STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345309	A. BUILDING _____ B. WING _____	C 01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY	101 CAROLINE AVENUE WELDON, NC 27890

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification and Compliant survey was conducted on 1/06/19 through 1/08/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # OSMV11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey on 1/08/2020. Event ID #OSVM11. Four of the four allegations were unsubstantiated.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete a Discharge Return Not Anticipated Minimum Data Set Assessment for 1 of 1 residents reviewed. (Resident # 1). The findings include: Resident #1 was originally admitted to the facility on 5/3/2019 with diagnoses including Chronic Obstructive Pulmonary Disease with acute lower respiratory infection, Hypertension, Muscle Weakness (generalized) and Osteoarthritis. According to the most recent Quarterly Minimum Data Set dated 8/19/19, Resident #1 was cognitively impaired, and required extensive assistance in most areas of activities of daily living. Resident #1 was discharged from the facility on 9/7/19.	F 641	This Plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State Law. 1. MDS Nurse completed a Discharge Return Not Anticipated for Resident #1 on 1/8/2020. MDS Nurse was given 1:1 re-education on timely scheduling and completion of discharge assessments by the Director of nursing on 1/9/2020. 2. Audit of all discharges for the last 3	1/30/20

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

Electronically Signed | 01/28/2020

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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F 641	Continued From page 1 During an interview on 1/8/20 at 11:33 AM, the MDS Nurse revealed she did not know why a discharge was not put in. She stated Resident #1 was discharged to the hospital. The MDS Nurse stated usually she checked the census daily to make sure there were no changes with admissions or discharges. During an interview on 1/8/20 at 3:05 PM, the Director of Nursing (DON) stated they need to put assessments in the system when noted in tracking. She stated generally they talked about discharges in medicare meeting. She revealed her expectation was that a MDS assessment should be completed upon a resident's discharge. During an interview on 1/8/20 at 4:54 PM, the Administrator stated a MDS assessment should be completed upon a resident's discharge.	F 641	months completed on 1/22/2020 by DON. No other concerns identified during audit. . 3. MDS Nurse was re-educated on timely scheduling and completion of discharge assessments by the MDS nurse consultant on 1/27/2020 4. The DON or designee will audit discharge residents medical record 1 time per week for 4 weeks and then monthly for 2 months for timely scheduling and completion of discharge assessments. The MDS Nurse will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director, Medical Director, and the Director of Social Services.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's	F 655		1/30/20

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F 655	Continued From page 2 admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and resident interviews the facility failed to provide a written summary of the baseline care plan to 1 of 1 residents reviewed. (Resident #2).	F 655	This Plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of	

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F 655	Continued From page 3 The findings include: Resident #2 was originally admitted to the facility on 9/26/19, with diagnoses including Hypertension, End Stage Renal Disease and Heart Failure. According to the most recent Admission Minimum Data Set Assessment dated 10/3/19, Resident #2's cognition was intact and she required limited assistance to supervision in most areas of activities of daily living except bathing, in which she was totally dependent. During an interview on 1/7/20 at 1:42 PM Resident #2 revealed no one had talked to her about her a care plan and she did not get a written copy of her care plan. During an interview on 1/8/20 at 2:12 PM, the MDS Nurse stated she discussed information that was in Resident #2's care plan with her. She revealed the care plan was set up 48 hours after Resident #2 was admitted to the facility. The MDS Nurse revealed Resident #2 was not given a copy of her care plan. During an interview on 1/8/20 at 3:00 PM, when Resident #2 was asked if she would like to know what was in her care plan, she said yes. She stated she had not received a copy of her care plan. During an interview on 1/8/20 at 3:27 PM, the Director of Nursing stated Resident #2 should be given of copy of her care plan. During an interview on 1/8/20 at 4:52 PM, the Administrator stated a baseline care plan was supposed to be done within 72 hours of admission to the facility. She revealed her	F 655	the truth of the fact alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State Law. 1. Copy of updated care plan provided to resident #2 on 1/22/2020. MDS Nurse and Social Worker were given 1:1 re-education on baseline care plan process by the Director of nursing on 1/9/2020. 2. Audit of all admissions from 1/9/2020 to current completed on 1/22/2020 by DON. Two meetings have been scheduled for 1/24/2020 with the IDT, resident &/or responsible party. Once the care plan reviewed, the resident &/or responsible party will be provided with a copy. 3. IDT was re-educated by the MDS Nurse Consultant on Initial/baseline care plan process on 1/27/2020. 4. The DON or designee will audit new admission baseline care plan process 1 time per week for 2 weeks and then monthly for 3 months for timely baseline care planning process. The MDS Nurse will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director, Medical Director, and the Director of Social Services.	

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F 655	Continued From page 4 expectation would be that a copy of the care plan should be given to the resident.	F 655		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to properly dispose of expired medication, failed to date opened medication, and correctly store medication for 2 of 2 medication carts (the skilled hall cart and rehab unit cart) that were used to store medications for residents of	F 761	This Plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the fact alleged or conclusions	1/30/20

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F 761	Continued From page 5 the facility. Findings included: An observation was conducted on 1/7/2020 at 2:47 PM of the medication cart labeled as the skilled hall cart with Nurse #1 present. In the bottom drawer of the skilled hall medication cart, a bottle of ReNu eye drops with an open date of 10/11/2019 was found. Nurse #1 removed the bottle to be discarded. An interview was conducted with Nurse # 1 on 1/7/2020 at 2:55 PM. Nurse #1 revealed that the eye medications were to be discarded 30 days after opening. An observation was conducted on 1/7/2020 at 2:58 PM of the medication cart labeled as rehab unit cart with Nurse # 2 present. The rehab unit cart revealed a single Sensipar (medication to reduce calcium) 800 milligram (Dosage of medication) tab in blister wrap in the top drawer, and an opened undated bottle of Travatan eye drops with a dispense date of 12/19/2019. Nurse #2 immediately removed the Sensipar tablet to be discarded and dated the Travatan eye drops with the dispense date. An interview was conducted with Nurse #2 on 1/7/2020 at 3:10 PM. Nurse # 2 stated that medications, such as sensipar, pulled from the pyxis (a locked medication station) were to be administered immediately. Nurse # 2 stated that all eye drops were to be labeled when opened. An interview with the Director of Nursing (DON) on 1/7/2020 at 3:33 PM revealed that all expired medications were to be discarded and all opened	F 761	set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State Law. 1. Expired medication and Sensipar were removed from medication cart immediately on 1/7/2020. Travatan eye drops were immediately dated for the dispense date of 12/19/2019. Nurse #1 and Nurse # 2 were given 1:1 re-education on Medication Storage by the Director of nursing on 1/7/2020. No resident was identified to be affected. 2. Audit of all medication carts and medication storage room completed on 1/7/2020 by DON & RN Supervisor. No other expired or undated medications found. 3. Nurses were re-educated by the DON on Medication Storage per policy, this was complete on 1/27/2020. The pharmacist consultant has been notified of the survey findings on 1/22/2020 and will perform monthly audits of the medication carts and medication room to assist the facility in discarding expired medications and monitoring dating of medications that are opened. 4. The DON or designee will audit medication carts 1 time per week for 2 weeks and then monthly for 3 months for expiration dates and dating after medications opened. The Pharmacist Consultant will submit a monthly report to the Director of Nursing. The Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be	

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F 761	Continued From page 6 eye drops were to have been labeled with an opened date. The DON stated eye drops should be discarded 30 days after they are opened. The DON stated that any medication pulled from the pyxis station should be administered promptly.	F 761	corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director, Medical Director, and the Director of Social Services.	