STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	01/09/2020

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LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

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E 000	Initial Comments An unannounced Recertification survey was conducted on 01/06/2020 through 01/09/2020. The facility was found in compliance with the required CFR 483.73, Emergency Preparedness. Event ID # ZHXN11.	E 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews, physician interview and record review the facility failed to follow physician's orders to hold a blood pressure medication for Resident #72 if her systolic blood pressure (SBP) reading was less than 120 for 1 of 27 residents whose medications were reviewed. Findings included: Resident #72 was admitted to the facility on 07/06/17 with diagnoses that included, in part: Paroxysmal atrial fibrillation, hypertensive chronic kidney disease stage 3, and Type 2 diabetes mellitus. The physician's orders for December 2019 and January 2020 revealed Resident #72 had a blood pressure medication order for Losartan Potassium 50 Milligrams (MG) by mouth once a day for hypertension. The order specified for the medication to be held if the resident's SBP was	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 How corrective action will be accomplished for residents affected by the deficient practice- A. The Director of Nursing Notified the MD and assessed the resident(s) identified (72). No adverse reactions were noted.	2/6/20

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

Electronically Signed | 01/24/2020

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F 658	Continued From page 1 below 120. The Medication Administration Record for Resident #72 revealed on 12/1/19, 12/7/19, 12/10/19, 12/14/19, 12/21/19, 12/27/19, 12/28/19, 12/29/19, 1/4/20 and 1/5/20 the recorded SBP was less than 120 and for each of these days the blood pressure medication, Losartan, was documented as administered to the resident. On 17 other days during the reviewed time period the blood pressure medication was documented as held appropriately for a recorded SBP of less than 120. An interview was conducted with Nurse #11 on 01/07/20 at 2:41 PM. She stated she had worked at the facility for 4 years and usually cared for Resident #72. She stated on 12/10/19 when the resident had a recorded SBP of 98 she had not given the medication. She commented she had documented incorrectly. She noted the computer automatically documented a medication was given unless the user tabbed back after entering the blood pressure reading. She thought she had stroked the wrong key that caused the medication to document as given in error and she had failed to notice the error. An interview was conducted on 01/07/20 at 2:30 PM with Nurse #4. She stated she had started working at the facility in November 2019 and was still on orientation on 12/21/19 when she documented she gave Resident #72 Losartan after recording her SBP as 118. She stated the computer system was new to her and could have caused her to document incorrectly or that she gave the medication by mistake. She could not remember if she gave the medication.	F 658	How the facility will identify other residents having the potential to be affected by the deficient practice- All residents have the potential to be affected by the alleged deficient practice- A. The Director of nursing completed audits (completed on 1/10/2020) on all residents with medication that had parameters as an order. No other residents were identified as being affected. Measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur: A. All current clinical staff will be educated on how to complete the administration/documentation of a medication with parameters being administered or not administered in Point Click Care. B. All new hired clinical staff will be educated in the facility orientation and be checked off upon completion of orientation on their proficiency of administration/ documentation of a medication with parameters being administered or not administered in Point Click Care. C. The Staff development Coordinator or designee will add the administration/documentation of a medication with parameters being administered or not administered in Point	

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F 658	Continued From page 2 An interview was conducted with Nurse #9 on 01/07/20 at 3:00 PM. She stated she had given the medication in error on 12/01/19 after being shown the resident's SBP was recorded as 100. She commented she had not noticed the instruction to hold the Losartan if the resident's SBP was less than 120. An interview was conducted on 01/08/20 at 10:30 AM with Nurse #12. She stated on 12/27/19 when she documented she administered the blood pressure medication to Resident #72 (who had a documented SBP of 112) she was in orientation. She commented if she documented on the MAR that the medication was given then she had given it. She did not recall noticing the medication had a blood pressure parameter restriction. An interview was conducted with Nurse #10 on 01/09/20 at 9:47 AM. She had documented on 12/07/19 and 12/14/19 that she administered Losartan to the resident who had a SBP less than 120 recorded on both days (118 and 118 respectively). She stated although she documented she administered the medication she had not because she would not have given the medication if the SBP was less than 120. She commented she had documented in error because she had been so busy but had not actually given the medication. In an interview conducted with Nurse #12 on 01/09/20 at 9:57 AM she stated she always checked the SBP for Resident #72 before she administered her blood pressure medication. She stated she was 100% positive she did not administer the blood pressure medication on 01/04/20 (SBP=119) or on 01/05/20 (SBP=117)	F 658	Click Care to the annual clinical skills fair and be checked off as proficient in this area. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained- A. The Director of Nursing or designee will audit all medication administration for medication with parameters weekly for 4 weeks and then monthly until the QA committee deems that the POC has been successful and will be sustained. B. The Director of Nursing will produce audits at the facility monthly QA meetings until the QA committee deems the POC implemented is sustained and the alleged deficient practice will not occur with ongoing monitoring from the Director of Nursing. Completion Date: 2/6/2020	

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F 658	Continued From page 3	F 658		

even though it was documented she had. She commented she paid closer attention to the resident's blood pressure and felt she had charted incorrectly by hitting the wrong key on the computer. She stated she would have also made a progress note documenting that she had held the medication. (Record review of the progress notes revealed no notes had been made by Nurse #12 on either 01/04/20 or 01/05/20.)

Attempts were made to contact Nurse #13 by phone on 01/08/20 at 10:38 AM and on 01/09/20 at 9:59 AM. Messages were left both times. She did not return the calls. She had documented on the MAR on 12/28/19 and 12/29/19 that she administered Losartan to Resident #72 who had a recorded SBP of 112 and 92 respectively.

An interview was conducted with the Director of Nursing on 01/07/20 at 3:25 PM. She reviewed the MAR for Resident #72. She stated the blood pressure medication, Losartan 50 MG, should not have been given if the SBP was less than 120.

An interview was conducted with the physician of Resident #72 on 01/09/20 at 11:55 AM. He stated common side effects of receiving a blood pressure medication when the SBP was less than 120 could have been dizziness, hypotension, light headedness and loss of balance. He commented he appreciated this situation being brought to his attention because the number of times the blood pressure had been too low to receive the medication was higher than normal. He reported he would review the resident's medications the next day to determine if the resident needed this medication due to the high number of times she was not eligible to receive it.

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F 725	Continued From page 4	F 725		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the facility failed to provide sufficient nursing staff to provide monthly weights (October/2019 and November/2019), and to dispense (7:00 PM to 7:00 AM) night medications timely for 1 of 4 sampled residents reviewed for nutrition and for 1 of 5 sampled residents	F 725	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this	2/6/20

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F 725	Continued From page 5 reviewed for unnecessary medications (Resident #35). Findings included: An unannounced annual survey was conducted on 01/06/20 through 01/09/19. The investigation included resident observations, interviews of alert and oriented residents, staff interviews, and record reviews. The named resident was in the facility at the time of the survey. Resident #35 was admitted to the facility on 08/04/19 with the following diagnoses: hypothyroidism, dementia, anxiety, major depression, diabetes (DM), heart failure (HF), and chronic pain. Resident #35 ' s Minimum Data Set (MDS) dated 12/03/19 revealed resident had moderate cognitive impairments. Resident needed extensive to total assistance with bed mobility, locomotion, dressing, toilet use, and personal hygiene. During the initial tour on 01/06/19 at 11:00 AM a comparison of the staff posted to the actual staff working was made. There were no inconsistencies in the posting. A nurse Interview on 01/08/20 at 10:00 AM with Nurse #1 stated she was assigned 300/600 hall and that medication pass was running late due to her being busy on the unit and residents having additional needs when she went into rooms and gave medications. An interview with three resident council representatives on 01/08/19 at 10:33 AM	F 725	plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F725 How corrective action will be accomplished for residents affected by the deficient practice- A. The administrator and the Director of Nursing reviewed the staffing pattern on 1/8/2020 in order to ensure that staffing protocol was sufficient to meet the needs and acuity of the current resident population. B. DON or designee will ensure the following staffing pattern for a facility census of 72-82 SNF residents will be followed daily starting immediately: 7a-7p 5 LPN 7a-3p 6-7 CNA 7p-7a 2LPN and 1 Medication Aide 11p-7a 3-4 CNA RN coverage for 8 continuous hour in a 24 hour period How the facility will identify other residents having the potential to be affected by the deficient practice- All residents have the potential to be affected by the alleged deficient practice- A. See the aforementioned and also; B. The Administrator and Director of Nursing will monitor staffing hours daily to ensure that the aforementioned is adhered to via the facilities Work Force Management and Primeview staffing	

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F 725	Continued From page 6 revealed one concern about short nursing aide (NA) staffing on 2nd and 3rd shifts, and that they stated the Administration was working on it. A nurse interview on 01/8/20 at 12:05 PM with Nurse #2 stated she was running late with medication pass today due to "some days are busier than others" and what ' s going on in the facility at that time, due to resident needs. She stated today had been busy, she ' s was running late with medication administration due to residents ' needed additional help, and she had to help an NA weigh a resident. An interview on 01/08/19 at 12:45 PM with the new Administrator revealed the facility ' s NAs night shift 11:00 PM to 7:00 AM was currently budgeted for 3 NAs. She stated at times the night shift had to work with 1 to 2 NAs, due to being short staffed or had call-outs, which was not acceptable. A review of the facility ' s assessment tool dated 11/19/19 revealed the typical night shift nursing assistant (NA) range to be 3-5. A review of the facility ' s NA staffing sheets from October 10, 2019 through January 06, 2020 revealed 20 nights where 1 to 2 NAs worked the floor at night with a facility census around 80 residents. An interview on 01/08/20 at 2:50 PM with the facility ' s staffing Scheduler, revealed the facility recently put in place, an effective system to fill-in NAs and nursing staff who called out when they were scheduled to work. She said when an employee needed to miss their shift (for any reason) they were required to call their nurse	F 725	tools- ensuring that adequate staff were present in the facility via time clock and payroll. Measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur: A. In the event of a call out or schedule need of a direct care staff member the DON or designee will ensure the following: 1. The DON and/or scheduler will seek to fill the need with internal staff first via phone calls/text messages/verbal communication with staff on floor. Next, the contracted staffing agencies will be called to assist with staffing needs. Finally, if the aforementioned is unsuccessful clinical administrative staff will be assigned to fill the need by Administrator. B. Daily staffing will be addressed at the morning meeting for each day of the week- daily. Needs will be identified immediately and the aforementioned in #1 will be started immediately. C. Week-end Coverage of staffing will be delegated to the on-call nurse and all on call nurses will be educated on #1 process. D. The acuity of residents and new admissions will be discussed daily in the daily clinical meeting in reference to adequate staffing for changes in acuity and/or admissions.	

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F 725	Continued From page 7 supervisor, Director of Nursing (DON), or Assistant Director of Nursing (ADON) and they would in turn call one of the on-call nurses or one of the three agency staffing agencies directly to let them know that a nurse or NA was needed. The nurse said their current revised staffing process had worked well to ensure there was always enough staff to meet residents ' needs, and that the facility was working hard to hire more NAs, and to offer free training classes. Facility "Scheduler" further explained she was aware of the facility ' s current staffing situation and per previous administration she thought 2 NAs at night for 80 plus residents ' were sufficient. But, recently after speaking with the new Administrator and DON, and after a review of the facility ' s budget and Facility Assessment, 3 to 4 NAs would be needed for the night shift, according to their census and acuity levels. The Scheduler stated the facility had initiated several new programs such as offering bonuses, utilizing 3 staffing agencies, differential pay, and hiring more nurses and aides to meet their NA staffing needs. An interview on 01/09/19 at 8:35 AM with an alert and oriented Resident #35 revealed she did not get her evening medications last night until after midnight, and that she could not go to sleep until her night medications were given. She said her night medications were given late, due to there not being enough NAs on the halls at night, and with the nurse being busy helping the NA with their tasks. On 01/09/20 at 1:33 PM during an interview with the Director of Nursing (DON) she explained that since her and the Administrator ' s recent hire, they have both been aware of the facility ' s insufficient NA staffing, and that her focus had	F 725	E. The facility assessment will be updated by the administrator to reflect the aforementioned staffing pattern. D. For the concern of late medications: 1. Direct Care clinical staff will be educated that in the event they are falling behind on their med pass they are to immediately consult other staff within the facility for assistance and immediately notify administrative clinical leadership for guidance and/or assistance. 2. DON or Designee will audit late medication administration weekly for 4 weeks and then monthly until the QA committee deems that the POC has been successful and will be sustained. 3. The facility Social Worker will complete surveys to alert and oriented residents in regards to staffing and late medications weekly x4 weeks and then monthly until the QA committee deems that that POC has been successful and will be sustained. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained- A. The Director of Nursing or designee will audit late medication administration weekly for 4 weeks and then monthly until the QA committee deems that the POC has been successful and will be sustained. B. The facility Social Worker will complete surveys to alert and oriented residents in regards to staffing and late	

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F 725	Continued From page 8 been on getting agency staff and new hires in the facility. The DON stated that she was aware that about ½ of the facility ' s nursing staff and residents ' came to them from 2 of their other facility ' s that were closed due to the last hurricane, resulting in their census going from 40 to 80, which made it difficult. The DON stated once one of the closed facilities was re-opened in April 2020, the 40 re-located residents ' will be transferred to that facility, bringing their census back down to 40, and that at that time they were planning to close down the restorative wing, and focus their nursing staff on the remaining 40 residents. The DON stated they currently do not have a restorative aide, that she was pulled to the floor, where the need was greatest. And in the process, they forgot to assign someone else to do October/2019 and November/2019 monthly weights, until recently. DON said the October/2019 and November/2019 monthly weights for Resident #35 should have been done, and were not, due to reassigning the restorative NA to the floor, where the need was greatest. An interview with the Assistant Director of Nursing (ADON) on 01/09/20 at 1:35 PM revealed the 1 facility ' s restorative aide (RA) was re-assigned from doing resident ' s restorative care and monthly weights to the floor as a nursing aide (NA), due to the facility not having enough NA staff. DON said for 2 months, prior to administration change, Resident #35 ' s October/2019 and November/2019 monthly weights were not done, and should have. DON stated the facility currently had no restorative aides, and were trying to get NA staffing up to the level where they could again have a restorative aide. ADON stated on 12/31/19 the facility brought in a weight team, to do all residents '	F 725	medications weekly x4 weeks and then monthly until the QA committee deems that that POC has been successful and will be sustained. C. Staffing will be added to the daily stand up tool and addressed at this meeting. D. The Director of Nursing and Administrator will produce audits at the facility monthly QA meetings until the QA committee deems the POC implemented is sustained and the alleged deficient practice will not occur with ongoing monitoring from the Director of Nursing and Administrator. Completion Date: 2/6/2020	

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F 725	Continued From page 9	F 725		

weights in the building, and were re-checking and tracking all resident weights with a facility weight spreadsheet. She said they were in the process of finishing all residents ' ordered daily, weekly, and monthly weights, and were actively reviewing and discussing significant trending weight fluctuations during their daily administrative stand-up meeting, as well as reviewing the trending weights during their monthly quality assurance (QA) meetings.

An interview with Nurse #3 on 01/09/20 at 3:20 PM revealed there were days when she was pulled to work the 7:00 PM to 7:00 AM shift with just herself and another aide, for 80 plus residents. She explained that made it difficult to complete residents medication pass timely, because either the Medication Tech (on the other side of the building) or the 1 nursing aide (NA) often needed assistance with their own tasks. Nurse stated if she did not help with the NA ' s assignments, they would not be completed, which resulted in her 9:00 PM medication pass being given to Resident #35 not until around 10:55 PM.

Facility ' s new hires in the last 30 days, prior to the 01/06/20 survey listed: 4 Nursing Aides (NA), 1 personal care assistant (PCA), 2 Nurses, and 1 Cook.

Resident #35 ' s weights: 09/05/19 - 175.2 lbs., 12/31/19 - 168 lbs., and 01/09/20 - 170 lbs.

Daily facility nursing staffing shifts 7-3 PM, 3-11 PM, 11-7 AM consisted of: 01/05/19 - census 80, 11 PM -7 AM 1 NA, 7 PM -7AM 2 Nurses.

A review of the resident council meeting minutes for June/2019 and December/2020 revealed an

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F 725	Continued From page 10 issue with the lack of staffing noted. Resident Council Communication Forms listed: Residents felt like there was a shortage of NAs at night. Residents ' heard staff say there was 1 NA for every 40 residents.	F 725		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain a sanitary ice machine free from brown debris on the interior of the machine. During initial tour at 11:00 on 01/06/20 an inspection of the interior of the ice machine revealed brown debris was present on the metal. The Dietary Manager put on a glove and easily	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of	2/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 11 removed the debris with her finger. She commented she had only been at the facility for three months and had not noticed there was not a cleaning schedule in place for the ice machine. A second observation of the ice machine on 01/08/20 at 8:30 AM revealed a small amount of new ice in the bottom of the machine. The interior had been cleansed and no brown debris present. In an interview conducted with the Dietary Manager on 01/08/20 at 8:30 AM she stated the ice machine had been emptied and sanitized. She produced a weekly cleaning schedule she had developed after the inspection on 01/06/20 to ensure the ice machine was cleaned weekly. In an interview with the Maintenance Director on 01/08/20 at 9:00 AM he stated he had helped clean out the ice machine on 01/06/20. He remarked he had ordered a new ice machine to replace the one they were currently using.	F 812	compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 How corrective action will be accomplished for residents affected by the deficient practice- A. The ice machine was cleaned immediately by the dietary manager when the brown debris was brought to her attention on 1/6/2020. B. A weekly cleaning schedule was implemented for the ice machine to prevent this from occurring again on 1/6/2020. How the facility will identify other residents having the potential to be affected by the deficient practice- All residents have the potential to be affected by the alleged deficient practice-to prevent this from occurring the following was implemented on 1/6/2020 A. The ice machine was cleaned immediately by the dietary manager when the brown debris was brought to her attention on 1/6/2020. B. A weekly cleaning schedule was implemented for the ice machine to prevent this from occurring again on 1/6/2020. Measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur: A. All Dietary staff will receive education on Food Service Sanitation Practices including proper cleaning of the ice	

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F 812	Continued From page 12	F 812	machine, completion of scheduled cleaning assignments and monitoring of completed assignments by the dietary manager or designee. New Hires will receive this upon orientation from the Dietary Manager. Cleaning schedules are posted and staff are assigned to clean identified areas. Completed cleaning schedules will be kept on file in the Dietary Department for a period no less than one (1) year and will be stored at the facility for a period of five (5) years. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained- A. The Administrator or Designee will audit weekly cleaning of the ice machine/Overall Kitchen weekly x 4 weeks and monthly thereafter on administrator rounds to ensure the change is sustained. B. The Dietary Manager and Administrator will produce cleaning completion sheets and audits at the facility monthly QA meetings until the QA committee deems the POC implemented is sustained and the alleged deficient practice will not occur with ongoing monitoring from the Dietary Manager and Administrator. Completion Date: 2/6/2020	