PRINTED: 01/17/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
					С	
		345503	B. WING _		12/15/2023	
	ROVIDER OR SUPPLIER	AB CTR OF ROWAN COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147		
(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 APPROPE DEFICIENCY)	BE COMPLETION	
E 000	Initial Comments		E 00	00		
F 000	investigation survey was to 12/15/2023. The factor complaince with the remergency Prepared	requirement CFR 483.73, Iness. Event ID#7B2K11.	F 0	00		
	survey were conducted 12/14/2023. Aditional on 12/15/2023. There changed to 12/15/202 following intakes were NC00199267, NC001	ll information was obtained efore, the exit date was 23. Event ID # 7B2K11. The				
F 565 SS=E	3 of 18 complaint alle deficiency. Resident/Family Grou CFR(s): 483.10(f)(5)(up and Response	F 50	65	1/5/24	
	and participate in res (i) The facility must progroup, if one exists, we reasonable steps, with to make residents and upcoming meetings in (ii) Staff, visitors, or or resident group or fample the respective group's (iii) The facility must preson who is approved group and the facility	ther guests may attend ally group meetings only at sinvitation. brovide a designated staff are by the resident or family and who is responsible for and responding to written				
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			(X6) DATE	

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

Electronically Signed 01/05/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345503	B. WING _		1	C 2/15/2023
	ROVIDER OR SUPPLIER	AB CTR OF ROWAN COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147	<u> </u>	2/13/2023
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 565	resident or family gruthe grievances and a groups concerning is in the facility. (A) The facility must response and ration. (B) This should not be facility must impleme request of the resides. §483.10(f)(6) The reparticipate in family shallow the facility must impleme request of the resides. §483.10(f)(7) The reparticipate in family shallow the facility member(s) or representative(s) metamilies or resident residents in the facil This REQUIREMEN by: Based on record reand staff interviews, repeat grievances rewere reported during meetings for 8 of 11 2023, February 2023 May 2023, Septemb November 2023). The findings include Resident Council mereviewed and reveal Council had identified a. The Resident Council had identified a. The Resident Council and council had identified a. The Resident Council had identified a.	consider the views of a pup and act promptly upon recommendations of such assues of resident care and life to be able to demonstrate their ale for such response. The construed to mean that the cent as recommended every ent or family group. Sident has a right to groups. Sident has a right to have other resident eet in the facility with the expresentative(s) of other ty. To is not met as evidenced views, observations, resident the facility failed to resolve elated to dietary issues that the Resident Council months reviewed (January 3, March 2023, April 2023, er 2023, October 2023 and deceiting minutes for 2023 were ed issues the Resident	F 5	The statements made on this plan correction are not an admission to not constitute an agreement with the alleged deficiencies. To remain in compliance with all fer and state regulations the facility has or will take the actions set forth in the plan of correction. The plan of corrections that all alleged deficiencies cited have been or will corrected by the dates indicated. F565 The facility failed to resolve repeated grievances that were reported to the resident council meetings related to dietary issues for 8 of 11 months the resident council meetings were hell	and do ne deral s taken his ection of be ed ne o	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT (X2) MULTIPLE CONSTRUCT (X3) MULTIPLE CONSTRUCT (X4) MULTIPLE ((X3) DATE SURVEY COMPLETED		
		345503	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	0-70000			STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	/15/2023
NAIVIE OF FI	NOVIDER OR SUFFLIER						
LIBERTY (COMMONS NSG & REHA	AB CTR OF ROWAN COUNTY			1412 SOUTH MAIN STREET		
				•	SALISBURY, NC 28147		
(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 BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 565	Continued From page	÷ 2	F t	565			
		's written response to the d 1/13/2023 read: "We temp			(January 2023- November 2023).		
		re] of all food before it			Corrective action for resident(s)		
		tment for meal delivery]. We			affected by the alleged deficient practic	ce:	
	have spoons."				An additional Resident Council meeting	g	
					was held on 1/3/2024. Minutes were		
		uncil meeting minutes dated			taken by the Activities Director. On		
		at the facility was always out			1/3/2024, grievances/concerns were		
		grits were cold, and the			addressed with the Administrator and t	he	
	•	d without variety. The			appropriate department managers		
	Dietary Manager's wr	d 2/9/2023 read: "We do			following the facility's grievance proces for resolution.	;S	
		d once a month. I notified			Corrective action for residents with t	ho.	
		the food out faster, and			potential to be affected by the alleged	iic	
	sorry we go by a set i				deficient practice.		
	, , ,				Beginning with the 1/3/2024 resident		
	c. The Resident Co	uncil meeting minutes dated			council meeting, grievances/concerns,	as	
	3/9/2023 indicated that	at the food was always cold			well as any ongoing grievances/conce	rns	
		ents received their trays and			were reviewed by the administrator wit	h	
	_	always hot (no ice). There			resident council members for timely		
	was no response to tl	ne complaints.			resolution following the facility grievand process. No new grievances or concer		
		uncil meeting minutes dated			voiced during meeting. The Administra		
		hat residents were receiving			to attend monthly resident council mee	ting	
		the drinks, the coffee was			at the request of resident council		
		o the residents, the grits			members to address any outstanding		
		resident received out of			grievances or concerns and ensure fac	ality	
		entions dated 4/26/2023			following policy related to grievance		
	read: "Activity Directo	•			process for resolution. 3. Measures /Systemic changes to		
	manager to resolve the 4/27/2023 the Dietary				prevent reoccurrence of alleged deficie	ont	
		[were] resolved. I talked to			practice:	,11L	
	T	es to make sure we were all			On 1/3/2024, the Administrator educa	ted	
	on the same page."	22 12 mans sais no nois all			the facility department heads on the		
	p. 533.				following:		
	e. The Resident Co	ouncil meeting minutes dated			Grievance Process		
		nat the residents did not			The Administrator educated departmen	nt	
	want Mexican food ar	nd were requesting more			heads on the grievance process and a		
		The minutes documented			the daily standup meeting on 1/3/2024		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		345503	B. WING _			C 12/15/2023	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	15/2025
					412 SOUTH MAIN STREET		
LIBERTY	COMMONS NSG & RE	HAB CTR OF ROWAN COUNTY			ALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
1710					DEFICIENCY)		
1							
F 565	Continued From pa	-	F t	565			
		wanted more "Southern			and assigned responsibility for timely		
		eak, and fish. The Dietary			resolution of grievances.		
		esponse to the resident			Going forward, Administrator or Direct		
		2023 read: "Sorry, the food			of Nurses (in his absence) will continue	e to	
	comes off a menu t	hat's already put together and			assign responsibility for resolving		
	sent to me."				grievances the morning after the Resid Council meeting.	lent	
	f. The Resident 0	Council meeting minutes dated			This information has been integrated ir	nto	
		I the food was delivered cold			the standard orientation training and in		
	to the residents, an	d they were not receiving			required in-service refresher courses for		
	flatware or condiments. There was no response				all staff identified above and will be		
	to the complaints.	mile. There was no response			reviewed by the Quality Assurance		
	to the complaints.				process to verify that the change has		
	a The Posident (Council meeting minutes dated			been sustained. Any identified staff when sustained is the charge has	20	
		ed the residents wanted a			does not receive scheduled in-service	10	
		ety of menu items for breakfast			training will not be allowed to work unti		
		was no response to the edietary department.			training has been completed by 1/4/20.		
					4. Monitoring Procedure to ensure that	the	
	h. The Resident 0	Council meeting minutes dated			plan of correction is effective and that		
	11/20/2023 indicate	ed the residents were			specific deficiency cited remains correct	cted	
	requesting more sn	acks, and the food was not			and/or in compliance with regulatory		
	hot. The Dietary M	anager's response to the			requirements.		
	resident council dat	ed 11/20/2023 documented a			The Administrator will monitor complian	nce	
	response: "Residen	its discussed concerns with			utilizing the F565 Quality Assurance To	ool	
	the kitchen manage	er during today's resident			weekly for 4 weeks then monthly x 2		
	council meeting."	<i>.</i>			months or until resolved. The tool will		
	J				monitor to ensure that grievances from		
	The Resident Coun	cil meeting was observed on			resident council meetings are addresse		
		pm and 14 residents were in			following the grievance process and ar		
		resident interviews, Resident			compliance. Reports will be presented		
	_	ood was cold when delivered to			the weekly Quality Assurance committee		
		dent #19, Resident #4, and			by the Administrator to ensure corrective		
	·	ed. The Resident Council			action is initiated as appropriate.	,,,	
	_				Compliance will be monitored and the		
		t #58, reported the Resident			I · · · · ·	tho	
		the same dietary department			ongoing auditing program reviewed at		
	· ·	, but the facility did not resolve			weekly Quality Assurance Meeting. Th	Е	
	the issues.				weekly QA Meeting is attended by the Administrator, Director of Nursing, MD	S	
						_	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
		345503	B. WING			1	C 15/2023
NAME OF PE	ROVIDER OR SUPPLIER	0.000	<u> </u>	STE	REET ADDRESS, CITY, STATE, ZIP CODE	12/	15/2023
					12 SOUTH MAIN STREET		
LIBERTY	COMMONS NSG & REHA	AB CTR OF ROWAN COUNTY			LISBURY, NC 28147		
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F 565	Continued From page	e 4	F 5	65			
	An in-person interview former Administrator The former Administrator facility for a sister facinot recall the any gried Council. The former	w was conducted with the on 12/13/2023 at 3:21 PM. ator reported he left the ility in June 2023, and he did evances from the Resident Administrator reported he that the food was cold when			Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 1/5/2024	,	
	12/14/2023 at 8:47 A had been in her posit aware of the Residen food temperature, and the dish warmer to m the plates. The DM eshe could make chan recently, and the Reg of substitutions. The tested by the Corpora DM reported she warmed to the plates of the could make the plates.	istered Dietician made a list DM reported test trays were ate Dietary Manager. The ated the residents to have a hat was served at the right					
	reported she had bee months and when a r concern or complaint meetings, she went to discuss the issue. Th she had invited depar resident council meet questions or concerns During an interview w on 12/14/2023 at 3:06	M. The Activity Director on in her position for 3 esident expressed a during the Resident Council of the department head to e Activities Director reported of the Activities Director the the cings to address any					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345503	B. WING _			C 12/15/2023
	ROVIDER OR SUPPLIER	HAB CTR OF ROWAN COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147	·	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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
F 565	Continued From particles Resident Council has department. The Adresident Council proportunity to expression and resident the facility should issues and if the resident revision and resident revision and resident for CFR(s): 483.10(g)(14) Not (i) A facility must improve the consistent with the resident inverse that the resident inverse that the resident in the reside	ge 5 ad with the food and dietary diministrator reported the rovided the residents an ess concerns and have those d. The Administrator explained ald provide actions to resolve sponse by the individual ed revision, he should direct sponse. Injury/Decline/Room, etc.) 14)(i)-(iv)(15) iffication of Changes. Imediately inform the resident; ident's physician; and notify, or her authority, the resident hen there isolving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial threatening conditions or	F 5	65	PPROPRIATE	1/5/24
	a need to discontinutreatment due to accommence a new forms (D) A decision to train resident from the fall \$483.15(c)(1)(ii). (ii) When making not (14)(i) of this sectionall pertinent informatics available and prophysician.	treatment significantly (that is, ue an existing form of liverse consequences, or to orm of treatment); or ansfer or discharge the icility as specified in otification under paragraph (g) in, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345503	B. WING _		C 12/15/2023
	ROVIDER OR SUPPLIER	AB CTR OF ROWAN COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147	12/13/2023
(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 SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 580	when there is- (A) A change in room 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 (phone number of the representative(s). §483.10(g)(15) Admission to a comp that is a composite of §483.5) must disclose its physical configurat locations that compri part, and must speci- room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on record revi interviews the facility responsible party (R for 1 of 3 residents re-	dent representative, if any, n or roommate assignment 10(e)(6); or dent rights under Federal or ons as specified in paragraph n. record and periodically (mailing and email) and e resident posite distinct part. A facility distinct part (as defined in se in its admission agreement ation, including the various dise the composite distinct fy the policies that apply to den its different locations T is not met as evidenced view, family and staff of failed to notify the resident's P) of a change in roommate eviewed for notification of	F 5	The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies.	d do
		dmitted to the facility on noses of dementia and kidney		To remain in compliance with all federand state regulations the facility has to or will take the actions set forth in this plan of correction. The plan of correctionstitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be	aken s iion
	An annual Minimum	Data Set assessment dated Resident #13 was severely		corrected by the dates indicated. F580 The facility failed to notify the residen responsible party of a change in roommate for 1 of 3 residents reviewe	ts

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345503	B. WING			C	
NAME OF DE	ROVIDER OR SUPPLIER	0-70000		STREET ADDRESS, CITY, STATE, ZIP CODE] 1,	2/15/2023	
NAME OF F	NOVIDER OR SUFFLIER						
LIBERTY (COMMONS NSG & REHA	AB CTR OF ROWAN COUNTY		4412 SOUTH MAIN STREET			
				SALISBURY, NC 28147			
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 580	Continued From page	e 7	F 58	50			
	On 12/11/2023 at 3:5	5 pm the RP was		for notification of change.			
		and stated he was not		<u> </u>			
		would be getting a new		1.Corrective action for resident(s)affected		
		23. He stated when he		by the alleged deficient practice:	,		
	visited after 9/4/2023	the roommate was cussing,		Resident #13 RP was made awa	re of		
	and he was concerned	ed the cussing would upset		resident #50 room change while	in facility		
	Resident #13.			after room change occurred. Res			
				transferred to room 203 on 9/25/2	2023 at		
	•	vith Nurse #1 by phone on		request of RP.			
	12/14/2023 at 10:53			Corrective action for residents			
		nt #13 having a change of		potential to be affected by the all	eged		
	roommate when she resided on the 100-hall, and the RP was upset because the roommate would			deficient practice.			
				On 1/4/2024, the Social Worker a			
		ed the roommate had not		all residents with room change for			
		13, but she would talk to		past thirty days to ensure resider			
	thought the Social W	words. Nurse #1 stated she		resident RP was notified of room The results of the audited reveale	•		
	_	of the resident when they are		other residents affected by allege			
	•	room, but she was not sure if		deficient practice. This audit was			
		consible Parties of the		completed on 1/4/2024. On 1/4/2			
	resident that received			administrator reeducated Social			
				related to Transfer of Resident W			
	The Social Worker w			Facility Policy.			
	Telephone and the second se	m and she stated she was		2. Management (Occuptation) in the contract	4 -		
		sident #13 received the new		3. Measures /Systemic changes			
		id not know who called the		prevent reoccurrence of alleged	aeticient		
		#2, who was the interim		practice:	ina		
		time, was responsible for changes while she was on		On 1/3/2024 the Director of Nurs began in servicing all licensed nu	•		
	vacation.	manges wille sile was on		Registered Nurses (RN) and Lice			
	vacation.			Practical Nurses (LPN), and med			
	On 12/14/2023 at 3:47 pm Administrator #1, the			aides (full time, part time, and as			
		was interviewed, and he		including agency) on Transfer of			
		e administrator in the building		Within the Facility Policy	. toolaont		
		esident #13 received a new		The Director of Nurses will ensur	e that all		
	roommate.			licensed nurses, RNs, LPNs, and			
				Aides (full time, part-time, and as			
	Administrator #2. the	previous administrator, was		including agency) who do not cor			
		/2023 at 12:24 pm and		the in-service training by 1/4/202			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345503	B. WING			C	
NAME OF DE	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP C	,ODE	12/15/2023	\dashv
NAME OF T	TOVIDER OR SOLT FIER			4412 SOUTH MAIN STREET	ODL		
LIBERTY (COMMONS NSG & REH	AB CTR OF ROWAN COUNTY					
				SALISBURY, NC 28147			_
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIA	DATE	N
F 580	Continued From pag	e 8	F 5	580			
	stated she did not re did not remember no would be getting a ne stated she would hav Resident #13 to call was not available. The Director of Nurs 12:35 pm that Nurse the day shift and she remembered Reside ate that day. The Di Nurse #2 said she did	member Resident #13 and biffying the RP Resident #13 ew roommate. She also we asked the Nurse who had the RP if the Social Worker ing stated on 12/14/2023 at #2 worked on 9/2/2023 on		be allowed to work until the completed. This in-service incorporated into the new of facility and agency orientat licensed nurses and certifical assistants (full time, part time needed including agency.) reviewed by the Quality Assiprocess to verify that the orbeen sustained 4. Monitoring Procedure to plan of correction is effective specific deficiency cited remand/or in compliance with more requirements. The Administrator or design this process using the Quality Assiprocess using the Quality Assiprocess (and in the Facility). This audit will be Monday through Friday x 2 then weekly x 2 weeks, the months or until resolved. Represented to the Quality Assiprocess action is initiated appropriate. Compliance we and the ongoing auditing previewed at the Quality Assimplements. The monthly Quality Assimplements is attended by the Director of Nursing, Minimus Coordinator, Therapy Manager, Health Informatice	was employee tion for all ed nursing me, and as and will be surance hange has ensure that we and that mains correct regulatory nee will audi dity Assurance ance with the nsfers within be completed weeks and en monthly x deports will be surance rator to ensu d as vill be monito rogram surance lity Assurance Administrate um Data Set ager, Unit	t ce e e e e e e e e e e e e e e e e e e	
F 636 SS=B	Comprehensive Associated CFR(s): 483.20(b)(1)		F 6	and Dietary Manager. Date of Compliance: 1/5/20)24		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345503	B. WING			C 12/15/2023
	ROVIDER OR SUPPLIER	AB CTR OF ROWAN COUNTY		STREET ADDRESS, CITY, STATE, ZIP 4412 SOUTH MAIN STREET SALISBURY, NC 28147	CODE	12/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	
F 636	a comprehensive, ac reproducible assess functional capacity. §483.20(b) Compreh §483.20(b)(1) Resid A facility must make assessment of a resignals, life history and resident assessment by CMS. The assess the following:	esessment duct initially and periodically curate, standardized ment of each resident's ensive Assessments ent Assessment Instrument. a comprehensive dent's needs, strengths, d preferences, using the instrument (RAI) specified sment must include at least demographic information e. s.	F	536	CY)	
	(viii) Physical function (ix) Continence. (x) Disease diagnosis (xi) Dental and nutriting (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatmer (xvii) Discharge planton (xvii) Documentation regarding the addition on the care areas trighted the Minimum Data Scotting (xviii) Documentation assessment. The assessment.	ning and structural problems. s and health conditions. conal status. Ints and procedures. Ining. Ining of summary information Ining assessment performed Ining and procedures. Ining and procedures. Ining and procedures. In the status are also are also and procedures. In the status are also ar				

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		345503	B. WING _			C 2/15/2023	
	ROVIDER OR SUPPLIER	AB CTR OF ROWAN COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147		2113/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 636	licensed and nonlice members on all shift §483.20(b)(2) When timeframes prescribe chapter, a facility mussessment of a restimeframes specified through (iii) of this seprescribed in §413.3 apply to CAHs. (i) Within 14 calenda excluding readmissic significant change in mental condition. (For "readmission" means following a temporar or therapeutic leave. (iii) Not less than one This REQUIREMEN by: Based on record revisionity failed to comprehensive Minital assessments within (Resident #233) and comprehensive MDS of the Assessment Flast day of the assessment (Resident #30, Resident #30,	well as communication with nsed direct care staff s. required. Subject to the ed in §413.343(b) of this list conduct a comprehensive ident in accordance with the lin paragraphs (b)(2)(i) ection. The timeframes 43(b) of this chapter do not ar days after admission, ons in which there is no the resident's physical or or purposes of this section, as a return to the facility y absence for hospitalization) e every 12 months. T is not met as evidenced views and staff interviews, the olete 1 of 4 admission mum Data Set (MDS) 14 days of an admission failed to complete assessments within 14 days deference Date (ARD) [the asment period] for 5 of 26 Resident #7, Resident #19, ent #239, Resident #27). d:	F 6	Past noncompliance: no plar correction required.	n of		
	A review of Resident	#233's admission MDS ARD of 8/4/2023 was signed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345503	B. WING _			C 12/15/2023
	ROVIDER OR SUPPLIER	AB CTR OF ROWAN COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147	I	12/13/2023
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 636	as completed on 8/10 2. a. Resident #7 7/30/2023. A review of Resi an ARD of 5/11/2023 on 5/28/2023. b. Resident #7 was 10/22/2019. A review of the a 4/18/2023 was signed c. Resident #30 was 3/8/2019. A review of the a 5/2/2023 was signed d. Resident #239 was 6/19/2023. A Significant Ch		F 6	,		
	7/28/2023. A review of Resi Minimum Data Set (I assessment reference for 8/4/2023. The ME and completed on 8/	OS assessment was signed				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING CO	(X3) DATE SURVEY COMPLETED	
345503 B. WING	C 2/15/2023	
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY SALISBURY, NC 28147	2.10.2020	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 636 Continued From page 12 interview during the survey. An interview was conducted with the Clinical Reimbursement Consultant on 12/14/2023 at 2:09 PM. The Clinical Reimbursement Consultant revealed she became aware of the late admission and comprehensive MDS assessments after running a report in 9/14/2023 and a Performance Improvement Plan (PIP) was developed at that time. The Clinical Reimbursement Consultant explained the MDS nurse was unable to meet the expectations of the PIP and the PIP was modified on 11/30/2023, to include hirling additional MDS nurses to assist with completing the admission and the comprehensive MDS assessments in a timely manner. The Regional Nurse Consultant was interviewed on 12/14/2023 at 2:54 pm and she reported the facility had received the report from the Clinical Reimbursement Consultant in September 2023 and the facility developed a PIP and the goals were not being met by the MDS nurse, so they modified the plan on 11/30/2023. The Regional Nurse Consultant explained the facility had hired additional MDS nurses to help with the completion of MDS assessments. During an interview with the Administrator on 12/14/2023 at 3:06 PM, he reported he started his position on 9/14/2023 and received the late MDS report from the Clinical Reimbursement Consultant. The Administrator explained the facility had an ad hoc Quality Improvement Meeting and developed a PIP, but upon review on 11/30/2023, discovered that the goals were not		

` '		` ′		(X3) DATE SURVEY COMPLETED		
	345503	B. WING _			C 12/15/2023	
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY			STREET ADDRESS, CITY, STATE, ZIP COD 4412 SOUTH MAIN STREET SALISBURY, NC 28147		12/13/2023	
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d From pag	e 13	F 6	36			
se #4 report h the compl cility and sh g the timeline n and comp ty plan of co /2023 the fa n and comp ents were no d. The Clinic nt identified by the late ehensive MI ed 46 late as st 60 days fo . Education rator to the I on on 12/1/2 ed manager ents weekly susing the Co sessesments fill be preser the meeting b of Nursing. O d, and an or wed at the w The date o of correction ation provide	ed she was newly hired to etion of MDS assessments a had received education less of MDS completion for rehensive assessments. Forection was reviewed and it collity identified past due rehensive MDS of being completed and leal Reimbursement residents who were completion of the admission DS assessments and lesessments during an audit for all current and discharged awas provided by the MDS nurses on MDS of 1023. The Administrator or will monitor MDS for 4 weeks and monthly for Quality Assurance tools to were completed timely. The left to the weekly Quality by the Administrator or the Compliance will be agoing auditing program will leekly Quality Assurance for compliance was 12/2/2023. In was validated by review of led, review of the audits					
	SUPPLIER SUMMARY STACH DEFICIENCE GULATORY OR de From page was intervie se #4 report the the comple cility and ship the timeline on and comp ity plan of co led The Clinic ont identified I by the late set 60 days for the chensive MI and 46 late as set 60 days for the chensive MI and 46 late as set 60 days for the timeline on 12/1/2 the date as set 60 days for the chensive MI and 46 late as set 60 days for the chensive MI and 46 late as set 60 days for the date as the chensive MI and and an or the formation provide the date or of correction attion provide the date or	IDENTIFICATION NUMBER: 345503 SUPPLIER	SUPPLIER INSG & REHAB CTR OF ROWAN COUNTY SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) IN was interviewed on 12/14/2023 at 3:41 se #4 reported she was newly hired to the the completion of MDS assessments cility and she had received education to the timeliness of MDS completion for an and comprehensive assessments. Ity plan of correction was reviewed and it will be presented to the admission ehensive MDS assessments and dad late assessments during an audit at 60 days for all current and discharged and dad late assessments during an audit at 60 days for all current and discharged and dad as a seem of the modern of the manager will monitor MDS ents weekly for 4 weeks and monthly for a using the Quality Assurance tools to seessments were completed timely. The will be presented to the weekly Quality be meeting by the Administrator or the of Nursing. Compliance will be do, and an ongoing auditing program will wed at the weekly Quality Assurance The date of compliance was 12/2/2023. of correction was validated by review of ation provided, review of the audits ad by the facility, and interview with the end MDS nurse regarding education	SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD ALIZA SOUTH MAIN STREET SALISBURY, NC 28147 SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY TAG F 636 F 636	SUPPLIER 1 SUPPLIER 1 NSG & REHAB CTR OF ROWAN COUNTY SUMMARY STATEMENT OF DEFICIENCIES COLD DEFICIENCY MUST BE PRECEDED BY PULL SULATORY OR LSC IDENTIFYING INFORMATION) TAG 1 FREETX SUMMARY STATEMENT OF DEFICIENCIES COLD DEFICIENCY MUST BE PRECEDED BY PULL SULATORY OR LSC IDENTIFYING INFORMATION) TAG 1 FREETX TAG 1 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1 FREETX TAG 1 FROM THE STATE SALISBURRY, NC 28147 TAG 1 FROM THE STATE SALISBURRY, NC 28147 TAG 1 FROM THE STATE SALISBURRY, NC 28147 TAG 1 FROM THE STATE SALISBURRY, NC 28147 TAG 1 FROM THE STATE STATE STATE STATE STATE STATE STATE STATE STATE SALISBURRY, NC 28147 TAG 1 FROM THE STATE SALISBURRY, NC 28147 TAG 1 FROM THE STATE STATE STATE STATE STATE STATE STATE STATE STATE SALISBURRY, NC 28147 TAG 1 FROM THE STATE STATE STATE SALISBURRY, NC 28147 TAG 1 FROM THE STATE STATE STATE SALISBURRY, NC 28147 TAG 1 FROM THE STATE STATE STATE STATE SALISBURRY, NC 28147 TAG 1 FROM THE SALISBURRY, C 28147 TAG 1 FROM THE SAL	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345503	B. WING		C 12/15/2023	
	ROVIDER OR SUPPLIER	HAB CTR OF ROWAN COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147	12/13/2023	
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F 636	were were reviewed identified. The facilit 12/2/2023 was valid	S completed after 12/2/2023 I and no issues were by date of compliance of	F 63			
SS=B	CFR(s): 483.20(c) §483.20(c) Quarterl A facility must asses quarterly review insi and approved by CN once every 3 month This REQUIREMEN by: Based on record re facility failed to com Set (MDS) assessm Assessment Refere of the assessment presidents (Resident #7, Resident #19, R #50). The findings include A. Resident #30 w 3/8/2019. A review of Res assessment with an as complete on 8/ B. Resident #6 wa 2/7/2022. A review of Res	y Review Assessment as a resident using the strument specified by the State MS not less frequently than s. IT is not met as evidenced views and staff interviews, the plete quarterly Minimum Data tents within 14 days of the nce Date (ARD) [the last day period] for 6 of 21 sampled #30, Resident #6, Resident tesident # 236, and Resident decided: Vas admitted to the facility on sident #30's quarterly MDS ARD of 8/1/2023 was signed 1/17/2023. It is admitted to the facility on sident #6's quarterly MDS ARD of 11/10/2022 was		Past noncompliance: no plan of correction required.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		345503	B. WING		1	C 2/15/2023
	NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147		2/13/2023
(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 CORRECT (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRIES OF THE	JLD BE	(X5) COMPLETION DATE
F 638	Continued From page	e 15	F 63	88		
	C. Resident #7 was 7/30/2023.	readmitted to the facility on				
		dent #7's quarterly MDS ARD of 11/2/2023 was on 11/28/2023.				
	D. Resident #19 wa 10/22/2019.	s admitted to the facility on				
		dent #19's quarterly MDS ARD of 1/19/2023 was on 2/14/2023.				
	E. Resident #236 wa 2/17/2023.	s admitted to the facility on				
	A quarterly Minin assessment for Resid assessment reference was signed as complete	e date (ADR) of 5/17/2023				
	F. Resident #50 was 9/5/2023.	admitted to the facility on				
	assessment reference	assessment with an e date (ADR) of 11/3/2023 npleted on 11/29/2023.				
	The facility MDS nurs interview during the s	e was not available for urvey.				
	Reimbursement Cons 2:09 PM. The Clinica Consultant revealed s	she became aware of the ssessments after running a				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345503	B. WING _			C 2/15/2023
	ROVIDER OR SUPPLIER	EHAB CTR OF ROWAN COUNTY		STREET ADDRESS, CITY, STATE, ZIP COD 4412 SOUTH MAIN STREET SALISBURY, NC 28147	•	2.16/2020
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F 638	time. The Clinical explained the MDS expectations of the on 11/30/2023, to nurses to assist w MDS assessments. The Regional Nurson 12/14/2023 at 2 facility had receive Reimbursement C and the facility devere not being me modified the plant of Nurse Consultant additional MDS nucompletion of MDS. The Administrator at 3:06 PM, he reg 9/14/2023 and receive Clinical Reimb Administrator expl Quality Improvement PIP, but upon revithat the goals were Improvement team. Nurse #4 was inte PM. Nurse #4 repassist with the conforthe facility and regarding the time quarterly assessments.	(PIP) was developed at that Reimbursement Consultant Sonurse was unable to meet the PIP and the PIP was modified include hiring additional MDS ith completing the quarterly is in a timely manner. See Consultant was interviewed 2:54 pm and she reported the ed the report from the Clinical consultant in September 2023 veloped a PIP and the goals et by the MDS nurse, so they con 11/30/2023. The Regional explained the facility had hired arses to help with the Scassessments. Was interviewed on 12/14/2023 corted he started his position on eived the late MDS report from ursement Consultant. The ained the facility had an ad hoc ent Meeting and developed a new on 11/30/2023, discovered enot being met, and the Quality in developed another PIP. Tryiewed on 12/14/2023 at 3:41 corted she was newly hired to impletion of MDS assessments she had received education liness of MDS completion for	F			

	AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345503	B. WING		C 12/15/2023
	ROVIDER OR SUPPLIER	AB CTR OF ROWAN COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147	12/13/2023
(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 I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE.
F 638	On 11/29/2023 the far quarterly MDS assess completed and submit Reimbursement Consider who were impacted by quarterly MDS assess late assessments dur days for all current are Education was provide the MDS nurses on M 12/1/2023. The Admit manager will monitor for 4 weeks and monit Quality Assurance too were completed timel presented to the week meeting by the Admit Nursing. Compliance ongoing auditing programs.	cility identified past due sments were not being tted. The Clinical sultant identified residents by the late completion of the sments and discovered 46 ing an audit of the past 60 and discharged residents. The ed by the Administrator to an audit of the past 60 and discharged residents. The ed by the Administrator to an audit of the past 60 and discharged residents. The ed by the Administrator to an audit of the past 60 and 60	F 63	8	
F 641 SS=B	the education provide completed by the facinewly hired MDS nurreceived and monitor assessments comple reviewed and no issuressessments. The factorial section of the factor	ents	F 64	1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED			
		345503	B. WING _			l	C 15/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 12/	13/2023
				44	12 SOUTH MAIN STREET		
LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY		AB CTR OF ROWAN COUNTY			ALISBURY, NC 28147		
(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 641	facility failed to accurs Set (MDS) assessme residents (Resident #Resident #19). The findings included A. Resident #30 wa 3/8/2019. A review of medi #30 revealed he was medications. A review of the C 11/1/2023 documente was taking antipsychology. B. Resident #6 was 2/7/2022. A review of physical revealed no orders for A review of the q 10/10/2023 document not received enteral feassessment documen 500 milliliters or less a from enteral feedings. C. Resident #19 wa 10/22/2019.	ews and staff interviews, the ately code Minimum Data nts for 3 of 26 sampled 30, Resident #6, and : s admitted to the facility on cation orders for Resident not prescribed antipsychotic duarterly MDS dated and "yes" that Resident #30 offic medications. admitted to the facility on cian orders for Resident #6 or enteral feedings. uarterly MDS dated ted "no" Resident #6 had beedings. The MDS office the model of the model of the model of the section of	F	541	Past noncompliance: no plan of correction required.		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345503	B. WING			C 12/15/2023	
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY			STREET ADDRESS, CITY, STATE, ZIP COI 4412 SOUTH MAIN STREET SALISBURY, NC 28147	DE	,		
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F 641	9/27/2023 revealed of #19 received parents feeding, and she record and 51% of her calor. The facility MDS nursinterview during the sembursement Con. 2:09 PM. The Clinical Consultant revealed inaccurate MDS assereport on 9/14/2023 a Improvement Plan (Pitme. The Clinical Reexplained the MDS nexpectations of the Pon 11/30/2023, to inconurses to assist with timely manner. The Regional Nurse on 12/14/2023 at 2:5 facility had received to Reimbursement Contant the facility development being met be modified the plan on Nurse Consultant expanditional MDS nurse completion of MDS and Nurse Consultant repwas an important facility during an interview with 12/14/2023 at 3:06 Pitch 12/14/2023 at 3:06	uarterly MDS dated ocumentation that Resident ral feeding and enteral eived 500 or more milliliters fees via enteral feeding. See was not available for curvey. ducted with the Clinical sultant on 12/14/2023 at all Reimbursement she became aware of the ressments after running a rand a Performance IP) was developed at that imbursement Consultant rurse was unable to meet the IP and the PIP was modified rude hiring additional MDS MDS assessments in a Consultant was interviewed a pm and she reported the he report from the Clinical sultant in September 2023 roped a PIP and the goals by the MDS nurse, so they 11/30/2023. The Regional collained the facility had hired resessments. The Regional corted that MDS accuracy for in resident care. With the Administrator on M, he reported he started his B and received the late MDS	Fé	341			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345503	B. WING			C 12/15/2023
	NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY			STREET ADDRESS, CITY, STATE 4412 SOUTH MAIN STREET SALISBURY, NC 28147	, ZIP CODE	12/13/2023
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F 641	facility had an ad hoo Meeting and develop 11/30/2023, discovered being met, and the Q developed another P Nurse #4 was intervie PM. Nurse #4 report assist with the completor the facility and she regarding the accuracy. The facility plan of coread: On 11/29/2023 the factoded MDS assessment on MDS accuracy on Administrator or design MDS assessments were monthly for 2 months tools to ensure assess correctly. The reports weekly Quality Assurand Administrator or the D Compliance will be mauditing program will Quality Assurance mecompliance was 12/2. The plan of correction the education provide completed by the factors.	inistrator explained the Quality Improvement ed a PIP, but upon review on ed that the goals were not uality Improvement team IP. Ewed on 12/14/2023 at 3:41 ed she was newly hired to etion of MDS assessments e had received education by of MDS assessments. Firection was reviewed and it cility identified inaccurately tents. Education was nistrator to the MDS nurses 12/1/2023. The gnated manager will monitor eekly for 4 weeks and using the Quality Assurance is ments were coded will be presented to the ance meeting by the Director of Nursing. In incomplete in the date of 1/2023. The was validated by review of ed, review of the audits illity, and interview with the se regarding education	F	641		
		ted after 12/2/2023 were				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345503	B. WING		C 12/15/2023	
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147		12/10/2020	
(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 APPROFIDERICIENCY)	D BE COMPLETION	
F 641	Continued From page	e 21	F 64	1		
	identified. The facility 12/2/2023 was validated	date of compliance of attention of the detection of the d				
F 727 SS=F	RN 8 Hrs/7 days/Wk, CFR(s): 483.35(b)(1)		F 72	7		
	must use the service least 8 consecutive h §483.35(b)(2) Except paragraph (e) or (f) or must designate a reg director of nursing or §483.35(b)(3) The dias a charge nurse or average daily occupa This REQUIREMENT by: Based on record rev facility failed to use th Nurse (RN) for 8 con 10 of 10 dates review 7/23/23, 8/20/23, 8/20 and 9/9/23). The findings included The Payroll Based Jofiscal year 2023, the 9/30/23 was reviewed facility had the follow with no Registered N	t when waived under of this section, the facility is of a registered nurse for at a tours a day, 7 days a week. It when waived under of this section, the facility instered nurse to serve as the in a full time basis. In rector of nursing may serve only when the facility has an ancy of 60 or fewer residents. It is not met as evidenced or it is not met as evidence		Past noncompliance: no plan of correction required.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345503	B. WING			C 12/15/2023	
	NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY			STREET ADDRESS, CITY, STATE, ZIP CO 4412 SOUTH MAIN STREET SALISBURY, NC 28147	DE	12/10/2020	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA	DATE	
F 727	7/22/23, 7/23/23, 8/2 9/2/23, 9/3/23, and 9 RN was scheduled to dates. The time sher 7/22/23, 7/23/23, 8/2 9/2/23, 9/3/23, and 9 RN were documente shifts for the reviewe During an interview w (DON) on 12/13/23 a had started her posit was not aware a RN every day for 8 conso September 2023. Th scheduler had told he available to work tho not understand the ir on the schedule. The action plan had been conducting daily aud coverage. An interview was cor on 12/14/23 at 11:11 explained the facility in blank spots in the listed above, when si work, she had report of RN coverage. The schedule was discus and her every mornir concluded she had re RN coverage on 11/1 Assurance nurse.	es for 7/8/23, 7/15/23, 0/23, 8/26/23, 8/27/23, 1/9/23 were reviewed. No o work on the reviewed ets for 7/8/23, 7/15/23, 0/23, 8/26/23, 8/27/23, 1/9/23 were reviewed and no d to have had worked any d dates. With the Director of Nursing at 12:40 PM she reported she ion in May 2023, and she was to be scheduled to work ecutive hours until e DON reported the er there were no RNs see dates, but the DON did inportance of having an RN e DON explained a corrective in put in place and she was its of the scheduler for RN inducted with the Scheduler wised staffing agencies to fill schedule and on the dates he knew there was no RN to ed to the DON about the lack e Scheduler explained the sed by nursing managers	F7	727			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI	FIPLE CONSTRUCTION NG	(>	(X3) DATE SURVEY COMPLETED	
		345503	B. WING			C 12/15/2023
	NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY			STREET ADDRESS, CITY, STATE, ZI 4412 SOUTH MAIN STREET SALISBURY, NC 28147	IP CODE	12/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 727	started his position a took the position, he no RN hours for Qua Administrator explain Improvement Plan was recurrence of no RNs consecutive hours per The facility plan of coread: On 11/10/23 the facility occurrences when the scheduled. The facility identified 10 days who coverage: 7/8/23, 7/18/20/23, 8/26/23, 8/29/9/23. The Quality / Consultant in-service Assistant DON, and the regarding RN covera QA Nurse will monitor facility has RN covera Assurance tool for state completed daily for 5 and then weekly for 8 presented to the week committee by the Administrator, the DO leaders. The date of The plan of correction	uled to work were before he is Administrator, and when he received the PBJ report of of the received the PBJ report of of the received the PBJ report of the received the PBJ report of the received and received to prevent a secheduled for 8 of day. The received and it of the received and it of the received and	F ·	727		
		ed, review of the audits ility and interviews with the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2 IDENTIFICATION NUMBER: A. E		LE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		345503	B. WING		C 12/15/2023
	ROVIDER OR SUPPLIER	AB CTR OF ROWAN COUNTY	•	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC 28147	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 727	Continued From page	e 24	F 72	7	
	DON, Scheduler, and facility date of compli validated.	I the Administrator. The ance of 11/11/23 was			
F 804 SS=E		ar, Palatable/Prefer Temp (2)	F 80	4	1/5/24
	§483.60(d) Food and Each resident receive	drink es and the facility provides-			
		repared by methods that ue, flavor, and appearance;			
	attractive, and at a sa temperature.	and drink that is palatable, afe and appetizing is not met as evidenced			
	and resident and staf to serve food warm th	observation, record review, finterviews the facility failed nat should be served warm all). This practice had the her residents.		The statements made on this plan or correction are not an admission to ar not constitute an agreement with the alleged deficiencies. To remain in compliance with all fede and state regulations the facility has	nd do eral
	The findings included 1)Resident #30 was a 3/8/2019.	l: admitted to the facility		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	s ttion f
	(MDS) revealed Resi intact and had not ex	erly Minimum Data Set dent #30 was cognitively perienced weight loss.		deficiencies cited have been or will b corrected by the dates indicated. F804 1. For dietary services, a corrective action was obtained on 12/11/2023.	
		ducted with Resident #30 on m. and he revealed the food d.		Based on observation, record review resident, staff, and family interviews noted the facility failed to provide ser	it was
		meal tray line service in the ed on 12/13/2023 at 12:31		food warm that should be served war 1 of 4 halls.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345503	B. WING			C 2/15/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		2/13/2023	
				4412 SOUTH MAIN STREET			
LIBERTY	COMMONS NSG & REH	AB CTR OF ROWAN COUNTY		SALISBURY, NC 28147			
(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 (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 804	regular and puree co 135-degree Fahrenhoplaced on heated plated meals were conshaped lids with botted did not close complete brussel sprouts that pure pure pure pure pure pure pure pure	es of the food items of insistency were greater than eit. The food items were tes from a plate warner. The overed with insulated, dome oms. The dome shaped lids tely due to a bowl, containing prevented the closer. The M) was observed to provide etary staff to ensure the lids at plates were observed to be ell meal cart with the lids. The meals were placed in a steel delivery cart and 0-hall at 12:52 p.m. where ediately began serving the chall. A test meal tray of cured foods were included in the content of the c	F 80	For Resident #31 and intervier on 12/12/2023 he revealed the frequently arrives cold. For rean interview took place on 12 revealed his lunch on 12/13/2 good but it was cold. He added ask anyone to warm up his for this happens a lot and the Nuransistants would be spending time warming up meal trays. I had informed staff on many of food arrives cold. For resident #47 an interview on 12/13/2022 she revealed to n 12/13/2023 was cool to the she could have reheated it, she have. For Resident #19 an interview conducted on 12/13/2023 and Resident stated at lunch the Exprouts were cold.	e food sident #31 /13/2023 he /023 tasted ed he did not od because rsing g all their He stated he ccasions the took place he lunch tray e touch and if ne would v was d the		
	the puree test tray. The DM participated in the testing of the two meal trays and acknowledged these findings. An interview was conducted with Resident #30 on 12/13/2023 at 4:50 p.m. and he revealed his lunch on 12/13/2023 tasted good but it was cold. He added he did not ask anyone to warm up his food because this happens a lot and the Nursing Assistants would be spending all their time warming up meal trays. He stated he had informed staff on many occasions the food arrives cold.			Beginning 1/2/2023, Administ completed test tray audit x 3 of ensure holding temperature has for meals and reviewed temperatures to confirm cooking and holdin temperatures had been met for 01/03/2024.	days to ad been met erature logs g or meals on		
				Corrective action for resident	dents with		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345503	B. WING		1	C 2/15/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	2/15/2025	
				4412 SOUTH MAIN STREET	_		
LIBERTY	COMMONS NSG & REH	AB CTR OF ROWAN COUNTY		SALISBURY, NC 28147			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 804	Continued From pag	ne 26	F 80	04			
	2)Resident #47 was 9/5/2023.	admitted to the facility on		the potential to be affected by deficient practice.	the alleged		
	revealed Resident # had not experienced An observation of the kitchen was conduct p.m. The temperatur regular and puree con 135-degree Fahrenh placed on heated play plated meals were conshaped lids with bott did not close completorussel sprouts that Dietary Manager (Dinstructions to the dicclosed. A total of nin placed on the 300-had	terly MDS dated 11/9/2023 47 was cognitively intact and weight loss. The meal tray line service in the ed on 12/13/2023 at 12:31 res of the food items of consistency were greater than reit. The food items were retes from a plate warner. The covered with insulated, dome coms. The dome shaped lids retely due to a bowl, containing prevented the closer. The low observed to provide retary staff to ensure the lids e plates were observed to be all meal cart with the lids. The meals were placed in a		All residents have the potential affected by the alleged deficiency on 01/04/2024, the Administration completed an in-service to dissexperience and meal cooking temperatures with dietary stativilly be incorporated more offectomplaints reduce or resolve Residents mentioned above winterviewed and monitored on basis to ensure food delivered expectations. 3. Systemic changes In-service education was providul time, part time, and as neastaff. Topics included:	ent practice. Fator Scuss dining I and holding Iff. Test Trays In until food Completely. Will be In a regular Id is per		
	four-sided, stainless transported to the 30 the nursing staff imm residents on the 300 regular and puree te the meal delivery car. An interview was con 12/13/2023 at 3:34 plunch tray on 12/13/2 and if she could have have. 3) Resident #19 was 4/27/2021. A review of the quark	-steel delivery cart and 00-hall at 12:52 p.m. where nediately began serving the -hall. A test meal tray of xtured foods were included in		" Meal objectives and produce " Test Tray completion " Focus on dining experier Test Trays will be completed to satisfactory dining experience Dietary Manager will attend recouncil as invited and follow to food complaints as identified. This information has been into the standard orientation training required in-service refresher all staff and will be reviewed to Assurance process to verify the change has been sustained. Staff who does not receive so in-service training by 01/04/20	egrated into and and in the courses for by the Quality hat the Any dietary		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345503	B. WING _			l	C 15/2023
	ROVIDER OR SUPPLIER	AB CTR OF ROWAN COUNTY		44	REET ADDRESS, CITY, STATE, ZIP CODE 12 SOUTH MAIN STREET ALISBURY, NC 28147	1 2	10/2020
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 804	kitchen was conducted p.m. The temperature regular and puree cortists and puree conditions are gular and puree conditions and placed on heated plated meals were conshaped lids with botton did not close completed brussel sprouts that pure points and pure the placed on the die closed. A total of nine placed on the 300-hard opened on the sides. The four-sided, stainless transported to the 300-regular and puree text the meal delivery card. An interview was conditionally at lunch the brussel service food Procurement, State of Procurement, State of Procurement, State of Procurement, State of local authoritic, in This may include for the state of local authoritic, in This may include for state of local authoritic, in the state of local authoritic in the state of local authorities are state of local au	meal tray line service in the ed on 12/13/2023 at 12:31 es of the food items of ensistency were greater than eit. The food items were tes from a plate warner. The evered with insulated, dome oms. The dome shaped lids ely due to a bowl containing envented the closer. The ely was observed to provide tary staff to ensure the lids enveloped plates were observed to be ell meal cart with the lids. The meals were placed in a esteel delivery cart and containing the hall. A test meal tray of tured foods were included in electronic ducted with Resident #19 on entered means and the Resident stated prouts were cold. The electronic means were electronic		3312	be allowed to work until training has be completed. 4. Quality Assurance monitoring procedure. The Administrator. or designee will complete a test tray Monday through Friday weekly x 2 weeks, then weekly x weeks, and then monthly x 2 months. Monitoring will include reviewing food items for appearance and taste as well visiting with residents when complaints are received. Reports will be presented the weekly Quality Assurance committed by the Administrator to ensure correctivaction initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at a weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manage. Date of Compliance: 01/05/2024	x 2 as I to ee /e the	1/5/24

AND PLAN OF CORRECTION ID	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		TE SURVEY MPLETED
	345503	B. WING _		1	C 2/15/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		2/13/2023
			4412 SOUTH MAIN STREET		
LIBERTY COMMONS NSG & REHAB CT	R OF ROWAN COUNTY		SALISBURY, NC 28147		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 812 Continued From page 28 and local laws or regulation (ii) This provision does not facilities from using produce gardens, subject to complia safe growing and food-hand (iii) This provision does not from consuming foods not p §483.60(i)(2) - Store, prepal serve food in accordance we standards for food service sees. This REQUIREMENT is not by: Based on observations and facility failed to date and late 1 walk in cooler. The findings included: On 12/11/2023 at 10:52 a.m. made of the facility's walk-in Dietary Manager (DM). Upo the following items without seeds. A. Sliced ham opened and wrap. B. Two containers of slice plastic wrap. C. A freezer storage bag of food. This item also did not date. During the observation of the interview was conducted wi 12/11/2023 at 10:52 a.m. an sliced ham should contain a added the two containers of also contain a label and dat white substance stored in the	prohibit or prevent e grown in facility ince with applicable dling practices. preclude residents procured by the facility. Tre, distribute and prith professional safety. The met as evidenced distaff interviews the poel opened food in 1 of the poel opened food in 1 of the poel opened in a plastic distaft urkey wrapped in a with a white chunk of the poel opened food in 1 of the poel opened in a plastic distance of turkey wrapped in a with a white chunk of the poel opened food in 1 of the poel opened in a plastic distance of turkey wrapped in a with a white chunk of the poel opened food in 1 on the poel opened food in 2 opened food in 3 opened food in 3 opened food in 4 opened food in 4 opened food in 5 opened fo	F8	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 alleged deficiencies cited have been corrected by the dates indicated the facility failed to date opened food in 1 of 1 walk in action was obtained on 12/12. During walk through of the kith noted the facility failed to date opened food in 1 of 1 walk in action was obtained on 12/12. All residents have the potential affected by the alleged deficient practice.	all federal ity has taken the in this f correction pation of ed or will be red. crective //2024. chen it was a and label cooler. s with the alleged	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345503	B. WING			C) 15/2023
	ROVIDER OR SUPPLIER	AB CTR OF ROWAN COUNTY		STREET ADDRESS, CITY, STATE, ZIP COD 4412 SOUTH MAIN STREET SALISBURY, NC 28147	I E	12/1	13/2023
(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 CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	I	(X5) COMPLETION DATE
F 812	original packaging. S expectation that ever have a label and date An interview was con Administrator on 12/1 revealed it was his ex	ad been removed from the he stated it was her y item in the walk in cooler when it has been opened.	F	On 12/11/2024, the Dietary M discarded all items noted with label from walk in cooler. 2. Systemic changes Beginning 1/3/2024, In-service was provided to all full time, p as needed dietary staff. Topic "Inspections to observe all within their dates with label ar displayed. This information has been into the standard orientation training required in-service refresher call staff and will be reviewed be Assurance process to verify the change has been sustained. Staff who does not receive sold in-service training by 01/04/20 be allowed to work until training completed. 3. Quality Assurance monitor procedures by completing kitch inspections weekly x 4 weeks monthly x 2 months using the Quality Assurance Audit. Reports and ongoing auditing program the weekly Quality Assurance will be and ongoing auditing program the weekly Quality Assurance The weekly QA Meeting is atternal.	e education art time, as included I food are not date egrated in a gand in courses for any the Quanat the Any dietained I food are not then and then Dietary orts will be a greated as the mediated as the principal of the princip	on and d: to the or ality ry ot en itor e ator red d at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245502		_		1	С	
		345503	B. WING _			12/	15/2023	
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE			
LIBERTY	COMMONS NSG & REHA	AB CTR OF ROWAN COUNTY	4412 SOUTH MAIN STREET					
				S	ALISBURY, NC 28147			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 812	Continued From page			312	Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager Date of Compliance: 1/5/2024			
F 867 SS=E	•		F 8	367			1/5/24	
	monitoring. A facility must establis policies and procedur collections systems, a adverse event monito procedures must inclufollowing:	eedback, data systems and sh and implement written es for feedback, data and monitoring, including ring. The policies and ude, at a minimum, the						
	systems to obtain and from direct care staff, resident representativ information will be use	d use of feedback and input other staff, residents, and res, including how such ed to identify problems that ume, or problem-prone, and						
	systems to identify, coinformation from all donot limited to the facility \$483.70(e) and include	maintenance of effective bllect, and use data and epartments, including but ity assessment required at ling how such information p and monitor performance						
	and evaluation of per	ology and frequency for such						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345503	B. WING _			C 12/15/2023		
	ROVIDER OR SUPPLIER	AB CTR OF ROWAN COUNTY		STREET ADDRESS, CITY, STATE, ZIP COD 4412 SOUTH MAIN STREET SALISBURY, NC 28147	E	12/10/2020		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 867	including the method systematically identificantly and use data adverse events in the facility will use the daprevent adverse eve §483.75(d) Program systemic action. §483.75(d)(1) The facility aimed at performance implementing those and track performance improvements are respectively. The facility will be designed to elevel to prevent quality safety problems; and (iii) How the facility will have the f	y adverse event monitoring, ls by which the facility will fy, report, track, investigate, a and information relating to e facility, including how the ata to develop activities to ints. systematic analysis and cility must take actions be improvement and, after actions, measure its success, and the compact of the compac	F	BEFICIENCY)				
	performance improve high-risk, high-volum consider the incidence	activities. cility must set priorities for its ement activities that focus on ite, or problem-prone areas; ite, prevalence, and severity areas; and affect health						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345503	B. WING _			C / 15/2023	
	ROVIDER OR SUPPLIER	AB CTR OF ROWAN COUNTY		STREET ADDRESS, CITY, STATE, ZIP C 4412 SOUTH MAIN STREET SALISBURY, NC 28147		113/2023	
(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 ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 867	substitution of this security is a substitution of this security is substitution of this security in the substitution of the s	rafety, resident autonomy, quality of care. mance improvement medical errors and adverse lyze their causes, and exactions and mechanisms and learning throughout the ext of their performance es, the facility must conduct improvement projects. The cy of improvement projects exility must reflect the scope expanding facility's services and as reflected in the facility at at §483.70(e). Is must include at least expanding facilities or include at least expanding facilities at focuses on high risk or is identified through the data sits described in paragraphs extion.	F	BEFICIENC 367	Y)		
	assurance committee governing body, or d functioning as a gove activities, including in program required un (e) of this section. Th (ii) Develop and impl action to correct ider (iii) Regularly review	erning body regarding its nplementation of the QAPI der paragraphs (a) through					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION G	_	(X3) DATE SURVEY COMPLETED
		345503	B. WING _			C 12/15/2023
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE	,
I IDEDTY (COMMONS NSC & DEL	AB CTR OF ROWAN COUNTY		4412 SOUTH MAIN ST	REET	
LIDEKTI	COMMONS NSG & REH	AB CIR OF ROWAN COUNTY		SALISBURY, NC 28	3147	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION PRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY)	
F 867	Continued From pag	e 33	F 8	67		
	available data to mal This REQUIREMEN by:	egimen reviews, and act on ke improvements. It is not met as evidenced on, record review and staff		The statement	ts made on this plan of	
	interviews the facility Assurance Committee implemented proced interventions the con- into place following t and complaint invest deficiencies were in a Comprehensive Assessments at least Accuracy of Assessm Procurement and Ste Food in a Sanitary M were subsequently re- recertification and con- The continued failure	's Quality Assessment and be failed to maintain sures and monitor in mittee had previously put the 5/12/2022 recertification igation survey. The sthe areas of (F636) ressments; (F638) Quarterly the every three months; (F641) rents; and (F812) Food ore, Prepare, and Serve anner. These deficiencies		correction are r not constitute a alleged deficier To remain in co and state regul or will take the plan of correctic constitutes the compliance suc deficiencies cite corrected by the F867	not an admission to and an agreement with the	ıl ken on
	Findings included: The tag is cross-refe	Quality Assurance Program.		committee faile procedures and committee put recertification a	nd Assurance (QAA) ed to maintain implement d monitor interventions t into place following the and complaint investigati aducted on 7/15/2022 ar	he on
	admission comprehe (MDS) assessments admission and failed MDS assessments w Assessment Referer of the assessment per residents.	y failed to complete 1 of 4 Insive Minimum Data Set Within 14 days of an to complete comprehensive		recertification s 5/3/21. This wa were cited in th Assessment ar Assessment at (F638), accurac and Food Proce Prepare/Serve- continued failur federal surveys	survey completed on as for 4 deficiencies that he areas of Comprehens and Timing (F636), Qrtly Least Every 3 Months by cy of assessments (F64 surement, Store/Sanitary (F812). The reduring two or more sof record shows a patternability to sustain effect	ive 1), ern

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345503	B. WING			С	
NAME OF B		345503	B. WING _	077557 1775570 0177 07175 717 07	•	12/15/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
LIBERTY	COMMONS NSG & RE	HAB CTR OF ROWAN COUNTY		4412 SOUTH MAIN STREET			
				SALISBURY, NC 28147			
(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 ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 867	Continued From pa	age 34	F8	867			
	assessment within	14 days of the assessment					
		2 of 7 residents during a		2. Corrective action for resid	dents with the		
		complaint investigation survey		potential to be affected by the	ne alleged		
	conducted 5/12/20			deficient practice:	· ·		
				"Corrective action has been	taken for the		
		cord reviews and staff		identified concerns in the ar	eas of:		
		lity failed to complete quarterly		Comprehensive Assessmer	ıt and Timing		
		(MDS) assessments within 14		(F636)			
		sment Reference Date (ARD)		"Corrective action has been			
		assessment period] for 6 of 21		identified concerns in the ar	-		
	sampled residents.			Assessment at Least Every	3 Months		
	The facility failed to	a complete a guartarly		(F638)	takan far tha		
		complete a quarterly (MDS) assessment within 14		Corrective action has been identified concerns in the ar			
		ment reference date for 1 of 9		Accuracy of Assessment (F			
	·	I for timeliness completion of		"Corrective action has been	•		
	quarterly MDS ass	•		identified concerns in the ar			
		complaint investigation survey		Procurement, Store/Prepare			
	conducted 5/12/20			Sanitary (F812)			
				The Quality Assurance Perf	ormance		
	F641-Based on red	cord reviews and staff		Improvement (QAPI) comm	ittee held a		
	interviews, the faci	lity failed to accurately code		meeting on 1/4/2024 to revi	ew the		
		(MDS) assessments for 3 of		deficiencies from the 12/11/			
	26 sampled reside			annual recertification survey	/, CI survey,		
		o accurately complete the		and reviewed the citations.			
		data set (MDS) for 1 of 2		On 1/4 /2024, the Regional			
		reviewed for range of motion		Consultant in-serviced the f	•		
	during a recertifica	y conducted 5/12/2022.		administrator and the Qualit Committee on the appropria			
	investigation surve	y conducted 3/12/2022.		of the QAPI Committee and			
	F812-Based on oh	servations and staff interviews		of the committee to include			
		date and label opened food in		issues and correcting repea			
	1 of 1 walk in coole						
				3. Measures/Systemic chan	ges to prevent		
	The facility failed to	o maintain sanitary conditions		reoccurrence of alleged def	•		
		in 1 of 2 nourishment rooms by		Education:			
	not ensuring food i	tems were not stored on the		On 1/ 4/ 2024 the Regional	Clinical Nurse		
		ng resealed food items were		Consultant completed in-se			
	dated/labeled; by r	not ensuring food service		QAPI team members that in	clude the		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345503	B. WING _			C 12/15/2023	
NAME OF PI	ROVIDER OR SUPPLIER	1	'	STREET ADDRESS, CITY, STAT	ΓΕ, ZIP CODE	12.10.2020	
				4412 SOUTH MAIN STREET			
LIBERTY	COMMONS NSG & REH	AB CTR OF ROWAN COUNTY		SALISBURY, NC 28147			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI SED TO THE APPROPRIA FICIENCY)		TION
F 867	Continued From page equipment remained ensuring dietary staff preparing meal trays a recertification and survey conducted 5/ During an interview of 12/14/2023 at 3:50 padministrator during and complaint investinad put a plan of conworked to improve the Minimum Data Set at timely and accurately Administrator. The Administrator. The Administrator and the fin that area. The Adfacility's Quality Assection of Committee was meeting the staff of the	e 35 free from debris; and by not f wore hair covering while on the meal tray line during complaint investigation	F &	DE	cor of Nurses, Coordinator, Therapeger, Health r, and the Dietary propriate functioning tee and the purpose include identifying auding correcting incorporated in the ry orientation for the sum members in the stained. The second is seen completed in the receive schedular to ensure that it is effective and the red remains correct with regulatory or of Operations or sultant will monitor the F867 Quality kly x 4 weeks then The tool will monitor the tool will mon	g e any e led by t mat sted	
				addressed by the QA Reports will be prese Quality Assurance of Director of Nurses to action is initiated as Compliance will be n ongoing auditing pro	A Committee. ented to the weekly ommittee by the o ensure corrective appropriate. nonitored and the	′	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3)	DATE SURVEY COMPLETED	
		345503	B. WING _			C 12/15/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	12/15/2023	
LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY				4412 SOUTH MAIN STREET SALISBURY, NC 28147			
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 867	Continued From pag	e 36	F8	weekly Quality Assurance I indefinitely or until no longe necessary for compliance we laundry process. The week is attended by the Administ of Nursing, MDS Coordinat Manager, Unit Manager, and I Manager. Date of Compliance: 1/5/2	er deemed with the missing ty QA Meeting trator, Director tor, Therapy tealth the Dietary		

	OR MEDICARE & MEDICARD SERVICES	PROVIDER #		A TORN							
STATEMENT (STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		MULTIPLE CONSTRUCTION	DATE SURVEY							
NO HADMWITH ONLY A DOTENTIAL FOR MINIMAL HADM			A. BUILDING:	COMPLETE:							
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM				COMPLETE.							
FOR SNFs ANI	D NFs	345503		12/15/2023							
		343303	B. WING	12/15/2023							
		STREET ADDRESS (CITY STATE ZIP CODE	•							
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REHAB CTR OF ROWAN CO		STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET									
							LIDEKTI	SOMMONS NSG & REHAD CIR OF ROWAN CO	SALISBURY, NC		
ID											
PREFIX											
TAG	SUMMARY STATEMENT OF DEFICIENCIE	es.									
IAG	SOMEWHAT STATES AND ST										
F 582	Medicaid/Medicare Coverage/Liability Notice										
Г 302											
	CFR(s): 483.10(g)(17)(18)(i)-(v)										
	§483.10(g)(17) The facility must										
	(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and										
	when the resident becomes eligible for Medicaid of-										
	(A) The items and services that are included in nursing facility services under the State plan and for which the										
		resident may not be charged;									
	(B) Those other items and services that the facility offers and for which the resident may be charged, and the										
	amount of charges for those services; and										
	(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in										
	\$483.10(g)(17)(i)(A) and (B) of this section.										
	8403.10(g)(1/)(1)(A) and (b) of this section.										
	0.400.40(.)(40).7710.791										
	§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically										
	during the resident's stay, of services available in the facility and of charges for those services, including any										
	charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.										
	(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid										
	State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.										
	(ii) Where changes are made to charges for other items and services that the facility offers, the facility must										
	inform the resident in writing at least 60 days prior to implementation of the change.										
	(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must										
	refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid,										
	less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the										
	facility, regardless of any minimum stay or discharge notice requirements.										
	(iv) The facility must refund to the resident or resident representative any and all refunds due the resident										
	within 30 days from the resident's date of discharge from the facility.										
	(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must										
	not conflict with the requirements of these regulations.										
	This REQUIREMENT is not met as evidenced by:										
		Based on record review and staff interviews, the facility failed to provide a CMS-10055 (Centers for									
		Medicare and Medicaid Services) Skilled Nursing Facility Beneficiary Notice of Non-coverage (SNFABN)									
	prior to discharge from Medicare part A services to one of three residents (Resident #291).										
	The findings included:										
	Posident #201 was admitted to the feetites.	under Medicare Dan	A complete on 4/7/2022								
	Resident #291 was admitted to the facility under Medicare Part A services on 4/7/2023.										
	A review of the medical record revealed a C	CMS-10123 Notice o	f Medicare Non-Coverage letter was signed								
	by Resident #291 on 6/22/2023. The notice	indicated that Medic	care coverage for skilled services ended on								
	6/21/2023 and the resident would remain in the facility.										
	of 21/2020 and the resident would remain in the mentry.										
	Ī										

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

The above isolated deficiencies pose no actual harm to the residents

Event ID: 7B2K11 If continuation sheet 1 of 2

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY		
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM			A. BUILDING:	COMPLETE:		
OR SNFs ANI) NFs	345503	B. WING	12/15/2023		
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REHAB CTR OF ROWAN CO		4412 SOUTH MAI	STREET ADDRESS, CITY, STATE, ZIP CODE 4412 SOUTH MAIN STREET SALISBURY, NC			
O REFIX AG	SUMMARY STATEMENT OF DEFICIENCIE	s				
F 582	Continued From Page 1 A review of the medical record revealed a CMS-10055 SNF ABN was not provided to the resident until 06/22/2023. An interview was conducted with the Billing Office Manager (BOM) on 12/14/2023 at 2:19 p.m. and revealed Resident #291's Medicare A coverage was to end on 6/21/2023 and this should have been discussed with the Resident on 6/19/2023. The BOM added that she had been off work the day this occurred, and she had discussed it with the Resident upon return on 6/22/2023. An interview was conducted on 12/14/2023 at 11:01 a.m. with the Administrator and he revealed it was his expectation that all required notification forms for exhausted or ended benefits be presented to a Resident or the representative on the dates as required.					