

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
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	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35758</p> <p>Based on observations, record reviews, staff, and resident interviews the facility failed to maintain resident areas and equipment in a safe and sanitary manner for 2 of 3 shower (Shower room [ROOM NUMBER] on the 200 hall, Shower room [ROOM NUMBER] on the 300 hall), clean wheelchairs for 4 of 7 Resident's wheelchairs (Resident #24, Resident #132, Resident # 64, and Resident #3), and repair a wall behind the bed (room [ROOM NUMBER] bed A) for 1 of 10 rooms reviewed for environmental concerns.</p> <p>The findings included:</p> <p>1a. On 09/09/24 at 3:38 PM the entrance door of the 200 hall shower room [ROOM NUMBER] was propped open. Upon entering the shower room, a rancid odor permeated the entire shower room causing the surveyor to feel nauseous until the morning of 09/10/24. On the left side wall of the shower room where the sink was located a white ceramic toothbrush holder on the right side of the sink was loosely attached to the tile wall. The round floor drain cover located in the center of the shower room floor was observed with unidentified debris and hair covering more than half of the floor drain cover. An observation of the tiled wall dividing the shower stall and bathtub area revealed the lower right side of the divider wall had 5 cracked, jagged edged tiles. The plastic corner guard, which would have covered the cracked, jagged edged tiles, was observed on the floor at the back of the shower stall. Observation of the tiles and grout on the surrounding walls and floor of the shower stall revealed thick dark-brownish black dirt and debris at the joints of the wall and floor tiles. Upon closer inspection it was revealed there were 2 missing tiles on the shower room floor that measured 1 inch x 1 inch. The round drain cover located on the floor of the shower stall was covered with thick gray debris and visible hair.</p> <p>b. On 09/09/24 at 4:08 PM an observation of the shower room [ROOM NUMBER] on the 300 hall revealed there was no trash can liner in the trash can, and trash was observed on the floor around the trash can. A white ceramic toothbrush holder to the left of the sink was observed loosely fastened to the wall. The left faucet handle of the sink was observed without the top cover and the exposed inside screw was covered with rust. The shower stall area next to the bathtub revealed a silver nail clipper and soiled washcloth on the floor. The inside tiles and grout on the surrounding walls and floor of the shower stall revealed thick dark-brownish black dirt and debris at the joints of the wall and floor tiles.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2a. On 09/09/24 at 4:16 PM an observation of the wheelchair of Resident #24 revealed crumbs of dried food debris on the seat cushion, and dried spill marks were observed in the wheelchair arm side pieces. The wheelchair frame and wheel spokes were observed covered with a layer of thick gray dust.</p> <p>b. The wheelchair that belonged to Resident #132 was observed on 09/09/24 at 4:16 PM and revealed the frame and wheel spokes covered with a layer of thick gray dust.</p> <p>c. On 09/09/24 at 4:18 PM an observation of the wheelchairs that belonged to Resident # 64 and Resident #3 revealed food crumbs on both wheelchair seats and the frames and wheel spokes of both wheelchairs were covered with a layer of thick gray dust.</p> <p>On 09/10/24 at 1:42 PM an environmental tour was conducted with the Administrator and included an observation of shower room [ROOM NUMBER] on the 300 hall, and shower room [ROOM NUMBER] on the 200 hall. There was a faint, rancid smell detected from shower room [ROOM NUMBER] on the 200 hall. The Administrator revealed during the tour, the shower rooms needed repair and cleaning. The Administrator observed the wheelchairs of Resident #64 and Resident #3 and revealed the nurse staff on the night (11:00 PM - 7:00 AM) Monday through Friday.</p> <p>On 09/10/24 at 2:14 PM the wheelchair cleaning schedule was reviewed and revealed each room with a wheelchair, including the wheelchairs of Resident #24, Resident #132, Resident #64, and Resident #3, were to be cleaned monthly on night shift. Review of work orders revealed no concerns reported related to shower room cleanliness or wheelchair cleaning. Wheelchairs that were assigned to be cleaned were observed in the assignment book. There was no documentation to confirm if wheelchairs were cleaned or not.</p> <p>On 09/11/24 at 7:29 AM Nurse #2 was interviewed. Nurse #2 revealed that she worked the night shift when the Nursing Assistants (NAs) were scheduled to clean wheelchairs as scheduled posted in the assignment books. Nurse #2 revealed 4 wheelchairs were scheduled to be cleaned every night and there was no place to document if they were cleaned or not, but she had never received a report that wheelchairs had been cleaned or not cleaned.</p> <p>On 09/11/24 at 7:45 AM an interview with Housekeeper #1 was conducted and revealed she was assigned to clean the 200 hall shower room, shower room [ROOM NUMBER] and sometimes left the door propped open to dry the floor after it was mopped. Housekeeper #1 revealed she did smell an odor in the shower room [ROOM NUMBER] on the 200-hall and believed the odor was from the trash and the soiled linen bins. Housekeeper #1 revealed if she had any concerns about any room, she was assigned to clean she would have notified her manager.</p> <p>Housekeeper #2 interviewed at 7:52 AM on 09/11/24 revealed she was assigned the 200 hall and 300 hall shower rooms, shower rooms, #2 and #3, she had not smelled any strong odors in either of them and had not noticed the cracked tiles or concerns with the privacy curtains because she would have verbally reported any concerns to her manager.</p> <p>An interview with Nurse Assistant (NA) #1 who worked the night shift was conducted on 09/10/24 09:25 AM. NA #1 revealed she knew there was a wheelchair cleaning schedule in the daily assignment book. She reported the staff tried to clean as many wheelchairs as scheduled but were not always able to get to them all and there was nowhere to document if they had been cleaned or not.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation and interview conducted with the Maintenance Director on 09/11/24 at 10:43 AM of the 200 hall shower room revealed he did not check the shower room frequently for maintenance concerns or housekeeping concerns. The Maintenance Director revealed he knew the shower room needed repairs and multiple items needed to be replaced. He also revealed he did notice a foul odor from shower room [ROOM NUMBER] on the 200 hall shower room at times and believed the odor came from either stagnant water in the drain system or dirty water clogged the drains. There was a faint odor of the rancid smell detected on the observation on 09/09/24, in shower room [ROOM NUMBER]. The Maintenance Director revealed he had previously smelled an odor that was stronger than it was during our tour. The physical structural and cleanliness issues identified on 09/09/24 at 3:38 PM were also found during the observation with the Maintenance Director .</p> <p>On 09/11/24 at 1:40 PM a follow up interview with the Administrator was conducted and he revealed all shower rooms were expected to be clean, neat, and orderly, and wheelchairs were to be cleaned as per the schedule.</p> <p>37281</p> <p>3. room [ROOM NUMBER] bed A was observed on 9/8/24 at 3:53 PM. Resident #1 was in bed and her family members were at the bedside. Behind the bed, the wall had streaks of dried adhesive, and the drywall had gouges, and the paint appeared to be rubbed off in spots.</p> <p>Resident #1's family members were interviewed during the observation, and they reported the plastic wall protector had fallen off the wall a while ago and that they had placed the sheet of plastic beside the bed A closet. The sheet of wall protector was brittle and discolored yellow. The family members explained they had reported the plastic wall protector sheet had come off the wall to a staff member. The family members were unable to recall the name of the staff member. The family members said they had been told room [ROOM NUMBER] was scheduled to be repainted over a year ago.</p> <p>Nursing assistant (NA) #1 was interviewed on 9/10/24 at 9:25 AM and she reported if she noticed repairs needed completed, she filled out a work order and put in in the maintenance department mailbox. NA #1 explained she had not noticed the wall behind 309 bed A needed repaired.</p> <p>NA #2 was interviewed on 9/10/24 at 9:38 AM. NA #2 reported she filled out a work order for repairs, or she verbally notified the maintenance department.</p> <p>An interview was conducted with Nurse #1 on 9/10/24 at 10:01 AM. Nurse #1 reported she was usually assigned to the 300 hall, but she had not noticed the wall behind bed A in room [ROOM NUMBER]. The nurse explained if repairs need to be made, she filled out a work order and placed it in the maintenance department mailbox.</p> <p>An observation of room [ROOM NUMBER] with the maintenance director occurred on 9/11/24 at 10:46 AM. The maintenance director reported he was not aware of the condition of room [ROOM NUMBER] bed A's wall, and he reported his assistant was responsible for completing work orders on resident rooms.</p> <p>The maintenance assistant was interviewed on 9/11/24 at 11:02 AM during an observation of room [ROOM NUMBER]. The maintenance assistant reported he was not aware of the condition of the wall behind bed A, and he had not received a work order for repairs. The maintenance assistant explained he would have replaced the plastic wall protector sheet and repaired the walls behind bed A.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Work orders for the facility were reviewed and there were no work orders for room [ROOM NUMBER] bed A.</p> <p>The Administrator was interviewed on 9/11/24 at 2:07 PM and he reported he expected the resident rooms to be clean and in good repair with maintenance completing repairs as quickly as possible. The Administrator reported he expected nursing staff to use a work order form to report repairs to the maintenance department.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35758</p> <p>Based on staff interviews and record review the facility failed to complete a comprehensive significant change in status Minimum Data Set (MDS) assessment for 1 of 7 residents (Resident #11) reviewed for significant change in condition.</p> <p>The findings included:</p> <p>Resident #11 was readmitted to the facility on [DATE] with diagnoses that included urine retention and chronic kidney disease.</p> <p>A review of hospital discharge note dated 08/26/24 revealed in part Resident #11 had a urinary tract infection and a wound to her sacrum.</p> <p>Review of a readmission skin assessment dated [DATE] revealed in part that Resident #11 had a stage 3 pressure ulcer of the sacrum.</p> <p>A review of a nurse progress note dated 8/27/24 at 10:24 AM revealed in part that Resident #11 had a urinary catheter.</p> <p>A weight loss note dated 08/28/24 at 12:20 PM revealed that Resident #11 had a weight loss of 10% or greater in the last 180 days.</p> <p>A quarterly MDS assessment dated [DATE] included in part that Resident #11 had severe cognitive impairment, she was always incontinent of bladder and bowel, had no weight loss or weight gain and was at risk to develop pressure ulcers.</p> <p>The MDS Coordinator was interviewed on 09/11/24 10:46 AM she revealed she missed coding those areas and should have completed a significant change in status MDS assessment for Resident #11 upon her readmission.</p> <p>On 09/11/24 at 1:40 PM an interview with the Administrator revealed he expected significant change MDS assessments be completed in a timely manner.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160</p> <p>Based on observations, record review, and staff interviews, the facility failed to provide care according to professional standards when Unit Manager #1 failed to ensure Resident #50 swallowed her medications prior to leaving her room and was observed with a pill lying on her chest, and Resident #13 was observed to have a medicine cup with pills left unattended on her bedside table. The deficient practice occurred for 2 of 2 residents reviewed for professional standards (Resident #50 and Resident #13).</p> <p>The findings included:</p> <p>1. Resident #50 was admitted to the facility 4/23/24 with diagnoses that included cerebral infarction (stroke) and gastrostomy.</p> <p>A review of Resident #50's physician orders revealed an order dated 5/20/24 for Tramadol 50 milligrams (mg) one tablet by mouth every 8 hours. The physician orders further revealed Resident #50 was able to swallow medications whole and all her pills were ordered to be administered by mouth.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #50 had severe cognitive impairment.</p> <p>An observation conducted on 9/8/24 at 5:48 PM revealed Resident #50 was lying in bed talking but her speech was unclear and there was no one else in her room. Resident #50 was further observed to have a white oblong pill lying on the right side of her chest that was dry and intact.</p> <p>An interview conducted with Unit Manager #1 on 9/8/24 at 6:00 PM indicated Resident #50 was able to swallow her medications whole and they were ordered to be administered by mouth. Unit Manager #1 revealed she gave Resident #50 one tablet of Tramadol 50mg at 4:42 PM. She stated she placed the pill in Resident #50's mouth and watched her swallow 5 to 6 sips of water indicating to her she also swallowed the pill. Unit Manager #1 revealed she could not explain why the pill was found on Resident #50's chest but she must have spit it out after she left her room.</p> <p>An interview was conducted with the Director of Nursing (DON) on 9/9/24 at 9:41 AM. She stated Resident #50 was able to take her medications by mouth and she was not aware of any concerns related to her pocketing or spitting out pills. The DON further stated Unit Manager #1 should have confirmed Resident #50 swallowed her medication before leaving her room.</p> <p>2. Resident #13 was admitted to the facility 4/27/21 with diagnoses that included type 2 diabetes and chronic kidney disease.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #13 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #13's 9/9/24 active physician orders revealed orders for citalopram hydrobromide 20 milligrams (mg) one tablet by mouth once daily, potassium chloride extended release 20 milliequivalent two tablets by mouth once daily, amlodipine besylate 5mg one tablet by mouth once daily, bupropion hydrochloric acid (HCL) 75mg one tablet by mouth once daily, acetaminophen extra strength 500mg two tablets by mouth twice daily, metoclopramide HCL 5mg one tablet by mouth twice daily, torsemide 10mg one tablet by mouth twice daily and lorazepam 0.5mg one half tablet by mouth twice daily.</p> <p>An observation conducted on 9/9/24 at 9:48 AM revealed Resident #13 was in her bathroom with the door closed. Further observation of Resident #13's room revealed a medicine cup was left unattended on her bedside table which contained two large oblong white pills, one round dark orange pill, four round white pills, one round orange pill, one small oblong white pill, and half of a round white pill.</p> <p>An interview conducted with Nurse #3 on 9/9/24 at 10:06 AM revealed she went to Resident #13's room to administer her morning medications but Resident #13 had to use the bathroom. She indicated she placed Resident #13's medications on the bedside table and then left the room. Nurse #3 stated she should have waited for Resident #13 to return from the bathroom to administer the medications and they should not have been left unattended on the bedside table.</p> <p>An interview was conducted with the Director of Nursing (DON) on 9/9/24 at 9:41 AM. She stated nurses should ensure a resident takes their medications prior to leaving the room and medications should not be left unattended at the bedside.</p>		