade by the Consultant					
	interviews, the consuidentify incorrect med	ew, staff and pharmacist Itant pharmacist failed to liation administration route eviewed for gastric feeding					
	Consultant, Psychiate NP #1 and NP #2, Di and Medical Director observations and recto attempt a gradual prescribed antipsyche 4/21/21(Resident #29 ensure orders for as (antianxiety) medicat (Resident #45 and Resident #45 and Re	ord review, the facility failed dose reduction (GDR) of a potic last increased on a). The facility also failed to needed (PRN) psychotropic ions had a stop date esident #12) for 3 of 6 lications were reviewed for					
	During the recertification and CI of 2/6/20, the facility failed to have an adequate clinical indication for the use of an antipsychotic medication for 1 of 4 residents reviewed for						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345532	B. WING _	B. WING		C 02/09/2023	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		02/03/2020	
				310 COMMERCE DRIVE			
LIBERTY	COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	D 4.T.E.	
F 867	Continued From page 160 psychotropic medication use.		F 8	367			
	the facility failed to ai bases prior to stackin for 44 of 44 insulated practice may increase contamination.  During the recertifica facility failed to discar food items in 2 refriger	tion and CI of 2/6/20, the rd expired and or spoiled erators and opened and n the freezer for 3 of 3 food					
	#1 and Director of Nuther facility administral systems in place to putreat, and manage repressure sores. This #16 developing an avoid left leg immobilizer id orthopedic consult visuantreated, and area of unstageable pressure and tissue loss in which damage within the ulbecause the wound be eschar) on 9/13/22. The resolved Resident #1 on 1/10/23 with an orchanges to protect of of reassessment after Wound Physician being where she observed.	e ulcer (Full-thickness skin ich the extent of tissue cer cannot be confirmed bed is obscured by slough or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
345532		B. WING _			C <b>02/09/2023</b>		
NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY				STREET ADDRESS, CITY, STATE, ZIP CO 310 COMMERCE DRIVE SANFORD, NC 27332	ODE	02/03/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 867	the muscle, ligament was for 1 of 4 reside ulcers (Resident #16 provide care to a dia Wound Physician for care to maintain well During the recertifica 2/17/22, the facility a provide effective ove system was fully open F842 - Based on recinterviews, the facility medical records for diabetic wound care During the recertificate facility failed to have medical records in the protective skin cover topical treatment for Interview with Admin 1/26/23 at 12:13 PM facility's failure to impronitor the intervent QAA committee was administration and signal	is of bone) on 1/24/23. This ints reviewed for pressure is). The facility also failed to betic ulcer as ordered by the interest of 3 residents reviewed for abeing (Resident #10).  Intion and CI survey of administration failed to be insight to ensure the call be interest of a resident in accurate in a courate in the call of 1 resident reviewed for	F	367			