STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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/complaint investigation survey was conducted. The survey team was onsite 04/19/21 through 04/22/21.. Additional information was obtained on 04/23//21 through 05/03/21. Therefore, the exit date was 05/03/21. The facility was found in compliance with the required CFR 483.73, Emergency Preparedness. Event ID #BGYS11	E 000		
F 000	INITIAL COMMENTS An unannounced recertification/complaint investigation survey was conducted. The survey team was onsite 04/19/21 through 04/22/21.. Additional information was obtained on 04/23//21 through 05/03/21. Therefore, the exit date was 05/03/21. Event ID #BGYS11. 2 of 16 complaint allegations were substantiated with deficiency, and 1 of 16 complaint allegations was substantiated without defeiciency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 553		5/28/21

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

Electronically Signed | 05/26/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 553	Continued From page 1 (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review the facility failed to obtain resident input and preferences about diet and possible nutritional supplementation for 1 of 1 sampled residents (Resident #34) with intact cognition and weight fluctuations. Findings included: Record review revealed Resident #34 was admitted to the facility on 03/05/19. The resident's documented diagnoses included skin ulcers, diabetes with neuropathy, congestive heart failure (CHF), and chronic kidney disease (CKD)-stage 4. Review of the resident's physician orders revealed she received med pass 2.0 liquid nutrition supplement in the past (12/08/20 - 12/17/20 and 01/02/21 - 02/05/21) and a diabetic	F 553	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 date or dates indicated. F 553 Corrective Action for Affected Residents: For resident # 34, the Assistant Dietary Manager (ADM) completed a Dietary Preference Form with Resident on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 553	Continued From page 2	F 553		

bedtime snack in the past (12/23/20 - 04/06/21).

Resident #34's weight record documented she weighed 221.4 pounds on 11/02/20, 223.2 pounds on 11/06/20, and 223 pounds on 12/04/20.

In his 12/16/20 Dietitian Nutritional Assessment the Registered Dietitian (RD) documented, "Nutritional needs met with (meal intake) ....Consistent (meal) intake of 50% or more of meals, gradual weight loss/maintenance." The RD calculated the resident's nutritional needs based on her goal weight of 145 pounds.

Resident #34's weight record documented she weighed 228 pounds on 12/17/20 and 212 pounds on 12/23/20.

On 12/28/20 "I have a nutritional problem r/t (in regard to) heel wounds, variable (meal) intake and (diagnosis) CHF (on a high dose of diuretics), weight changes r/t diuresing. Obesity per BMI (body mass index), receiving therapeutic diet, snacks in room and outside foods that family brings in" was identified as a problem in the resident's care plan. Interventions for this problem included, "RD (Registered Dietitian) to evaluate and make diet change recommendations PRN (as needed)."

Resident #34's weight record documented she weighed 215.8 pounds on 12/31/20, 200.4 pounds on 01/07/21, 204.4 pounds on 01/14/21, and 210 pounds on 02/06/21.

The resident's 02/12/21 quarterly minimum data set (MDS) documented her cognition was intact, she was independent with eating, and she had

5/24/21.

Corrective Action for Potentially Affected Residents:
All residents have the potential to be affected by this alleged deficient practice. On 05/24/21, the Certified Dietary Manager (CDM) & ADM audited all care plans and completed Dietary Preference forms. This was completed on 05/25/21.

Systemic Changes:
On 05/20/21 the Administrator began in-servicing the current CDM. This in-service included the following topics: Completing a Dietary Preference Form on all residents upon admission and as needed. The Registered Dietician was also educated on meeting with the resident to discuss preferences with the resident and obtain feedback to honor choice and preference for their diet and nutritional preferences.

Quality Assurance:
The Administrator or designee_ will monitor this issue using the Survey Quality Assurance Tool for Monitoring Diet Preference Forms and Care Plans. The monitoring will include reviewing accurate likes and dislikes. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 553	Continued From page 3	F 553		

experienced both significant unplanned weight loss and gain.

Resident #34's weight record documented she weighed 211 pounds on 02/14/21.

The RD's 03/02/21 dietitian note documented, "CBW (current body weight) 211 pounds, BMI 36.2 (obese status) as of 02/14/2021. Weight loss is optimal. Recorded weights show a weight loss of 22.6 pounds (9.7%) in 6 months 7 days. Receives (40 milligram) Furosemide (Lasix diuretic) tab BID (twice daily). Some weight fluctuations are expected. Diet order of LCS (low concentrated sweets), Liberalized Renal...Recorded meal intakes are 0-100%, on average eating 50%. Nutritional needs met. No nutrition recommendation at this time..."

Resident #34's weight record documented she weighed 204.6 pounds on 03/08/21.

The RD's 04/06/21 dietitian note documented, "...Recorded meal intakes are 0-100%, on average eating 50%. Nutritional needs met. No nutrition recommendation at this time..."

During an observation of Resident #34 on 04/22/21 she had eaten two chicken wings off her lunch tray, but stated she did not want the pasta salad or zucchini. Her tray slip documented she was to receive large portions. The resident reported she did not like a lot of the foods that the facility served, but commented she had not gone hungry. According to Resident #34, she had not talked with the RD, but back at the beginning of the year a direct care staff member (she could not remember who) inquired if she might like to receive a diabetic supplement with meals, and

Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 553	Continued From page 4	F 553		

even though she stated she was interested, had not received any of the product yet. Resident #34 stated she did not think the kitchen would provide her with the supplement if she asked them about it. She commented she would like to try a strawberry drink in the mornings because breakfast was her most difficult meal. She explained she slept late, and food did not seem that appealing to her when she got up. She remarked that she thought it would be easier to drink something for breakfast rather than trying to eat food.

During a telephone interview with the facility's RD on 04/23/21 at 10:03 AM he stated he had not interviewed Resident #34 even though he had assessed her multiple times. He reported the resident was experiencing beneficial weight loss with a BMI greater than 30. He stated per staff the resident was not very active, was on a high dose of a diuretic, and had CKD. He commented he did not want to put resident the resident in fluid overload or make her wounds worse by using nutritional supplements unwisely.

During a telephone interview with Nursing Assistant (NA) #4 on 04/23/21 at 2:24 PM she reported Resident #34 was not an early morning person. She reported the resident did not always get up before lunch, and if she did, the resident frequently ate a little cold cereal and drank a little juice. She commented the resident was a picky eater, and left what she did not like on her plate. According to NA #4, Resident #34 was alert and oriented and reliable.

During a telephone interview with Physician #1 on 04/26/21 at 3:36 PM she stated even though Resident #34 was on a high dose of diuretic and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 553	Continued From page 5 had CKD it did not mean the resident had to forego nutritional supplements. She reported if the RD was unsure about implementing supplementation he could reach out to the physician group to have labs drawn and the resident assessed. She commented it would be beneficial to talk to Resident #34 to see if she had ideas about what was causing her weight loss. According to Physician #1, she did not think the physician team was alerted to Resident #34's weight fluctuations and loss because she saw no physician notes that addressed it. During a telephone interview with the facility's Certified Dietary Manager (CDM) on 04/27/21 at 12:23 PM she stated Resident #34 was placed on large portions in 2019 per resident request. She commented the resident was experiencing gradual weight loss. She commented Resident #34 wanted to continue to receive large portions although she frequently left food items on her meal tray. Therefore, she commented she was not sure large portions were doing the resident a lot of good. She remarked the resident was more of a snacker, and the family helped provide the resident with snacks. During a telephone interview with the Director of Nursing on 04/27/21 at 3:12 PM she stated assessments involving Resident #34 should include interviews with the resident so that she could participate in her care and share her viewpoints. She reported the resident's cognition was very good, and the resident communicated well.	F 553		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g)	F 641		5/25/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 641	Continued From page 6 §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 review and staff interviews, the facility failed to accurately code the quarterly Minimum Data Set (MDS) assessments for 3 of 26 residents reviewed for palliative care (Resident #28, Resident #2, and Resident #268) who were on palliative care without a terminal illness diagnosis or life expectancy of six months or less and coded as hospice residents; failed to accurately code on a quarterly MDS assessment a fall that had occurred for 1 of 26 residents reviewed for falls (Resident #28); failed to accurately code 1 of 26 residents reviewed for wander guards (Resident #24); and failed to accurately code 1 of 26 residents whose medications were reviewed (Resident #60) to include insulin and anticoagulants (blood thinner) that were administered. Findings included: 1a. Resident # 28 was admitted to the facility on 10/29/19 with a readmission date of 01/25/21. Diagnoses included stroke with left sided weakness, aphasia, dysphasia, and gastrostomy. A review of the physician ' s order written on 01/26/21 revealed the resident had a consult for palliative care. The MDS quarterly assessment dated 02/08/21 revealed the resident was cognitively impaired. The resident was not coded as having a life expectancy of less than 6 months or terminal illness and was coded as being on hospice care	F 641	F641 Corrective Action for Affected Residents: For resident #28 a corrective action was obtained on 04/22/21 by modifying and correcting MDS assessment for assessment reference date of 02/6/21. Section O100K (hospice) coding was corrected to accurately reflect that resident was not receiving hospice care at time of assessment. Correction was completed by facility MDS nurse on 04/22/21. Also for resident #28 a corrective action was taken to modify and correct the MDS assessment with assessment reference date of 04/17/20. The assessment was modified so that section J1800 (Falls) could be accurately coded to reflect resident□s recent fall history. This correction was completed by the MDS Consultant on 05/25/21. For resident #2 a corrective action was obtained on 05/06/21 by the MDS Consultant by modifying and correction the MDS assessment with assessment reference date of 02/29/21. The assessment was modified and coding for Section O100K (Hospice) corrected in order to accurately reflect that resident was not receiving hospice care at the time	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 641	Continued From page 7	F 641		

while at the facility.

An interview was conducted with the facility MDS Nurse on 04/22/21 at 4:40 PM. The facility MDS nurse stated when a resident was on palliative care, no terminal diagnosis was needed, but for a resident under hospice care a resident would have to have a terminal illness to be coded as hospice. The facility MDS nurse stated she was told by the Corporate MDS Nurse to code hospice even when a resident was receiving palliative care with no terminal diagnosis.

In an interview conducted on 04/22/21 at 4:34 PM with the MDS Corporate Consultant stated for residents receiving palliative care from an outside agency, hospice was coded if a resident also had a terminal diagnosis. She confirmed if a resident received palliative care from an outside provider but did not have a terminal illness then hospice was not coded. She stated she assumed any resident receiving palliative care and coded for hospice services also had a terminal diagnosis.

An interview was conducted with the Director of Nursing (DON) on 04/22/21 at 4:00 PM. The DON reported she expected the information on the MDS assessments to be accurate. She commented that palliative care was different from hospice care; that palliative care was a bridge to hospice care and did not need a terminal diagnosis like hospice care did.

1b. Resident #28 was admitted to the facility on 10/29/19 with a readmission date of 01/25/21. Diagnoses included stroke with left sided weakness, aphasia, dysphasia, and gastrostomy and contractures to bilateral upper and lower extremities.

of assessment.

For resident #268 a corrective action was obtained on 05/25/21. MDS assessment with assessment reference date of 06/16/20 was modified and coding for J1400 (Prognosis) was corrected in order to accurately reflect resident□s condition at the time of the assessment. This correction was completed by the MDS Consultant.

For resident #24 a corrective action was obtained on 04/22/21 by the facility MDS nurse by modifying and correcting the coding for P0200E (Alarms) on the MDS assessment with assessment reference date of 01/14/21.

For resident #60 a corrective action was obtained on 05/25/21 by the MDS Consultant. The MDS assessment with reference date of 02/25/21 was modified and coding for N0350 (Insulin) and N0410E (Anticoagulants) were corrected.

Corrective action for residents with the potential to be affected by the alleged deficient practice:

All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all current residents was conducted on the following areas by the Minimum Data Set Consultant. Audits were completed on 05/24/21 and 05/25/21.
" All Minimum Data Set assessments completed over the past 30 days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 641	Continued From page 8 Record review of a fall incident report revealed Resident #28 sustained a fall on 02/08/20 with no injury noted. The MDS quarterly assessment dated 04/17/20 revealed Resident #28 was cognitively impaired. No falls were indicated on the MDS assessment. An interview was conducted with the facility MDS Nurse via phone on 04/23/21 at 10:05 AM. The MDS Nurse stated she obtained her information to update an MDS assessment with regard to falls by reviewing the medical records to include any new physician orders, progress notes, and incident reports as well as discussion in the weekly meetings on Thursdays when falls were discussed. An interview was conducted with the DON via phone on 04/27/21. The DON reported the MDS nurses had several ways to ascertain information regarding a resident ' s fall and she expected the MDS nurses to use all their resources to ensure they were updating the MDS assessments to reflect the residents ' current care. 2. Resident #2 was admitted to the facility on 07/27/20 with diagnoses that included, in part: end stage renal disease, anemia in chronic kidney disease, cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery (stroke), and type 2 diabetes mellitus. Review of the admission MDS assessment for Resident #2 dated 02/29/21 revealed the resident had moderately impaired cognition. Resident #2 was not coded as having a life expectancy of less	F 641	(04/23/21-05/24/21) for current residents were audited in order to validate accurate coding of N0350 (Insulin). o Results of audits were: 2 of 6 residents were identified with inaccurate coding of insulin in N0350. Both MDS assessments were modified and corrected on 05/24/21 by the Minimum Data Set Consultant. " All current residents who currently receive anticoagulants were audited in order to validate accurate coding of anticoagulants in N410E. o Audit results: 4 of 9 residents identified with inaccurate coding of N410E. All four of the inaccurate assessments were modified and corrected on 05/24/21 and 05/25/21 by the Minimum Data Set Consultant. " All MDS assessments completed during the past 60 days (03/24/21-05/24/21) were audited in order to validate if Falls in Section J1800 was accurately coded. o Audit results: 16 of 16 residents were identified to have accurate coding of falls in J1800. " All current residents who have an order for a wander guard bracelet had an audit of their most recently completed and accepted MDS assessment completed to determine if Section P (Alarms) was accurately coded. o Audit results: 11 of 11 residents were identified as having accurate coding of P0200E (alarms). " All current residents who are currently receiving hospice services had an audit of their most recently completed and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 641	Continued From page 9	F 641		

than 6 months or terminal illness and was coded as being on hospice care while at the facility.

Review of the medical record for Resident #2 revealed she received palliative care from a community agency.

Review of an email provided by the facility MDS Nurse on 04/22/21 documented Nurse #13, (a part time MDS nurse at the facility), had emailed the MDS Corporate Consultant on 02/01/21 and asked, "Is palliative coded in hospice care section of the MDS?" The MDS Corporate Consultant replied on 02/02/21: "Yes, I would code it under hospice." The email did not address if a resident also had a diagnosis of a terminal illness.

In an interview conducted on 04/22/21 at 4:00 PM with the DON she stated she expected the information in an MDS assessment to be accurate. She commented that palliative care was different from hospice care; that palliative care was a bridge to hospice care and did not need a terminal diagnosis like hospice care did.

In an interview conducted on 04/22/21 at 4:34 PM with the MDS Corporate Consultant stated for residents receiving palliative care from an outside agency, hospice was coded if a resident also had a terminal diagnosis. She confirmed if a resident received palliative care from an outside provider but did not have a terminal illness then hospice was not coded. She stated she assumed any resident receiving palliative care and coded for hospice services also had a terminal diagnosis. Resident to receive palliative care no terminal diagnosis was required but for a resident to receive hospice services, a terminal diagnosis was needed. She commented she had been told

accepted MDS assessment completed in order to validate whether J1400-Prognosis was coded correctly.
o Audit results: 6 of 6 residents audited were identified as having accurate coding of Prognosis in J1400.
" All current residents who are currently receiving palliative services had an audit of their most recently completed MDS assessment in order to validate that Section O (Hospice) was appropriately coded.
o Audit results: 8 of 12 residents were identified as having inaccurate coding of O100K (Hospice).

Systemic Changes

On 05/24/21, the Regional Minimum Data Set Education and Compliance Consultant completed an in-service training for the facility Minimum Data Set Coordinator that included the importance of thoroughly reviewing the medical record during the assessment process and before coding the MDS assessment. Special emphasis was highlighted on the following areas:
" Section J1400 □ Prognosis of six months or less life expectancy for hospice residents
" Section J1800- Falls
" Section N □ Medications (Insulin and Anticoagulants)
" Section O □ Hospice
" Section P □ Alarms (Wander guard alarms)

This information has been integrated into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 641	Continued From page 10 by the MDS Corporate Consultant to code Hospice as "yes" when a resident received palliative care and did not have a terminal diagnosis. 3. Resident #24 was admitted to the facility on 02/26/15 with diagnoses that included, in part: cerebral infarction (stroke), intracranial injury, epilepsy, anxiety and major depression. Review of the care plan for Resident #24 dated 04/04/21 included the following focus area: I am at risk for elopement related to going to the doors with a keypad and trying to put in the codes to open the door. The goal was elopement would be minimized through current interventions over the next 90 days. Interventions included to check placement of the wander guard every shift and to check the wander guard transmitter for proper functioning frequently and replace as needed.In an interview conducted on 04/22/21 at 4:40 PM with the facility MDS Nurse she stated she knew for a Review of a quarterly MDS assessment dated 01/14/21 for Resident #24 revealed she had physical behavioral symptoms directed towards others, required extensive assistance with all activities of daily living (ADL ' s) except eating. She had an impairment on one side of both upper and lower extremities. She used a wheelchair for mobility. The wander/elopement alarm was coded as not used. Review of the Treatment Administration Record for January 2021 documented Resident #24 had a wander guard on every day, every shift. In an interview conducted with the DON on	F 641	the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nursing or designee will begin auditing the coding of MDS items: J1400 (Prognosis); J1800 (Falls); O100K (Hospice); N350 (Insulin) and N410E (Anticoagulants) and Section P0200E (Wanderguard Alarms) using the quality assurance audit tools entitled Accurate Minimum Data Set Coding Audit Tool □ J1400 (prognosis), J1800 (falls); O0100K (hospice); N350 (insulin); N410E (anticoagulants) and P0200E (Wanderguard alarm). This audit will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 641	Continued From page 11 04/22/21 at 4:00 PM she stated she expected the MDS assessments to be accurate. In an interview with the facility MDS Nurse on 04/22/21 at 4:40 PM she stated she had never known Resident #24 to be without a wander guard in place. She commented the MDS assessment in January 2021 had been coded incorrectly. 4. Resident #268 was admitted to the facility on 11/15/17 and date of death in facility was 08/17/20. Her diagnoses included in part, end stage vascular dementia with behaviors, diabetes, and chronic pain. A physician order dated 12/02/19 for Resident #268 revealed an order for Hospice services. The MDS significant change assessment dated 06/16/20 revealed Resident #268 had severely impaired cognition and required extensive assistance with activities of daily living. She was not noted as having a life expectancy of less than 6 months but was noted as receiving Hospice care. A physician note dated 08/18/20 revealed Resident #268 was placed on Hospice care in December 2019 and continued Hospice services due to end stage vascular dementia. An interview was conducted with the MDS nurse on 04/22/21 at 4:40 PM. She stated with palliative care no terminal diagnosis was needed but for Hospice care a resident did have to have a terminal illness. She indicated life expectancy of less than 6 months should have been coded as yes.	F 641	Administrator and /or Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 641	Continued From page 12	F 641		

An interview was conducted on 04/22/21 at 4:00 PM with the Director of Nursing. She stated she expected the information in an MDS assessment to be accurate.
5. Resident #60 was admitted to the facility on 02/18/21 and had diagnoses of uterine cancer, anxiety disorder and chronic pain.

The admission MDS dated 02/25/21 specified Resident #60 received zero anticoagulant medications during the seven day look back period. The admission MDS also specified that Resident #60 received seven days of injections and seven days of insulin during the seven day look back period.

Resident #60's Medication Administration Record (MAR) dated 02/18/21-02/25/21, which reflected the seven day look back period, revealed that Apixaban (an anticoagulant) was administered all seven days for anticoagulation. The MAR also revealed that Humalog (an insulin) was ordered on 02/23/21 to be given as needed on a sliding scale for steroid induced hyperglycemia. The MAR revealed that for the three days of the look back period covering the order, the Humalog was coded as "No insulin required per order" signifying that no insulin had been administered. The MAR also revealed no other medications were ordered to be injected.

In an interview on 04/22/21 at 4:05 PM the Director of Nursing (DON) stated that she expected each section of the MDS to be accurate. She indicated that if the nurse was unsure about a medication it should be researched, and the classification verified. The DON stated that the MDS nurse should review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 641	Continued From page 13 the MAR and read the instructions and codes so the correct information could be transcribed to the MDS. In an interview on 04/23/21 at 2:11 PM the MDS Nurse verified that she had completed Resident #60's MDS. She stated that she reviewed the MAR and counted the days a resident was administered the medications that needed to be documented. She stated that she had recorded Resident #60's insulin injections in error as she confirmed that no insulin had been administered. The MDS Nurse stated that she did not record the Apixaban as it was not on her list as a medication that needed to be documented. She indicated that she did not know where the list had originated from.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		5/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 657	Continued From page 14 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to revise a plan of care to include an intervention for a contour mattress that was put in place to prevent falls for 1 of 5 residents (Resident #28) reviewed for accidents. Findings included: Resident #28 was admitted to the facility on 10/29/19 with a readmission date of 01/25/21. Diagnoses included stroke with left sided weakness and contractures to bilateral upper and lower extremities. Record review of a fall incident report revealed Resident #28 sustained a fall on 02/08/20 with no injury noted. The incident report revealed the fall was reviewed by the interdisciplinary team (IDT) on 02/10/20 and the resident reported she was too close to the end of the bed and rolled off. The report indicated the IDT implemented a contour mattress to be added to the bed to help the resident with proper positioning in the bed. A review of the at risk for falls care plan for Resident #28 updated on 04/17/20 did not include the intervention for a contour mattress to be in	F 657	F657 Corrective action for affected resident(s); A corrective action was taken for Resident # 28 on 5/6/21 by the MDS Nurse, by updating the resident□s care plan to include all current interventions for falls prevention. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all current residents who have had a fall during the past 30 days (4/4/21 - 5/6/21) was conducted on 5/6/21 by the facility MDS Coordinator to validate that the care plan reflects the current interventions for falls prevention. The results of this audit were: 41 Residents audited 6 of the 41 residents□ care plans did not reflect current falls interventions. 35 of the 41 residents□ care plans did accurately reflect their current falls	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 657	Continued From page 15	F 657		

place related to an actual fall on 02/09/20.

A review of the most current at risk for falls care plan for Resident #28 updated on 02/02/21 did not include the intervention for a contour mattress to be in place as a fall prevention.

An observation of Resident #28 on 04/19/21 at 12:25 PM revealed an alert resident lying in a bed noted to have a contour mattress in place.

An interview with Nurse #4 (Unit Manager) on 04/19/21 at 1:18 PM revealed Resident #28 had a contour mattress due to a fall she had when she rolled out of bed.

An interview was conducted with the MDS nurse on 04/22/21 at 5:10 PM. The MDS Nurse stated she would update the care plan with any new interventions as soon as the intervention was determined. The MDS nurse stated she would not wait until the quarterly assessments to update a plan of care to include interventions to prevent falls.

A follow up interview was conducted with the MDS Nurse via phone on 04/26/21 at 1:45 PM. The MDS Nurse revealed the IDT team has a weekly meeting on Thursdays to discuss weights, wounds, and any falls that had occurred and any new interventions that were put in place to prevent falls. She stated after that meeting, she would update the care plan. The MDS Nurse stated she would review the care plans quarterly to ensure what was in the care plan was appropriate. The MDS Nurse stated the Unit Manager should have informed her of the contour mattress because she did not go into the residents ' rooms because the MDS

interventions.

All care plans identified as not reflecting the current falls interventions were updated by the facility MDS Coordinator. This was completed on 5/6/21.

On 05/24/21, the MDS Nurse Consultant in-serviced the MDS Nurse on the importance of maintaining up to date care plans that are reflective of the resident□s current condition and needs, including current falls interventions, and that the care plan should be updated as the resident□s needs change. Emphasis was placed on the importance of ensuring that resident care plans are updated and revised each time that a resident falls to include any new falls prevention measures initiated.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;

The Director of Nursing or designee will review up to 5 (current) residents who have sustained a fall during the past 90 days in order to validate whether or not the care plan accurately reflects the current falls prevention interventions. This will be done on a weekly basis for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 657	Continued From page 16 assessments and care plans were done remotely. The MDS Nurse stated she did not know why the care plans did not reflect Resident #28 had a contour mattress and added it may have been because there was no physician order, so she did not capture it on the record review. An interview was conducted with the Director of Nursing (DON) on 04/27/21 at 12:20 PM. The DON stated the contour mattress was a nursing measure and would not have necessarily been a physician order, and it would have been discussed in the weekly falls meeting. The DON reported she expected the care plans to be updated as soon as a new intervention was determined and put in place to prevent falls. The DON reported she was not aware that the MDS nurses were not going into the resident ' s rooms and that she expected them to go into the resident ' s rooms whenever they were doing an assessment and not only assess the resident, but also their surroundings in their room to ensure any interventions that were in place were on the care plan.	F 657	appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 658 SS=D	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 observations, record review and staff interviews, the facility failed to obtain a reweight for 1 of 4 sampled residents reviewed for nutrition (Resident #28) to ensure accuracy of the	F 658	F 658 Corrective Action for Affected Residents;	5/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 658	Continued From page 17 resident's weight who showed a 23 pound weight gain in one month. Findings included: Resident #28 was admitted to the facility on 10/29/19 with a readmission date of 01/25/21. Diagnoses included stroke with left sided weakness and gastrectomy (insertion of abdominal feeding PEG tube). The Minimum Data Set (MDS) quarterly assessment dated 02/08/21 revealed the resident was moderately cognitively impaired. Resident #28 ' s weight was recorded as 85 pounds. Resident #28 required a feeding tube and was also on a mechanical altered diet and therapeutic diet. A review of an updated care plan on 02/08/21 revealed a plan of care for nutritional problems related to receiving mechanically altered diet and bolus tube feeding assistance needed with meals. The goal was to maintain adequate nutritional status as evidenced by no significant weight changes within next 90 days. Interventions included, in part, to obtain weights per physician orders. Record review revealed physician's order written on 04/13/21 to obtain weekly weights on Tuesdays. Resident ' s weights were recorded as: On 02/15/21 - 83 pounds on a mechanical lift. On 03/12/21 - 84 pounds on a mechanical lift. On 04/13/21 - 100 pounds sitting. On 04/17/21 - 107 pounds on a mechanical lift.	F 658	For resident # 28 □ On 5/11/21 Facility obtained new weight of 88.2 lbs by CNA. Corrective Action for Potentially Affected Residents; All residents have the potential to be affected by this alleged deficient practice. On 5/19/21, the IDT audited/reviewed monthly weights and found 10 residents in need of re-weigh. Re-weigh completed 5/20/21 by CNA. Re-weights verified by hall nurse and documented in resident□s weight record on this date. Systemic Changes; On 5/19/21 the Staff Development Coordinator began in-servicing on re-weigh process on the following: " If there is a 5 lb gain or loss, a re-weigh of the resident must immediately be re-taken and verified by the hall nurse " If the 5 lb discrepancy in weight gain or loss is still evident immediately notify the primary care provider " Weights should only be obtained by the same method every time " Always check the previous weight right away against the most previously obtained in the EMAR The Director of Nursing will ensure that all re-weights of residents who have a 5 lb discrepancy from last weight will be re-weighed, verified by hall nurse, and documented in resident□s weight record. On 5/19/21 the Staff Development Coordinator began in-servicing all licensed nurses, certified nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 658	Continued From page 18 A review of a progress note written by the Director of Nursing on 04/19/21 revealed weight change note: Note Text: WEIGHT WARNING: Vital Date 04/17/21, +10% change, Need Reweigh. An interview was conducted with Nursing Assistant (NA) #6 on 04/20/21 at 11:49 AM. NA #6 reported she recorded the weight of 100 pounds for Resident #28 on 04/13/21. She stated she was not aware of the previous weight when she recorded the 100 pounds. NA #6 stated she believed if a resident had a weight loss or weight gain of 5 pounds or greater, staff were supposed to get a reweigh to make sure it was an actual gain or loss and then let the nurse know. NA #6 stated she did not get a reweigh for Resident #28. An interview was conducted with Nurse #4 (Unit Manager) on 04/22/21 at 12:48 PM. Nurse #4 confirmed Resident #28 had weight gain of 23 pounds since 03/1/2/21 per the recorded weight documentation. Nurse #4 stated she was not sure why the note regarding obtaining a reweigh was in the progress notes. Nurse #4 stated she would not read the progress note to see if a resident had a recommendation for a reweigh. Nurse #4 stated she did not know of the process as to how it was to be communicated to staff to obtain a reweigh if there was a significant change in a resident ' s weight, but she would find out. An observation of a reweigh for Resident #28 was conducted on 04/22/21 at 1:50 PM with NA #3 and NA #9 using a mechanical lift. The weight was noted to be 87.8 pounds. A follow up interview was conducted with Nurse #4 on 04/22/21 at 3:08 PM and she revealed the Director of Nursing (DON) put the note in the progress notes and Nurse #4 added, the DON	F 658	assistants, and Agency staff who have not received this training by 5/26/21 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all licensed nurses and certified nursing assistants and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance; The Director of Nursing will monitor this process using the Survey Quality Assurance Tool for Monitoring Re-Weight. The monitoring will include reviewing 5 lbs discrepancies and verification of documentation in resident□s weight record. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 658	Continued From page 19 would verbalize to the staff that she needed a reweigh. Nurse #4 stated she was not made aware of the recommendation to reweigh the resident by the DON. An interview with the DON on 04/22/21 at 4:30 PM revealed the Interdisciplinary team (IDT) met daily to discuss any weight gains or losses. The DON stated the weight change note for Resident #28 was put into the progress notes on 04/18/21 by her because the resident was noted to having a possible significant increase in her weight and she wanted to ensure that the weight was accurate. The DON reported the resident had weekly weights because she was on tube feeding and was also eating a pureed diet, so they wanted to monitor her weight more closely. The DON reported she was supposed to verbally let the Unit Manager (Nurse #4) know she needed a reweigh and stated she must not have told her. The DON stated, at this time, this was the system they had in place to notify staff of reweighs. An interview with the DON on 04/27/21 at 1:13 PM revealed her expectation of ensuring reweighs are followed through with was to have a system in place where recommendations for getting a resident ' s reweigh was more visible to the Unit Managers and to follow up with a verbal reminder to the Unit Managers to make sure they obtain the reweight.	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		5/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 684	Continued From page 20 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on physician interview, nurse practitioner (NP) interview, staff interview, and record review the facility failed to assess venous/arterial ulcers before the first and after the last assessment completed by contracted wound services for 1 of 2 sampled residents (Resident #119) reviewed for non-pressure wounds. The facility also failed to involve facility physician services in the management of Resident #119's non-compliance with dressing changes/elevation of legs, and failed to document the resident's refusal of dressing changes. The facility also failed to provide adequate post-fall neurological assessment for 1 of 5 sampled residents (Resident #43) reviewed for falls. Findings included: 1. Record review revealed Resident #119 was admitted to the facility on 06/24/20. Her documented diagnoses included cellulitis of the right and left lower limbs, varicose veins of the right and left lower extremity with ulcers, non-pressure ulcer of right and left calf, non-pressure ulcer of left heel and mid-foot, peripheral vascular disease (PVD), morbid obesity, and chronic kidney disease (stage III). A 06/24/20 Weekly Skin Check documented Resident #119 had wounds to bilateral legs. A 06/24/20 Weekly Wound Review documented, "Resident has wounds from cellulitis on bilateral	F 684	F 684 Corrective Action for Affected Residents: For resident #43 □ Resident neurological assessment completed on 5/20/21 by Unit Manager. For resident #119 □ Resident no longer in facility. Corrective Action for Potentially Affected Residents; Resident #43 - All residents have the potential to be affected by this alleged deficient practice. On 5/20/21 the Nurse Manager audited all current residents who have had a fall within the past 30 days. Nurse Manager completed a neurological assessment on these residents. This was completed on 5/20/21 by Nurse Manager. Resident #119 □ All residents have the potential to be affected by this alleged deficient practice. On 5/26/21 the Nurse Manager reviewed all residents with wounds and open areas to ensure they have up to date assessments and any refusals are documented and care planned. Systemic Changes;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 684	Continued From page 21 legs, dressings had recently been changed and resident was in a lot of pain from transport to facility, she did not want me to take the dressings off to assess the wounds. Wound care nurse to assess on next shift." Record review revealed no facility staff (including the facility's former Treatment Nurse) or member of the facility physician team completed an assessment of Resident #119's venous/arterial wounds before the resident was seen by contracted wound services on 07/07/21. On 06/26/20 "I have cellulitis of the BLE r/t PAD (bilateral lower extremities due to peripheral arterial disease)" was identified as a problem in Resident #119's care plan. Interventions to this problem included, "Notify MD (physician) of any s/s (signs and symptoms of any abnormal drainage, odor or (temperature). Monitor/document healing of the cellulitis. Any new or worsening symptoms should be reported to MD (physician)." Resident #119's 07/01/20 Admission minimum data set (MDS) documented she had moderately impaired cognition, she required extensive assistance from staff to being dependent on staff for her activities of daily living, she was frequently incontinent of bowel and bladder, she was 64 inches tall and weighed 238 pounds, and the resident had three venous/arterial wounds, a surgical wound, a foot infection, and moisture associated skin damage. On 07/01/20 "I have chosen to receive palliative care with _____ (name of hospice company)" was identified as a problem in the resident's care plan.	F 684	Resident: #43 - On 5/24/21 the Staff Development Coordinator began in-servicing all current licensed nurses and Agency nurses to include the following: " The facility will provide adequate post-fall neurological assessments and document findings accurately The Director of Nursing will ensure that any license nurse who has not received this training by 5/26/21 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all license nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Resident #119 □ On 5/25/21 the Director of Nursing began in-servicing all current licensed nurses and Agency nurses to include these topics: " Wounds should be assessed weekly. Any refusals should be documented and reported to the Physician, the RP, and the MDS nurse for follow up and for care planning The Director of Nursing will ensure that any license nurse or Agency nurse who has not received this training by 5/26/21 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all license nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 684	Continued From page 22 Resident #119's 07/07/20 Initial Wound Evaluation & Management Summary (completed by the former Wound Physician) documented Resident #119 had a venous wound to the right posterior lower lateral leg which measured 23.5 x 14 x 0.5 centimeters (cm). The wound bed was 100% granulation tissue, and there was moderate serosanguinous drainage. The resident also had a venous wound to the left posterior lower lateral leg which measure 9.8 x 5.8 x 0.7 cm. The wound bed was 100% granulation tissue, and there was moderate serosanguinous drainage. The resident also had a wound to the left thigh which measured 0.4 x 1.4 x 0.1 cm. The wound bed was 100% slough, and there was light serous drainage (this wound was debrided and the physician recommended observation for worsening infection). The Wound Physician recommended elevation of the resident's legs and limitation of sitting with legs down to two continuous hours. On 07/08/20 "I have peripheral vascular disease r/t heart disease" was identified as problem in the resident's care plan. Interventions for the problem included, "Elevate legs when sitting or sleeping. Encourage resident to change position frequently, not sitting in one position for long periods of time. Monitor the extremities for s/s of injury, infection or ulcers." A 07/08/20 8:34 AM Skilled Nursing Review documented, "...Patient has a venous wound BLE: Frequent repositioning is utilized for prevention/healing. Off-loading of area has been implemented to promote healing/prevention. Nutritional supplements are administered to promote wound healing. An air mattress is	F 684	The Director of Nursing will monitor this issue using the Survey Quality Assurance Tool for wound assessments and Monitoring neurological checks completed post fall. The monitoring will include reviewing assessments/UDA. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 684	Continued From page 23	F 684		

utilized to promote wound healing."

In her 07/9/20 2:02 PM Physician Note NP #2 documented, "...C/o (complains of) pain in her legs, but says she is doing ok."

A 07/10/20 Skin & Wound Evaluation completed the former Treatment Nurse documented Resident #119 had wounds to the right thigh (medial), coccyx, and left ischial tuberosity. However, there was no measurements or wound assessment provided.

The former Wound Physician assessed Resident #119's wounds again on 07/16/20.

In her 07/20/20 4:51 PM Physician Note NP #2 documented, "Pt (patient) up in her bed this AM . Pt c/o pain in her legs. Nursing staff reports a foul odor from her legs...."

A 07/20/20 4:56 PM Palliative Note documented, "Legs covered but nurses indicate the RLE (right lower extremity) is open and foul smelling. No fevers....(former Wound Physician) will see her tomorrow."

The former Wound Physician assessed Resident #119's wounds again on 07/21/20.

A 07/22/20 2:51 PM Physician Note documented the former Wound Physician recommended that Resident #119 lay down after therapy and elevate her legs.

A 07/25/2020 11:06 AM Health Status Note documented, "Nurse received report that resident refused to change her leg bandages yesterday, and resident refused today."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 684	Continued From page 24	F 684		

In her 07/27/2020 2:38 PM Physician Note Facility Physician #1 documented, "Leg wounds open and still draining."

In her 07/28/20 4:26 PM Physician Note NP #2 documented, "Ulcers to left leg look worse. She is supposed to have her legs elevated when she is not in therapy to help with the edema."

The former Wound Physician assessed Resident #119's wounds again on 07/21/20.

A 07/29/20 Weekly Wound Review (not pressure) initiated by the former Treatment Nurse was blank except for documentation that the resident's temperature was 97.7 degrees.

Resident # 119's 08/06/20 Wound Evaluation and Management Summary (completed by the former Wound Physician) documented the resident had a venous wound to the right posterior lower lateral leg which measured 22 x 11.5 x 0.3 cm. The wound bed was 80% granulation tissue and 20% slough, and there was moderate serosanguinous drainage (this wound was debrided, and the physician documented it had improved). The resident also had a venous wound to the left posterior lower lateral leg which measure 9 x 5.5 x 0.2 cm. The wound bed was 100% granulation tissue, and there was moderate serosanguinous drainage (this wound underwent cauterization for hypergranulation tissue, and the physician documented the wound had improved). A wound to the resident's right proximal posterior medial thigh had healed.

A 08/17/20 10:51 AM Skilled Nursing Review documented, "Cellulitis and ulcer to bilateral lower

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 684	Continued From page 25	F 684		

legs. Unna boots intact (without) any dressing. Toes warm to the touch. Prompt capillary refill. Frequent repositioning is utilized for prevention/healing. Off-loading of area has been implemented to promote healing/prevention."

A 08/18/20 Progress Note written by the former Wound Physician documented, "Patient refuses to lie down for lower extremity wound evaluation, precluding adequate evaluation. Her visit has been rescheduled."

In her 08/20/20 10:05 AM Physician Note NP #2 documented, "Nurse was changing the dressing to BLE stasis ulcers. Both legs with a foul odor and a lot of green purulent drainage. Pt in a lot of pain today."

A review of Resident #119's August 2020 Treatment Administration record documented treatment for the right and left post calves was not initialed off as being completed or coded that the resident refused the treatment or was unavailable for the treatment on 08/04/20, 08/11/20, and 08/18/20. Treatment for the left thigh was not initialed off as being completed or coded that the resident refused the treatment or was unavailable for the treatment on 08/03/20 - 08/05/20 and 08/10/20 - 08/11/20.

Record review revealed no facility staff (including the facility's former Treatment Nurse) or member of the facility physician team completed an assessment of Resident #119's venous/arterial wounds between 08/07/20 and 08/19/20.

A 08/20/20 Emergency Department Encounter documented, "...present with bilateral lower leg ulcers. Patient was sent from nursing home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 684	Continued From page 26	F 684		

because they could not get an IV to give her vancomycin (antibiotic). Patient has a history of PVD with chronic lower leg ulcers and chronic cellulitis....Patient stated that the dressings were just changed today and they felt like there was increasing infection and her doctor wanted her started on vancomycin. Patient does have pain to both lower legs but is worse in the right leg. The ulcer on the right leg is worse than the left...."

A 08/21/20 hospital History and Physical documented, "...Apparently yesterday she appeared much more lethargic than usual and wounds had foul odor. Lab work was ordered as well as IV placement to start IV (intravenous) vancomycin, however they were unable to get blood or place IV....Patient appears non-toxic. Her white blood cell count is normal, she did have a very slightly elevated lactic acid bus has been afebrile....She will be admitted for cellulitis and acute CHF (congestive heart failure)...."

A 08/21/20 hospital wound consult documented Resident #119 had a abscess to her right inner thigh, an irregularly shaped ulcer to the left posterior leg with yellow/pink/red tissue in the wound bed and no odor and a small amount of serosanguinous drainage, and an irregularly shaped ulcer to the right posterior leg with yellow/pink/red/granulation tissue in the wound bed and no odor and a small amount of serosanguinous drainage. A wound to the resident's left posterior calf was documented as a "full thickness ulceration, non-granulating pin and 80% slough." A wound to the resident's right posterior calf was documented as a "large full thickness ulceration, 90% granular with some fibrinous slough." Bilateral Ankle/Brachial Indexes could not be obtained due to resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 684	Continued From page 27	F 684		

pain.

A 08/24/20 hospital Discharge Note documented Resident #119's diagnoses included cellulitis, peripheral artery disease, and leg ulcers.

In his 08/25/20 Progress Note the former Wound Physician documented, "Patient has been non-compliant with wound care and refusing wound visits. Hospitalized 08/20/20 for wound-associated lower extremity cellulitis, readmitted to facility 08/24/20. Parenteral vancomycin initiated...and wounds treated with Dakins Solution per hospital (wound consult). Recommend referring patient to hospital wound center for continuing care. Discussed with PCP (primary care physician), and she concurs...."

During a telephone interview with NP #2 on 04/23/21 at 1:24 PM she stated she remembered the green drainage and odor coming from Resident #119's leg wounds on 08/20/20. However, other than that she reported all she recalled was that the wounds were painful due to their severity, and they sometimes had an odor and produced a lot of drainage.

During a telephone interview with the Administrator on 04/23/21 at 2:15 PM he stated the Treatment Nurse completed dressing changes Monday - Friday, and the hall nurses completed them on the weekends and when the Treatment Nurse was out of the building.

During a telephone interview with former Medication Aide #2 (the former Treatment Aide) on 04/23/21 at 2:24 PM she stated Resident #119's cognition varied greatly from day to day. She reported the resident was non-compliant with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 684	Continued From page 28	F 684		

the Wound Physician's repeated requests for her to go back to bed after therapy, elevate her legs, and cooperate with dressing changes. She reported most of the time the resident would allow herself and the former Treatment Nurse to complete dressing changes, but rarely allowed the hall nurses to do so. She commented the resident's wounds "leaked a lot" and produced a lot of drainage. She stated the Treatment Nurse was supposed to complete weekly wound assessments on the weeks the contracted wound service did not see residents.

During a telephone interview with Nurse #11 (who cared for Resident #119 a couple of nights a week) on 04/23/21 at 3:11 PM she stated the resident was very confused most of the time. She reported the resident had severe wounds to her bilateral legs. She commented the resident would not elevate her feet, and did not go back to bed after therapy as the former Wound Physician recommended. She stated there was a problem with the resident refusing dressing changes. According to Nurse #11, this was reported to the Treatment Nurse, and was supposed to be documented on the TAR. She stated it would be good to involve the physician team with the resident's non-compliance, and she assumed this was done by the Treatment Nurse or Director of Nursing (DON) at the time. She reported most of the time Resident #119's wounds had odor and there was a lot of drainage and weeping.

During a telephone interview with the current DON on 04/23/21 at 3:28 PM she stated all wounds were supposed to be assessed weekly which included measurements, staging (for pressure wounds), and descriptions of the wound bed, odor, drainage, and tunneling. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 684	Continued From page 29	F 684		

commented these assessments were important to catch wound declines so interventions could be put in place quickly. According to the DON, if the hospital wound clinic or contracted wound services was not assessing wounds weekly, then the facility's Treatment Nurse was expected to assess them so that the weekly pattern would be sustained. The DON stated there was a coding system which allowed staff to document treatment refusals and the unavailability of residents for dressing changes on the TARs. She reported her expectation was for all nurses to capture refusals of treatment and unavailability of residents correctly by using this coding system.

During a telephone interview with Physician #1 on 04/26/21 at 3:36 PM she stated she was not sure if the physician team was notified of Resident #119 being non-compliant, but it did not appear so because there were no physician notes which captured non-compliance as the reason for the visit. She explained in the physician practice the lead sentences in the physician notes described the purpose of the visits. She commented if the physician team was notified of non-compliance they would talk with the resident and staff and try to determine the cause of non-compliance and determine how it could be remedied. According to Physician #1, she wrote a physician note after the resident returned from the hospital regarding the resident's unwillingness to cooperate with the former Wound Physician anymore and the plan to start sending her to the hospital wound clinic. After reading her physician notes regarding Resident #119, Physician #1 reported she gathered the resident's venous/arterial wounds were severe with a lot of drainage, the resident had some edema, and there was probable cellulitis. She commented normally wounds could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 684	Continued From page 30	F 684		

deteriorate to the point of needing antibiotic treatment within a week, but because of Resident #119's diagnoses and wound severity, it could have happened more quickly for her.

During a telephone interview with the former Treatment Nurse on 04/29/21 at 4:08 PM she stated the resident would refuse dressing changes periodically and would also remove her dressings. She reported the resident did not want to elevate her legs or get back in bed after therapy. She commented the resident's wounds produced a lot of drainage. According to the former Treatment Nurse, she tried to assess the resident's wounds, but the resident would not cooperate. She stated she decided the best thing to do was rely on the assessments which the former Wound Physician completed. She explained the resident was more willing to cooperate with a doctor. The former Treatment Nurse also stated she asked Physician #1 to look at the resident's leg wounds several times. She commented the former Wound Physician kept educating the resident that she needed to reduce the amount of time she was sitting up, elevate her feet and legs, and allow dressing changes, but the resident remained noncompliant. The former Treatment Nurse reported when dressing changes/treatments were refused there was a code that was entered on the TAR's to capture the refusals. She commented resisting care contributed to the resident's leg wounds getting worse on 08/20/20.

During a 04/29/21 5:24 PM telephone interview with Nursing Assistant (NA) #8, who was assigned to care for Resident #119 on 08/06/20 and 08/07/20 and could have helped other NAs assigned to care for the resident between

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 684	Continued From page 31	F 684		

08/08/20 and 08/20/20, she stated the resident frequently refused help even though she required extensive assistance with her ADLs. She commented she cared for the resident on the 3 - 11 shift, and changed the resident who was incontinent and occasionally had to bathe the resident. She reported she did not see any green drainage coming from the resident's legs, and the leg wounds had a faint odor, but nothing strong. According to NA #8, the resident did not always want to elevate her legs, and she would sometimes removed her wound dressings.

During a telephone interview with the former Wound Physician on 05/03/21 at 4:39 PM he stated Resident #119 's arterial disease was not severe and was mainly of the venous nature. He reported the resident was diabetic, had PVD, and chronic ulcer disease. He commented unfortunately the resident just could not get ahead of her disease because most of the time she was sitting with her legs dangling. According to the physician, Resident #119 was not compliant with his recommendations to elevate her feet and legs and to spend more time off-loading pressure. He stated as a result the resident's wounds produced a large amount of drainage. He reported all this moisture created a condition known as pseudomonas overgrowth so there was odor to the resident's wounds, and ultimately the condition resulted in the production of green drainage. He commented the discolored drainage and odor could have been treated through the use of a strong acidic solution. According to the former Wound Physician, he felt when Resident #119 was sent out to the hospital on 08/20/20 she did not have what we think of as a traditional wound infection, but was suffering from this pseudomonas overgrowth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 684	Continued From page 32	F 684		

2. Resident #43 was admitted to the facility on 08/01/17. Her documented diagnoses included dementia, disorders of bone density, and displaced fracture of first cervical vertebra, fracture of the lower end of left radius, and contusion of the scalp (injuries added to diagnosis list on 07/03/20).

On 08/09/19 "I am at increased risk for falls" was identified as a problem in Resident #43's care plan. Interventions for this problem included, "Monitor for and document x 72 (hours) post-fall following s/sx (signs and symptoms): pain, bruising, mental status change, or new onset: confusion, sleepiness, inability to maintain posture, agitation. Report to MD (physician) any of the above s/sx."

Resident #43's 06/26/20 quarterly minimum data set (MDS) documented her cognition was severely impaired, she required extensive assistance from staff with transfers and locomotion on the unit, and she had no falls since her last MDS assessment.

A 06/30/20 3:34 PM Falls Review and Follow Up documented, "Initial falls note. Observed on floor (unwitnessed). Location: Hallway. Hematoma to right side of forehead. Vital signs documented. Neuro checks completed. Assessed by Nurse Practitioner (NP) #1 and no new orders."

A 06/30/20 4:01 PM Health Status Note documented, "Resident observed by staff lying in hallway in prone position; resident large hematoma to right side of forehead noted; resident c/o (complains of) headache; c/o pain medicated with PRN (as needed); resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 684	Continued From page 33	F 684		

assessed by NP; resident assisted to wheelchair by staff..."

Record review revealed follow-up neurological checks were completed for Resident #43 on 06/30/20 at 4:34 PM, on 06/30/20 at 5:34 PM, on 06/30/20 at 6:34 PM, and on 07/01/20 at 3:37 PM. All neurological checks documented the resident was not experiencing any changes in her neurological condition following her fall.

A 07/02/20 4:03 PM Health Status Note documented Resident #43 was sent to the hospital due to headaches and a bruised and swollen left wrist.

A 07/03/20 hospital Discharge Summary documented Resident #43 was hospitalized from 07/02/20 until 07/03/20. Her discharge diagnoses included closed fracture of the first cervical verebra, closed fracture of the left distal radius (wrist), and hematoma of the frontal scalp.

During an interview with NP #1 on 04/22/21 at 10:20 AM she stated following a fall with head injury she expected the facility to follow its neurological assessment policy.

During a telephone interview with NP #2 on 4/22/21 at 11:28 AM she stated because Resident #43 hit her head and sustained a hematoma during her 06/30/20 fall she would expect the facility to implement neuro checks, and immediately notify the physician team if there were any neurological changes. She commented the facility should follow its policy for neuro checks which should detail out the frequency of the checks and the neurological symptoms it should be monitoring for.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 684	Continued From page 34 During a telephone interview with the Director of Nursing (DON) on 04/26/21 at 1:20 PM she stated facility policy required staff to complete post-fall neuro checks hourly x four hours and then every shift for a total of 48 hours. She reported the frequency of checks for Resident #43 was inadequate because if a shift was defined as eight hours then neuro checks were not completed on 06/30/20 third shift and 07/01/20 first shift, and if a shift was defined as twelve hours then a neuro check was missed between 06/30/20 7:00 PM and 07/01/20 7:00 AM.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, Wound Specialist Physician interview, Nurse Practitioner interview, staff interviews and record review the facility failed to provide services to prevent an avoidable pressure ulcer by not applying heel protector	F 686	F 686 Corrective Action for Affected Residents; For resident # 317 □ facility applied heel protectors to bilateral feet as per MD	5/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 35 boots as ordered by the physician (Resident #317) and failed to treat a pressure ulcer by not applying skin prep to the peri wound area as ordered by the physician (Resident #33) for 2 of 5 residents in the survey sample reviewed for the treatment of pressure ulcers. Findings included: 1) Resident #317 was admitted to the facility on 03/11/21 with diagnoses that included: Atrial fibrillation, heart disease with heart failure, and Type 2 Diabetes Mellitus. The admission Minimum Data Set assessment dated 03/18/21 was noted to be in progress. Review of the Nurse Practitioner #1 admission note written on 03/12/21 revealed the resident was alert and oriented to person, place, time, and situation. She had requested admission to the facility. She was able to move all extremities with limited range of motion in both lower extremities and her left shoulder. She was pleasant with no evidence of delusions or hallucinations. A baseline care plan dated 03/11/21 was reviewed. The resident was admitted with no open wounds. Review of a progress note written by Nurse Practitioner #1 on 03/23/21 read: "Heels noted to be getting dark pink and heel protectors ordered, discussed with nursing and therapy." Review of the physician orders for Resident #317 revealed the following order dated 03/23/21 (on the MAR): Heel protectors to bilateral feet every shift for redness to heels, note if protectors in place.	F 686	order as of 5/24/21 by Unit Manager For Resident #33 □ Resident #33 No longer in facility. Corrective Action for Potentially Affected Residents; On 5/20/21 the nurse management team audited all current residents with orders for heel protectors. This was accomplished by auditing orders and care plan task for the heel protectors. Once it was determined all heel protectors were identified the nurse manager and MDS nurse ensured the heel protectors were in place, had a MD order, NA task, and were care planned. This process will be completed by Unit Manager and MDS Nurse on 5/26/21. Unit manager and MDS nurse ensured the orders for skin prep for peri-wounds and heel protectors were in place, complied with as per MD order, and care planned. This process was completed on 5/24/21. Systemic Changes; On 5/21/21 the Staff Development Coordinator began in-servicing all current licensed nurses. This in-service included the following topics: " All residents with orders for Skin Prep to be applied as per MD order " Orders for skin prep and heel protectors, ski prep, or float heels must be applied by the nursing staff, as appropriate to prevent skin irritation and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 36 The Initial Wound Evaluation and Management Summary dated 4/20/21 by the Wound Specialist Physician was reviewed. The physician assessed Resident #317 to have a Stage 2 pressure wound of the left heel for at least 1 day duration. The wound size was 1.5 Centimeters (CM) x 0.9 CM x not measurable CM (L X W X D). The treatment plan read: "skin prep, apply twice daily for 30 days-primary dressing; skin prep, apply twice daily for 30 days-peri wound treatment. Plan of care: off-load wound; reposition per facility protocol; and assure vigilant use of the heel lift boots at all times. Clinical Data and Materials Reviewed: ...Discussed with wound care nurse, pt (patient) and state surveyor regarding etiology, assessment, diagnosis, prognosis and management of wound, including importance of consistent vigilant use of heel lift boots to help more optimally off load heels, promote healing, and help prevent deterioration." An observation of Resident #317 was made during the initial tour on 04/19/21 at 1:10 PM. She was laying in bed with both heels laying against the mattress. She complained that her heel hurt. She stated she was supposed to have boots on her feet to keep her heels off the bed but they had been missing for 8 to 10 days. The facility Treatment Nurse was called to the room and removed the resident's socks. A black scab the size of a fifty-cent piece was observed on the resident's left heel. The Treatment Nurse searched the resident's room for heel protector boots but could not find any so she went to the supply cabinet, retrieved a new pair of heel protector boots, cleansed the resident's left heel with skin prep and applied the heel protector boots to both feet. The Treatment Nurse stated	F 686	breakdown The Director of Nursing will ensure that any licensed nurse, certified nursing assistants, and agency staff who have not received this training by 5/26/21 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all licensed nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance; The Director of Nursing will monitor this issue using the Survey Quality Assurance Tool for Skin Prep Application and Heel Protectors. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 37	F 686		

the Wound Specialist Physician was scheduled to visit the facility the next day and she would have him assess the wound.

An observation of wound care provided by the Wound Care Specialist Physician was made on 04/20/21 at 1:30 PM. He cleansed the wound on the resident's left heel with normal saline soaked 4 x 4 gauze, and measured the wound as 1.5 Centimeters (CM) long x 0.9 CM wide x 0 CM depth. The wound area was bright pink. The physician assessed the area as 10% dermis and 90% skin. During an interview at 4:45 PM on 04/20/21he stated he expected the wound on the resident's left heel would heal in a week. He confirmed the wound had been caused by pressure and likely would have been avoided if the resident would have had heel protector boots on her feet. He explained the purpose of the boots was to off load pressure and that he always put in his plans of care to "assure vigilant use of heel lift boots." He added that it wouldn't take long for the resident to develop a pressure wound, 12 to 48 hours, because she was immobile. He confirmed the constant pressure of her heels on the bed and immobility would have caused the wound.

In an interview with Nurse Aide #4 on 04/20/21 at 4:00 PM she stated she had cared for Resident #317 on 04/16/21 and remembered it well because the resident had a visitor that day. She recalled she got the resident up because of the visit and said she took the resident's heel boots off and put a pair of blue socks on her "because they did not leave the heel boots on when a resident was up in a chair." She reported on 04/16/21 she noticed a black scab on the resident's heel but did not report it to the nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 38	F 686		

She stated she assumed nursing was aware of the wound because the resident had heel protectors. She did not know if the boots were reapplied after the resident's visitation because she was off shift when the resident was put back to bed by Nurse Aide #6.

In an interview with Nurse Aide #6 on 04/21/21 at 9:25 AM she stated she had cared for Resident #317 on 04/16/21 from 3:00 PM to 7:00 PM. She confirmed she had transferred the resident back to bed. She remembered the resident had the heel protector boots with black and blue Velcro straps that she put on the resident's feet after she returned to bed.

In an interview with Nurse #2 on 04/21/21 at 9:29 AM by telephone she stated she had cared for Resident #317 on the evening and night shifts of 04/18/21. She commented she did not remember seeing the heel protector boots on the resident and had documented in error on the Medical Administration Record (MAR) that the heel protector boots were in place. She explained the shift had been "crazy" because she had her own assignment and was covering a Medication Aide on another hall. She recalled she was "all over the place" plus the computer was running slow which added to the confusion. She confirmed again that she did not remember seeing the heel protectors on the resident's feet.

In an interview with Medication Aide #2 on 04/21/21 at 10:00 AM she stated she had cared for Resident #317 on 04/17/21 and 04/18/21. She could not recall seeing heel protector boots on the resident even though she had helped the nurse aide pull her up in bed. She acknowledged she had signed on the MAR that the boots were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 39	F 686		

on the resident when she could not recall seeing the boots. She explained the computer ran "slow" on the weekends and when she was able to log on she "went down through the MAR's and clicked things off to stay in compliance." She stated that may have been why she documented Resident #317 had her heel protector boots on when she had not actually seen them on the resident or she may have been thinking of another resident on the hall who also had heel boots and checked Resident #317's MAR by mistake.

In an interview with Nurse #1 on 04/21/21 at 8:56 PM by telephone she stated when she had worked from 7:00 PM to 7:00 AM on Saturday 04/17/21 she did not recall seeing heel protector boots on the resident. She stated she would make an initial round then rely on the nurse aides to ensure the heel boots were in place. She said it could have been an error that she initialed the heel boots were on the resident because she could not remember seeing them. She said it was like playing catch up at the end of the night to do charting because the internet goes on and off and all the charting was done at the end of the shift.

In an interview with Nurse Practitioner #1 on 04/22/21 at 10:18 AM she stated she was familiar with Resident #317. She commented she would expect for the resident to have heel protector boots on when in bed. She reported that it was possible not having had the heel protector boots on contributed to the Stage 2 pressure ulcer on the resident's left heel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 40	F 686		

2) Resident #33 was admitted to the facility on 04/09/21. Diagnoses included an unstageable sacral pressure ulcer.

The MDS dated 04/09/21 was noted to be in progress. Resident was a new admission. Resident was cognitively impaired and had an unstageable pressure ulcer that was present upon admission.

A review of the initial care plan dated 04/09/21 revealed a plan of care for at risk for pressure ulcer with interventions to include apply moisture barrier with each brief changes and as needed, assist with position changes throughout the shift in order to minimize pressure and to increase comfort, and observe skin for redness and open areas.

A physician order written on 04/09/21 revealed an order to apply Hypochlorite Solution 0.5% to sacrum topically every day and night shift for wound care for 7 days after cleansing area. Apply Dakin ' s moistened gauze, moist to moist, directly on wound bed, cover with dry gauze and an abdominal pad and secure with tape. To be done twice daily and as needed. This order was discontinued on 04/13/21.

A review of the VOHRA Wound Physician ' s evaluation and management summary written on 04/13/21 revealed Resident #33 had an unstageable sacrum wound which measured 6.5 X 4.0 X 0.1 centimeters (cm). The primary dressing treatment plan included to apply Santyl and Calcium Alginate with Silver for 30 days and cover with dressing, and a secondary treatment plan for the peri wound (surrounding area)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 41	F 686		

included to apply skin prep daily for 30 days.

A physician order written on 04/13/21 revealed an order to clean the sacrum with normal saline, pat dry, apply Santyl and then Calcium Silver Alginate and cover with dry sterile dressing daily. There was no order written to apply skin prep to the peri wound daily for 30 days.

A review of the Treatment Administration Record (TAR) for the month of April 2021 revealed an order written on 04/13/21 to clean the sacrum with normal saline, pat dry, apply Santyl and then Calcium Alginate Silver and cover with dry sterile dressing daily. There was no order on the TAR dated 04/13/21 to apply skin prep to the peri wound daily for 30 days.

A review of the VOHRA Wound Physician ' s evaluation and management summary written on 04/20/21 revealed Resident #33 had an unstageable sacrum wound which measured 6.3 X 3.5 X 0.2 cm. The primary dressing treatment plan included to apply Santyl once daily for 14 days and apply Calcium Alginate with Silver for 30 days and cover with dressing, and a secondary treatment plan for the peri wound included to apply skin prep daily for 30 days.

A review of the physician ' s orders on 04/20/21 revealed there was no order to change the daily Santyl treatment application from 30 days to 14 days and there was no order to apply skin prep to the peri wound daily for 30 days.

A review of the TAR for the month of April 2021 revealed there was no order written on 04/20/21 to change the daily Santyl application from 30 days to 14 days and there was no order on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 42	F 686		

TAR dated 04/20/21 to apply skin prep to the peri wound daily for 30 days.

An observation of wound care was conducted on 04/21/21 at 11:00 AM with the Wound Treatment Nurse (WTN) and the Occupational Therapist (OT). Resident #33 was noted to be positioned on his right side with the OT assisting him. The WTN assessed the resident for pain which he denied. The dressing had already been removed prior to entering the room for observation. The wound was noted to be on the resident ' s sacrum and was noted to have about 40% slough (moist necrotic (dead) tissue) and 60% granulated (healthy) tissue. There was no drainage or odor noted. The wound was not measured at this time. The WTN nurse washed her hands, applied hand sanitizer, and applied gloves. She proceeded to wash the wound with normal saline and pat dry. She applied the Santyl with a cotton tip dispenser to the slough area, covered the entire wound bed with Calcium Silver Alginate and then covered the wound with a dry sterile dressing. Resident #33 was noted to have mild erythema (redness) in the peri wound area. Resident #33 tolerated the procedure well and had no complaints of pain.

An interview was conducted with the WTN on 04/21/21 at 12:10 PM. The WTN revealed when she rounded with the Wound Physician, he would verbally advise her of any new orders, and she would input the new orders right then and there. The WTN stated she was not aware of the VOHRA wound evaluation and management summary documentation which was located in the electronic medical record under documents. She stated she was not aware she was to use skin prep to the peri wound as indicated on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 43	F 686		

VOHRA wound evaluation and management summary dated 04/13/21 and 04/20/21. WTN stated skin prep was used to toughen the skin around the peri wound to prevent further breakdown to the skin. The WTN stated if she had seen that information she would have entered the treatment plans and any revisions to the treatment plans in the physician orders to appear on the TAR.

An interview was conducted with the Wound Physician from VOHRA via phone on 04/26/21 at 12:39 PM. The Wound Physician revealed when he rounded with the WTN she would visit with the resident with him and help get the resident positioned so that he could clean, measure and assess the wounds. The Wound Physician reported he would discuss any new treatment plan orders that may need to be implemented or changed based on the assessment. The Wound Physician reported he documented his findings, treatment orders and recommendations immediately. The Wound Physician added, the notes were communicated via access through the online portal through which the facility could access on the electronic medical record immediately. The Wound Physician stated before he left the facility all of his documentation (the evaluation and management summary reports) were done. The Wound Physician stated he had ordered skin prep to be applied to the peri wound to help against moisture and prevent further skin breakdown especially given the wound was in the sacral area where moisture developed easily. He added, the skin prep offered that extra layer of protection to keep the skin intact. The Wound Physician stated he would have expected the WTN to review the notes he left and to follow the facility protocol of writing orders and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 44 recommendations so that the orders were reflected as part of the resident ' s treatment. An interview was conducted with the Director of Nursing (DON) on 04/27/21 at 1:13 PM. The DON reported her expectation of the WTN was to follow the Wound Physicians ' dressing treatment plans or any changes or recommendations in the treatment plan. The DON stated she would expect the nursing staff to be fluent in navigating the system to know where to review for any wound notes, treatment plan orders, and recommendations.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to apply left	F 688	F 688	5/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 688	Continued From page 45 resting hand splints to be worn daily for up to 8 hours a day as ordered by the physician for 2 of 2 residents (Resident # 65 and Resident #28) observed for contracture management. Findings included. 1.) Resident #65 was admitted to the facility on 01/20/20 with diagnoses to include, history of traumatic brain injury, hemiplegia, and left-hand contracture. A review of the physician orders revealed an order written on 02/07/20 wear left resting hand splint for up to 8 hours during the day as tolerated. Check skin integrity before and after applying splint, every day shift apply splint and every evening shift remove splint. The Minimum Data Set quarterly assessment dated 04/06/21 revealed Resident #65 was cognitively intact and had left upper and left lower extremity impairment. She exhibited no behaviors and no rejection of care. A review of the care plan dated 02/25/21 for Resident #65 revealed a plan of care to remain free of injuries or complications related to contractures to left upper and lower extremities. Interventions included in part; resident to wear resting hand splint up to 8 hours per day, to monitor and report to the physician any complications including contracture changes. A review of the Medication Administration Record (MAR) revealed from 04/15/21 - 04/21/21 the left-hand splint was applied only on the evening of 04/17/21 and 04/21/21.	F 688	Corrective Action for Affected Residents For resident # 65 □ On 5-19-21 resident #65 was referred to OT to ensure left resting hand splint is appropriate for this resident. Physician orders received per OT recommendations on 5/25/21 and splints applied per order by Unit Manger. For resident # 28 - On 5-19-21 resident #28 was referred to OT to ensure left resting hand splint is appropriate for this resident. Physician orders received per OT recommendations on 5/25/21 and splints applied per order by Unit Manager. Corrective Action for Potentially Affected Residents; All residents with splints have the potential to be affected by this alleged deficient practice. On 5/19/21 the nurse management team and therapy audited all current residents with orders for splints, palm guards, hand rolls, and braces to ensure appropriateness and availability. On 5/25/21 all physician orders were received per OT and splints were applied per recommendations by Unit Manager. Once it was determined all splints, palm guards, hand rolls, and braces were identified appropriate the nurse manager and MDS nurse ensured the device was in place, had a MD order, NA task, and care planned. This process was completed on 5/26/21 by Unit Manager. Systemic Changes;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 688	Continued From page 46 An observation of Resident #65 on 04/19/21 at 3:00 PM revealed resident lying in bed with no hand splint in place. The splint was not visible in the resident's room. An observation of Resident #65 on 04/20/21 at 2:00 PM and 5:41 PM revealed no hand splint in place. An interview was conducted with Resident #65 on 04/20/21 at 5:41 PM. She reported she had not worn the splint all day and stated she should have it on. An observation of Resident #65 on 04/21/21 at 11:01 AM revealed no hand splint in place. An interview was conducted on 04/21/21 at 1:36 PM with Nurse #4 who was assigned to Resident 65's care. She stated the resident had an order for splints and she thought the splint was worn at night, but indicated she was not sure. An observation of Resident #65 on 04/21/21 at 4:44 PM revealed no hand splint in place. An interview was conducted with Resident #65 on 04/21/21 at 4:44 PM. She reported she would allow staff to apply the splint anytime and stated she should be wearing it. An interview was conducted on 04/22/21 at 9:58 AM with the facility Rehab Director. She stated Resident #65 was discharged from Occupational Therapy on 02/12/20 and had an order to wear left hand splint for up to 8 hours during the daytime and indicated not during the evening hours.	F 688	On 5/19/21, the Staff Development Coordinator began an in-service education to all full time, part time, as needed nurses, CNA□s, Medication Aide□s, Medication Tech□s, and agency staff. Topics included: " The importance for applying splints, palm guards, hand rolls as ordered by the MD " Inspecting skin at least daily or more frequently as ordered for irritation, redness or skin breakdown. " What to do when the device cannot be located. Any staff that has not received this in-service by 5/26/21 will not be allowed to work until it is completed. This information has been integrated into the standard orientation training for identified facility staff as well as Agency staff and in the required in-service refresher courses for all nurses, medication aides, and medication tech□s and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance; The Director of Nursing will monitor this issue using the Survey Quality Assurance Tool for Monitoring Splints. The monitoring will include reviewing orders and applications. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 688	Continued From page 47 An interview was conducted on 04/22/21 at 4:34 PM with Nurse Aide #1. He stated Resident #65 did have hand splints and reported he was unaware that she did not have them on at all that day. He stated that nurse aides were responsible for applying splints, or the nurses, and staff were trained on how to apply splints. He reported he would continue to make sure Resident #65 had the splint applied daily during the daytime hours. An interview was conducted on 04/22/21 at 5:32 PM with the Director of Nursing. She stated her expectation was for the resident's hand splints to be applied daily according to the physician orders. 2. Resident #28 was admitted to the facility on 10/29/19 with a readmission date of 01/25/21. Diagnoses included stroke with left sided weakness and contractures to bilateral upper and lower extremities. A review of the physician orders revealed an order written on 01/26/21 to apply left resting hand splint for up to 8 hours during the day as tolerated. The Minimum Data Set dated 02/08/21 quarterly assessment revealed the resident was moderately cognitively impaired and had impairments on both sides to upper and lower extremities. Resident #28 did not demonstrate any behaviors such as refusing care. A review of Resident #28 ' s care plan updated 02/02/21 revealed a plan of care for alteration in musculoskeletal status related to contractures to left wrist, left hand, left elbow, bilateral hips and bilateral knees. Interventions included, in part,	F 688	corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 688	Continued From page 48	F 688		

monitor/document/report to physician signs or symptoms or complications related to arthritis; joint pain, joint stiffness, usually worse on wakening, swelling, decline in mobility, decline in self-care ability, contracture formation/joint shape changes, crepitus (creaking or clicking with joint movement) and pain after exercise or weight bearing.

A review of the Medication Administration Record (MAR) revealed on 04/19/21 the resting left-hand splint was signed off as being applied as evidenced by nursing initials. (Nurse #14)

Observations of Resident #28 on 04/19/21 at 11:18 AM, 12:35 PM, 2:26 PM and 5:10 PM revealed an alert resident lying in bed. There was no splint noted on the resident ' s left hand and the splint was not visible in the resident ' s room.

An interview was conducted with Resident #28 on 04/19/21 at 5:10 PM. The resident reported no one had applied a splint on her left hand today. Resident #28 stated she would not refuse to wear the splint and stated if the staff applied it, she would wear it.

An observation of Resident #28 on 04/20/21 at 11:18 AM revealed the resident was lying in bed and there was no splint noted on the resident ' s left hand. The splint was not visible in the resident ' s room.

An interview was conducted with Resident #28 on 04/20/21 at 11:18 AM. The resident reported she was supposed to wear a left-hand splint, but no one has put it on her. Resident #28 stated she did not know where the splint was and had not seen it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 688	Continued From page 49	F 688		

An observation of Resident #28 on 04/20/21 at 2:30 PM and 5:45 PM revealed an alert resident lying in bed with no hand splint to her left hand.

Record review of the MAR on 04/20/21 revealed N/A (not applicable) was documented by Nurse #4 for the application of the left-hand splint.

An observation of Resident #28 on 04/22/21 at 9:22 AM revealed the resident was lying in bed and was noted to have no left-hand splint applied. The splint was not visible in the resident ' s room.

An interview was conducted with Nursing Assistant (NA) #9 on 04/22/21 at 9:22 AM. NA #9 stated she had not worked on this unit very often and was not familiar with the residents. NA #9 stated to know how to take care of the residents she would look at the Kardex in the point click care computer system. NA #9 stated she did not know Resident #28 wore a left-hand splint.

An interview was conducted with Nurse #4 on 04/22/21 at 12:50 PM. Nurse #4 stated on 04/20/21 she put NA on the MAR because she did not see the splint on the resident ' s left hand and did not know where it was. Nurse #4 stated she could not be sure of the last time she put the splint on Resident #28. Nurse #4 stated she did not know why she signed off on the MAR that she applied it when she did not apply it on 04/21/21.

An interview was conducted with NA #3 on 04/22/21 at 1:30 PM. NA #3 reported she has not put the splint on the resident for a while and she thought it had been in the laundry and they were in the process of looking for it. NA #3 stated the Kardex on the computer system would be where

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 688	Continued From page 50	F 688		

she would go to know how to take care of a resident and applying the left-hand splint was listed as a task in the resident ' s Kardex. NA #3 stated Resident #28 was supposed to have the splint on daily for as long as she could tolerate it.

An interview was conducted with the Occupational Therapist (OT) on 04/22/21 at 3:11 PM. The OT reported the resident had been discharged from therapy with regard to her left resting hand splint since 04/29/20. He reported when she was discharged she was very compliant with the use of the splint and tolerated it well and it fit well. He stated he notified nursing via email for them to write the order for nursing to apply the splint.

An interview was conducted with Nurse #14 via phone on 04/26/21 at 2:26 PM. Nurse #14 stated she did not recall putting a hand splint on Resident #28 ' s left hand. She stated she did not personally put the splint on her and she did not know if any other staff member applied because she did not check the resident. Nurse #14 confirmed the left-hand splint was a nursing measure and it was up to nursing to apply the left-hand splint as ordered. Nurse #14 stated she should not have signed off on the MAR that the splint was on when she did not apply it or check to see if it was applied.

An interview was conducted with the Director of Nursing (DON) via phone on 04/27/21 at 1:13 PM. The DON reported her expectation of the nursing staff was to ensure that splints were being applied as ordered to help maintain function and increase the ability to use the limb, decrease pain and to prevent the contracture from worsening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Nurse Practitioner interviews, the facility failed to document post dialysis weights as ordered by the physician for 1 of 1 resident reviewed for dialysis (Resident #2). The findings included: Resident #2 was admitted to the facility on 07/27/20 with diagnoses that included, in part: End stage renal disease and anemia in chronic kidney disease. Review of the admission Minimum Data Set assessment for Resident #2 dated 02/29/21 revealed the resident had moderately impaired cognition and received hemodialysis treatment. Physician orders included the following order originally written on 07/29/20 and re-written on 03/12/21: Enter post dialysis weight every evening shift every Monday/Wednesday/Friday. The care plan for Resident #2 dated 3/12/21 documented the following focal areas: 1) "I am scheduled to received hemodialysis 3 times per week at (the dialysis center) due to renal disease with risk for complications such as infection, fluid imbalances, and hemorrhage from dialysis	F 698	F 698 Corrective Action for Affected Residents; For resident #2 On 5/19/21 resident #2 received a pre-dialysis assessment prior to dialysis. Post dialysis weights were documented on 5/19/21 per MD order by floor nurse. Corrective Action for Potentially Affected Residents; All residents receiving dialysis have the potential to be affected by this alleged deficient practice. On 5/25/21, the Unit Manager audited 100% of all dialysis residents to ensure the dialysis orders contained pre-dialysis vital signs prior to dialysis and post dialysis weights to be documented on the Dialysis Communication Form. This was completed on 5/25/21 by Unit Manager. Systemic Changes; On 5/20/21 the Staff Development Coordinator began in-servicing all current dialysis residents. This in-service	5/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 698	Continued From page 52	F 698		

vascular access port"; and 2) "I have a nutritional problem or potential nutritional problem related to poor meal intake, receiving a mechanically altered diet, receiving a therapeutic diet and wounds." The goal was for the resident to have immediate intervention should any signs or symptoms of complications from dialysis occur and to maintain an adequate nutritional status through the next review date. Interventions included, in part, encouragement to attend dialysis and weights per protocol and as needed.

Review of the Dialysis Communication Book for Resident #2 for the months of March and April 2021 revealed there were no post-dialysis weights documented by dialysis on the following dates: 03/01/21, 03/22/21, 03/24/21, 04/05/21, 04/07/21, 04/09/21, 04/12/21 and 04/21/21.

Review of the Medication Administration Record (MAR) for the months of March and April 2021 revealed facility staff had not documented a post-dialysis weight on 03/01/21, 03/03/21, 03/05/21, 03/08/21, 03/10/21, 03/22/21, 03/26/21, 03/31/21, 04/05/21, 04/07/21, 04/09/21, 04/14/21, or 04/16/21.

In an interview with Nurse #4 on 04/21/21 at 3:00 PM she reported each resident who went to dialysis had a dialysis communication book. She stated a pre-dialysis assessment was recorded in the book by facility staff and sent to dialysis with the resident. On return, the staff would get the book from the resident, review the post-dialysis assessment recorded by the dialysis staff and document the residents post dialysis weight on the MAR. She explained this was a scheduled task in the electronic MAR for the evening shift nurse caring for the resident. She stated if the

included the following topics:
" Pre-dialysis vital signs
" Post dialysis weights
" Dialysis Communication Form documentation

The Staff Development Coordinator will ensure that any licensed nurses and agency staff who have not received this training by 5/26/21 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all licensed nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

Quality Assurance;

The Unit Manager will monitor this issue using the Survey Quality Assurance Tool for Monitoring post dialysis weights and pre-dialysis assessments. The monitoring will include reviewing pre-dialysis vital signs and post dialysis weights in the Dialysis Communication Book. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 698	Continued From page 53	F 698		

dialysis unit did not record a post-dialysis weight on the communication sheet then it was the responsibility of the facility staff to weigh the resident or call the dialysis unit to obtain the weight and document the result on the MAR. She could not explain why the post-dialysis weights had not been documented on the MAR.

In an interview with the facility Nurse Practitioner #1 on 04/22/21 at 10:18 AM she stated she was familiar with Resident #2. She explained it was important for the facility to have a post-dialysis weight recorded for the resident because it was a "true" weight. She added because the resident had a poor appetite it was important to have the weight to accurately assess any changes in the resident's nutritional status and to make sure the resident was not losing weight. She expected staff to document the resident's post-dialysis weight after each dialysis visit. She commented the staff at dialysis were supposed to document the weight on the dialysis communication sheet but if they didn't facility staff were to weigh the resident on her return.

In an interview with the Director of Nursing on 04/22/21 at 4:00 PM she stated each resident who received dialysis had a communication book that was sent to dialysis with the resident. Facility staff were to complete a pre-dialysis assessment and dialysis completed the bottom portion of the form. She expected the dialysis staff to take and record a post-dialysis weight on the communication form but if they did not she expected the facility staff to either call dialysis and obtain the weight or weigh the resident and record the finding. She explained it was important for the facility to have "clean" weights to show if the dialysis treatments were working.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 732		5/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 732	Continued From page 55 by: Based on observation and staff interviews the facility failed to post the required nurse staffing information in the facility lobby for three days. Findings included: On Monday, 04/19/21 at 10:45 AM upon entry into the facility the nurse staffing information was observed posted on the wall. The nurse staffing information was dated for Thursday, 04/15/21. In an observation on 04/19/21 at 11:59 AM the nurse staffing information for 04/19/21 was now posted. In an interview on 04/21/21 at 2:30 PM the Scheduler stated that even though she did not work on 04/16/21, 04/17/21 or 04/18/21 it was her responsibility to make sure that the nurse staffing information was posted daily. She indicated that she should have made sure that another staff member would post the information when she was not in the facility. The Scheduler stated that the daily nurse staffing information was important so that the facility could track the number of residents and staff that were in the building on each shift. In an interview on 04/22/21 at 4:10 PM the Director of Nursing (DON) stated that she expected the nurse staffing information to be posted daily. She indicated that the Scheduler, who was responsible for posting the nurse staffing information, was not working on 04/16/21, 04/17/21 or 04/18/21 and that the information had not been posted as required. The DON stated that the posting of the nurse staffing information was important so that families knew their loved ones were being cared for.	F 732	F 732 Corrective Action: The daily staffing records for 5/19/21 were verified and corrected to include all required information accurately. This was performed on 5/19/21 by the Director of Nursing. Corrective Action for Potential Staff Posting Sheets: The Director of Nursing reviewed the Daily Nursing Staff Posting Sheets from 4/15/21 to 4/19/21 to ensure that it included all required information accurately, which includes: " Facility name " Current Date " Total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered Nurses Licensed Nurses Unlicensed Nursing Staff (CNA) " Resident Census The required staffing information is posted daily in a clear and readable format. It is located in a prominent place readily accessible for residents and visitors. This was completed by 05/21/2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 732	Continued From page 56	F 732		

Systemic Changes;

On 5/19/21 the Staff Development Coordination began in servicing the full time, part time and prn RN□s and LPN□s, Administrator, and Nursing Secretary.

Topics included were:

The daily nursing staffing data must be posted daily at the beginning of each shift. The staffing data must include the following components:

" Facility name
" Current Date
" Total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

Registered Nurses
Licensed Nurses
Unlicensed Nursing Staff (CNA)

" Resident Census

The required staffing information is posted daily in a clear and readable format. It is located in a prominent place readily accessible for residents and visitors.

Any in-house staff member who did not receive in-service training by 5/26/21 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 732	Continued From page 57	F 732	Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing will monitor this issue using the Survey Quality Assurance Tool for Monitoring Daily Staffing Sheet. The monitoring will include reviewing Daily Staffing Sheet. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		5/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 755	Continued From page 58 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Consultant Pharmacist interviews the facility failed to accurately document on the Narcotic Count Sheet (declining inventory count sheet for controlled medications) and the Medication Administration Record (MAR) a) the administration of oxycodone (an opioid analgesic) 5 mg (milligram) tablets by inaccurately documenting the Oxycodone 5 mg scheduled dose on the Oxycodone 5 mg as needed narcotic count sheet, b) omitting documentation that a 5 mg dose was removed from the count on 04/11/21 and 04/18/21, c) not dating a dose that was removed, and d) documenting on the narcotic count sheet that oxycodone 5 mg was removed from the inventory on 03/17/21, 03/21/21 and 04/14/21 which did not reflect documentation on the Medication	F 755	F 755 Corrective Action for Affected Residents; For resident # 270 □ Narcotic Count Sheets (Declining Inventory) were reviewed for accuracy and reconciled with MAR to ensure MD orders were followed by the Director of Nursing on 5/26/21. Corrective Action for Potentially Affected Residents; All residents who have orders for a narcotic medication have the potential to be affected by this alleged deficient practice. On 5/26/21, the Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 755	Continued From page 59 Administration Record (MAR) for 1 of 23 residents (Resident #270) whose medications were reviewed. Findings Included. Resident #270 was admitted to the facility on 10/25/16 with active diagnoses to include in part, history of hip fracture, chronic low back pain, and neuropathy. Record review revealed a physician's order dated 08/21/20 for Oxycodone 5 mg tablets, administer one tablet by mouth every four hours as needed for hip fracture. Record review revealed an order dated 09/1/20 for oxycodone one and a half tablets (7.5 mg) give 1.5 tablets by mouth at bedtime for hip fracture for Resident #270. Record review revealed a discontinued order dated 03/15/21 for oxycodone one and a half tablets (7.5 mg) give 1.5 tablets by mouth at bedtime for hip fracture for Resident #270. Record review reveled an order dated 03/15/21 for Oxycodone 5 mg, give 1 tablet by mouth at bedtime for chronic low back pain. 1a.) A review of the Narcotic Count Sheet initiated on 11/10/20 for Resident #270 with a pharmacy label that read; Oxycodone 5 mg, give one tablet by mouth every four hours as needed for hip fracture revealed on 11/27/20, 11/28/20, 11/29/20, 12/02/20, 12/03/20, 12/04/20, 01/18/21, 01/19/21, 01/24/21, 02/09/21, 02/10/21, 02/11/21, and 02/12/21, that one and a half tablets were signed out on the narcotic count sheet to be	F 755	Nursing audited Narcotic Count Sheets (Declining Inventory). This was completed on 5/26/21 to ensure all doses are accounted for. Systemic Changes; On 5/21/21 the Staff Development Coordinator began in-servicing all current licensed nurses and Agency nurses. This in-service included the following topics: " Accurately documenting on the Narcotic Count Sheets (declining inventory count sheet for controlled medications) and the Medication Administration Record (MAR) The Director of Nursing will ensure that any licensed nurse or Agency nurse who has not received this training by 5/28/21 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all licensed nurse and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance; The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Narcotic Count Sheets (declining inventory). The monitoring will include reviewing Narcotic Count Sheets/MAR for reconciliation and accuracy. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 755	Continued From page 60 administered to Resident #270 which did not correlate with the physicians order on the pharmacy label. A review of the MAR from 11/27/20 through 02/12/21 revealed no documentation that Oxycodone 5 mg tablets every four hours as needed for hip pain was administered to Resident #270 for the dates documented on the narcotic count sheet. A review of the MAR from 11/27/20 through 02/12/21 revealed Oxycodone 5 mgs take 1.5 tablets by mouth at bedtime for hip fracture was administered on these dates as evidenced by the nurses initials which indicated the 1.5 tablets were signed out on the as needed dose narcotic count sheet instead of being accurately documented on the narcotic count sheet labeled with the scheduled bedtime dose. A review of the Narcotic Count Sheet initiated on 11/10/20 for Resident #270 with a pharmacy label that read; Oxycodone 5 mg, give one tablet by mouth every four hours as needed for hip fracture revealed on 02/14/21, 02/16/21, 03/17/21, 03/19/21, 03/20/21, 03/21/21, 03/23/21, 03/23-03/29/21, 04/04/21, and 04/14/21 one tablet of Oxycodone 5 mg was signed out each day on the narcotic count sheet to be administered to Resident #270. A review of the MAR from 02/14/21 through 04/14/21 revealed no documentation that Oxycodone 5 mg tablets every four hours as needed for hip pain was administered to Resident #270 for the dates documented on the narcotic count sheet.	F 755	Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 755	Continued From page 61	F 755		

A review of the MAR from 02/14/21 through 02/16/21 revealed oxycodone 1.5 tablets were administered to Resident #270 as evidenced by the nurses initials indicating 1.5 tablets were signed out on the as needed dose narcotic count sheet instead of being accurately documented on the narcotic count sheet labeled with the scheduled bedtime dose.

A review of the MAR from 03/17/21 through 04/14/21 revealed oxycodone 1.5 tablets were administered to Resident #270 as evidenced by the nurses initials indicating 1.5 tablets were signed out on the as needed dose narcotic count sheet instead of being accurately documented on the narcotic count sheet labeled with the scheduled bedtime dose.

A phone interview was conducted on 04/26/21 at 09:08 PM with Nurse #1. She stated she was familiar with Resident #270 and he was on her assignment at that time. She stated he rarely had complaints of pain and received a scheduled dose of oxycodone 5 mgs at bedtime. She stated he could voice his needs, and never asked for the as needed dose of oxycodone. She stated she could attest that she administered his scheduled bedtime dose of oxycodone at night and had not administered the as needed dose, and added, if it was signed out on the wrong sheet then it was documented in error.

A phone interview was conducted on 04/27/21 at 09:44 AM with Nurse #2. She stated she was familiar with Resident #270; however, she did not always work on the med cart. She stated he was oriented to person, place, and time with periods of confusion. She reported he never required the as needed dose of oxycodone, and stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 755	Continued From page 62	F 755		

received a 5 mg scheduled dose every night at bedtime and rarely had complaints of pain. She stated if the narcotic count sheets were inaccurate, it had to be a documentation issue and indicated the medication counts were conducted every shift and the counts have been right or she would have been aware of a discrepancy. She recalled Resident #270 received 1.5 tablets of oxycodone for a while and stated that may have caused documentation errors for some nurses when documenting 1.5 tablets instead of 1 tablet. Nurse #2 stated when the medication order changed, the old order should have been returned to the pharmacy and a new count sheet should have been started with the new dose and instructions which would decrease the chance for documentation errors.

b.) Record review revealed a physician's order dated 03/15/21 for Oxycodone 5 mg tablets, administer one tablet by mouth at bedtime for chronic low back pain.

A review of the MAR dated April 2021 revealed Oxycodone 5 mgs give one tablet by mouth at bedtime for low back pain were initialed as administered to Resident #270 on the MAR on 04/11/21 and 04/18/21.

A review of the Narcotic Count Sheet initiated on 03/30/21 with a pharmacy label that read; Oxycodone 5 mg, give one tablet by mouth at bedtime for chronic low back pain revealed the dose for 04/11/21 and 04/18/21 were not signed out on the narcotic count sheet.

A phone interview was conducted on 04/27/21 at 09:44 AM with Nurse #2 who signed out both doses on 04/11/21 and 04/18/21 on the MAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 755	Continued From page 63	F 755		

She stated she was not in the facility and could not look at the narcotic sheet but if she didn't sign out the scheduled oxycodone dose on the narcotic sheet it was done in error. She attested that Resident #270 received his scheduled bedtime dose as evidenced by her signature on the MAR on 04/11/21 and on 04/18/21.

c) A review of the Narcotic Count Sheet initiated on 11/10/20 for Resident #270 with a pharmacy label that read; Oxycodone 5 mg, give one tablet by mouth every four hours as needed for hip fracture revealed a dose was signed out on the narcotic count sheet by Nurse #2 at 9:00 PM indicating only the month of April with no specific date.

A review of the MAR dated April 2021 revealed no dose of Oxycodone 5 mg tablets every four hours as needed for hip pain was documented as administered at 9:00 PM or any other time as needed to Resident #270 during April 2021.

A review of the MAR dated April 2021 revealed oxycodone 5 mgs give 1 tablet at bedtime for chronic low back pain was administered each night at 9:00 PM to Resident #270 as evidenced by the nurses initials.

A phone interview was conducted on 04/27/21 at 09:44 AM with Nurse #2 who signed out the oxycodone at 9:00 PM in April 2021 with no specific date. She stated she was not in the facility and could not look at the narcotic sheet but if she didn't record a date on the narcotic sheet it was done in error. She attested that Resident #270 received a scheduled bedtime dose at 9:00 PM each night which she administered when she was assigned to his care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 755	Continued From page 64	F 755		

d) A review of the Narcotic Count Sheet initiated on 11/10/20 for Resident #270 with a pharmacy label for Oxycodone 5 mg, give one tablet by mouth every four hours as needed for hip fracture revealed on 03/17/21, two doses were signed out on the narcotic count sheet at 9:00 PM and 10:10 PM, the nurses signatures were not legible.

A review of the MAR dated March 2021 revealed on 03/17/21 at 9:00 PM one tablet of Oxycodone 5 mg, give one tablet at bedtime was administered to Resident #270, no dose was documented as given at 10:10 PM on 03/17/21 on the MAR for the scheduled bedtime dose or the as needed dose for Resident #270.

A review of the Narcotic Count Sheet initiated on 11/10/20 for Resident #270 with a pharmacy label that read; Oxycodone 5 mg, give one tablet by mouth every four hours as needed for hip fracture revealed on 03/21/21, two doses were signed out on the narcotic count sheet at 8:00 PM and 10:41 PM, but the nurse's signatures were not legible.

A review of the MAR dated March 2021 revealed on 03/21/21 at 9:00 PM one tablet of oxycodone 5 mg, give one tablet at bedtime was administered to Resident #270, no dose was documented at 10:41 PM on 03/21/21 on the MAR for the scheduled bedtime dose or the as needed dose for Resident #270.

A review of the Narcotic Count Sheet initiated on 11/10/20 for Resident #270 with a pharmacy label that read; Oxycodone 5 mg, give one tablet by mouth every four hours as needed for hip fracture revealed on 04/14/21 at 9:00 PM, one tablet was signed out on the narcotic count sheet by Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 755	Continued From page 65	F 755		

1 for the as needed dose and one tablet was signed out at the same time at 9:00 PM by Nurse #3 on the scheduled bedtime dose narcotic count sheet. The doses were signed out by two different nurses (Nurse #1 and Nurse # 3) for Resident #270 with the same time and date.

A phone interview was conducted on 04/26/21 at 09:08 PM with Nurse #1. She stated she was familiar with Resident #270 and he was on her assignment at that time. She stated he rarely had complaints of pain and received a scheduled dose of oxycodone 5 mg at bedtime. She stated he could voice his needs, and never asked for the as needed dose of oxycodone. She stated she could attest that she administered his scheduled bedtime dose of oxycodone at night and had not administered the as needed dose, and added, if it was signed out on the wrong sheet then it was documented in error.

A voicemail was left with Nurse #3 on 04/27/21 at 9:00 AM who also documented in error on the narcotic count sheet for the Oxycodone 5 mg as needed dose on 03/17/21, 03/23/21, 03/24/21 and 03/25/21 but no response was received.

An observation of the 100-hall medication cart was conducted on 04/20/21 at 4:30 PM. The surveyor along with Medication Aide #1 reviewed the controlled medications that were stored on the cart for Resident #270. The Narcotic Count Sheets with the Oxycodone 5 mg tablets for the scheduled and the as needed dose reconciled with the medications that were stored on the cart.

A phone interview was conducted on 04/26/21 at 12:47 PM with the facility Consultant Pharmacist. She stated the Director of Nursing was usually

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 755	Continued From page 66 responsible for checking the Narcotic Count Sheets. She indicated she had no suspicion of staff misappropriating medications, and no reports from the facility of Resident #270's Oxycodone not reconciling. She reported it sounded more like a documentation issue and not any type of drug diversion. During an interview on 04/22/21 at 5:32 PM with the Director of Nursing, she stated she had only been employed at the facility for approximately 6 weeks and was not aware of the inaccurate documentation on the narcotic count sheets and MARs and would be reviewing these more frequently. She agreed the documentation was unacceptable and stated she would monitor the narcotic count sheets more frequently to assure documentation was correct. She stated her expectation was for the nursing staff to accurately document narcotic medications on the narcotic count sheet and on the MAR. She indicated accurate documentation on the narcotic count sheet was required to account for the controlled medications.	F 755		
F 761 SS=E	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	F 761		5/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 761	Continued From page 67 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; 1) report an equipment failure of the Pyxis (medication dispensing machine) System in the 300/400 hall medication room which had a broken draw that would not securely close and contained 6 different kinds of medications, and the facility failed to dispose of 2 expired Humalog Insulin Pens, and 1 bottle of expired Acetylcysteine from the refrigerator in 1 of 1 medication rooms observed, and 2) failed to dispose of expired medications in 2 of 2 medication carts observed on the 300/400 hall and 100 hall. Findings included: 1a) An observation of the secured medication room located on the 300/400 hall on 04/20/21 at 4:10 PM revealed the facility Pyxis machine had one draw which was noted to be unsecured. The draw contained 6 separate pockets which held 6 different medications which included 5 packages of Trazodone (an oral antidepressant), 3 bottles	F 761	F 761 Corrective Action for Medication Storage: Pyxsis drawer (medication dispense machine) was repaired by Pharmacy Tech on 4/20/21 All expired medication identified were removed by the Unit Manager on 4/21/21 and disposed of. Medication Dispense cart secured. Corrective Action for Potentially Affected Residents; All residents have the potential to be affected by this alleged deficient practice. On 5/21/21, the Nurse Manager audited all the med carts for expired meds and the medication storage room to ensure no expired medications were present. Also, all carts and med dispense cart were secured. This was completed on 5/21/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 761	Continued From page 68 of Benadryl (an intravenous antihistamine), 5 packages of Metformin (an oral antidiabetic), 5 packages of Simvastatin (an oral cholesterol reducing medication), 5 packages of Olanzapine (an oral antipsychotic), and 5 packages of Aricept (a medication used to slow the progress of Alzheimer ' s). An interview was conducted with Nurse #6 on 04/20/21 at 4:30 PM. Nurse #6 reported she did not know how long the draw on the Pyxis machine had been broken but it had been awhile. She stated she did not know if anyone was aware that it was broken, and she did not report it to anyone. Nurse #6 stated the medication storage room on the 300/400 hall was always locked. Nurse #6 stated only nurses were allowed in the medication storage room and the nurse on duty held on to the keys at all time. An interview was conducted with the Director of Nursing (DON) on 04/20/21 at 4:45 PM. The DON reported she was not aware of the broken draw on the Pyxis dispensing machine in the locked medication room and would have it fixed as soon as possible. An interview was conducted with the Pharmacy Technician on 04/21/21 at 8:45 AM. The Pharmacy Technician reported she had no knowledge of the draw not being able to close on the Pyxis dispensing machine. She stated she had reconciled the medications that were in that draw and they were all accounted for. The Pharmacy Technician added that the draw was now fixed and indicated the machine had been clearly marked with a label for any repair or operational concerns to call the phone number provided for assistance. The Pharmacy	F 761	Systemic Changes: On 5/21/21 the Staff Development Coordinator began in-servicing all current licensed nurses. This in-service included the following topics: " Director of Nursing or designated Nurse Manager will audit the Med Dispense system weekly x4 weeks then monthly x2 for any expired medications " Pharmacy/Director of Nursing will be notified immediately for any dysfunction of the Med Dispense System for repair The Director of Nursing will ensure that any licensed nurses or Agency nurses who has not received this training by 5/24/21 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all licensed nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance; The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring for expired medications. The monitoring will include reviewing the carts, Medication Dispense, and Med Room. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 761	Continued From page 69	F 761		

Technician stated she would have expected the nursing staff to call and report that the draw did not close and needed to be repaired. The Pharmacy Technician stated the technicians that answer the calls could usually trouble shoot and fix the problem over the phone.

1b) During the observation of the secured medication room refrigerator on 04/20/21 at 4:30 PM, there were noted to be 2 Humalog 70/30 Insulin pens that were expired with a date of 08/2020, and a bottle of Acetylcysteine (a liquid medication used to treat pulmonary disorders) 30 milliliter vial which was dated as opened on 03/24/21. The bottle indicated the medication expired 96 hours after opening.

An interview was conducted with Nurse #6 on 04/20/21 at 4:35 PM and she stated the Acetylcysteine was for a resident that no longer resided at the facility. Nurse #6 confirmed the medication expired 4 days after it had been opened and should have been discarded.

An interview was conducted with the Nursing Supervisor on 04/20/21 at 4:40 PM while the refrigerator in the secured medication room was being observed. The Nursing Supervisor stated she checked the refrigerator twice per week and there should be no expired medications in the refrigerator. The Nursing Supervisor confirmed there were two expired 70/30 Humalog Insulin pens dated 08/2020 in the refrigerator, and they should not have been in there and she did not know how she missed it.

1c) An observation of the 300/400 medication cart on 04/20/21 at 4:50 PM with Nurse #6 was conducted. The medication cart was noted to

the Administrator, Director of Nursing, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 761	Continued From page 70	F 761		

have an open bottle of Vitamin D3 2000 iu (international units) which expired on 03/21/21.

An interview with Nurse #6 on 04/20/21 at 5:00 PM revealed the medication cart was checked and cleaned out by the night nurses and she believed it was either nightly or weekly. Nurse #6 stated she would check her medications prior to administering them to a resident for any expirations. Nurse #6 stated she had not administered the Vitamin D3 2000iu on this day to any resident.

An interview was conducted with the DON on 04/27/21 at 1:13PM. The DON stated her expectation of the nurses was to go through their medication carts and the medication rooms each shift to ensure there were no expired medications and all equipment was in working order and not in need of repair. The DON added, she would expect her nursing staff to report any repairs that may be needed to the medication dispensing carts immediately.

2) An observation was conducted on 04/20/21 at 2:30 PM along with Medication Aide #1 of the 100-hall medication cart. The following opened medications were observed with expired dates: Mylanta Maximum Strength Liquid (a nonprescription antacid) used as house stock with an expiration date of 3/2021. Allegra (antihistamine) 180 mg (milligram) tablets used as house stock with an expiration date of 3/2021. Vitamin D3 2000 IU (50 microgram) tablets used as house stock with an expiration date of 3/2021. Aspirin (analgesic) 81 mgs used as house stock with an expiration date of 2/2021. An opened Combivent Inhaler labeled for Resident #50 with a discard date of 12/26/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 761	Continued From page 71 An interview was conducted on 04/20/21 at 2:30 PM with Medication Aide #1. She stated she rotated medication carts each day depending on her assignment, but she thought the nurses checked the carts daily for expired medications. She acknowledged the medications were expired and stated they should have been removed from the cart. Medication Aide #1 reported she had not administered any of the expired medications on this day. During a phone interview on 04/26/21 at 4:39 PM with the Director of Nursing, she stated she hoped to implement new measures moving forward such as a check list and cart audits to assure no expired medications were left on the carts. She indicated her expectation was for expired medications to be discarded and the carts checked routinely for expired medications.	F 761		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by:	F 773		5/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 773	Continued From page 72 Based on staff interview and record review the facility failed to notify the physician or nurse practitioner (NP) of a critical lab value as soon as it was received for 1 of 2 sampled residents (Resident #34) who experienced critical lab values. Findings included: Record review revealed Resident #34 was admitted to the facility on 03/05/19. The resident's documented diagnoses included anemia, chronic kidney disease (stage IV), and skin ulcers. Review of lab results for Resident #34 revealed on 01/28/21 at 4:38 PM the lab called a critical lab result to the facility's Staff Development Coordinator (SDC). "Results were read back to caller." Resident #34's hemoglobin (hgb) was 6.9 grams per deciliter (g/dL) with normal being 12 - 16 g/dL. In her 01/29/21 12:09 AM Health Status Nurse #12 documented, "Notified on-call (physician) of critical lab value (hemoglobin) 6.9. New order to send resident (Resident #34) to ER (emergency room) for follow-up. Resident made aware. Family made aware...." Resident #34's 02/05/21 hospital Discharge Summary documented, "...Hgb 6.4 today. Has received 1 unit PRBCs (packed red blood cells) so far. Will order 2 units to be given today. Nephrology probably going to start Epogen (a medication used to treat a low number of red blood cells caused by chronic kidney disease), but this will take a while to kick in, so may need transfusions b/w (between) now and then. (Family member) requesting a hematology consult as an outpatient to further assess the	F 773	F 773 Corrective Action for Affected Residents; Resident # 34 □ was sent to the hospital related to a critical HCB on 1/29/21. Resident received 3 U PRBC□s on 1/29/21 while in the hospital. HCB obtained on 5/20/21 by lab tech. Current HCB is 8.6. MD aware no new orders. Corrective Action for Potentially Affected Residents; All residents have the potential to be affected by this alleged deficient practice. On 5/25/21 the Nurse Manager audit reported critical labs over the past 30 days. The audit reviewed for identification of critical labs and reporting. This was completed on 05/25/21 by Unit Manager. Systemic Changes; On 5/25/21 the Director of Nursing began in-servicing all current licensed nurses and Agency nurses. This in-service included the following topics: " Critical lab value(s) must be immediately reported to the physician. You must document orders and conversation in EMR. The Director of Nursing will ensure that any licensed nurse or Agency nurse who has not received this training by 5/26/21 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all licensed nurses	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 773	Continued From page 73 anemia." During an interview with the Director of Nursing (DON) and SDC on 04/22/21 at 2:20 PM they reported lab services asked to speak to a nurse in the facility via phone when there was a critical lab. They stated the nurse who received the call from the lab would immediately contact a NP or physician (MD) within 10 minutes of taking the call. They commented if immediate contact was not made with the NP or MD the nurse might get involved in doing something else and forget to initiate the contact. If the lab called after 5:00 PM the DON and SDC reported on-call physician services might have to be utilized. According to the DON, the nurse who received the call from lab services should write a progress note about how the NP or MD wanted the critical lab situation handled. During a telephone interview with Nurse #12 on 04/22/21 at 8:31 PM she stated she thought what happened was that as she started her shift at 7:00 PM on 01/28/21 she picked up faxes, and found lab results documenting Resident #34's hemoglobin was critically low. She stated she followed protocol and immediately reached out to an on-call physician for an order to send the resident to the ER. She explained residents were sent to the hospital when their hemoglobin values were below 7. During a telephone interview with the facility's SDC on 04/23/21 at 11:54 AM she stated Resident #34 had chronic anemia, and her family did not want her sent out to hospital related to anemia (no documentation of such was found in the resident's medical record). The SDC reported she thought she let NP #2 know about Resident	F 773	and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance; The Director of Nursing will monitor this issue using the Survey Quality Assurance Tool for Monitoring Reporting of Critical Labs. The monitoring will include reviewing critical lab value(s), new orders, and documentation. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 773	Continued From page 74 #34's critically low hemoglobin after she received the call. During a telephone interview with NP #2 on 04/23/21 at 12:02 PM she stated she did not remember this specific incident involving a critical lab for Resident #34. However, she stated it was unlikely she was informed of the critical lab because she was in the facility until 5:00 PM daily during that time period, and the rule of thumb she always followed was to immediately send residents out to the hospital when their hemoglobin was below 7. During a telephone interview with the DON on 04/23/21 at 12:22 PM she stated the protocol was to send residents out to the hospital immediately when their hemoglobin was below 7. She reported if a NP or MD wanted something done other than what was outlined in the protocol then her expectation would be that the contacting nurse write a progress note documenting the rationale for not following the protocol. (Review of Resident #34's progress notes revealed the SDC did not write a note after she was notified of Resident #34's critically low hemoglobin on 01/28/21).	F 773		
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	F 812		5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 75 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 interview the facility failed to replace 40 of 48 abraded bowls and to remove grease and dust from 4 of 8 filters above the stove/oven system. The facility also failed to follow labeling instructions regarding storage for 1 of 1 opened food items, to discard 2 of 4 compromised saute/fry pans, and to remove stains from 15 of 40 coffee mugs. Findings included: 1. During an inspection of kitchenware, beginning at 9:49 AM on 04/21/21, 40 of 48 plastic soup and cereal bowls had abraded surfaces on the inside of the bowls. During an interview with the Assistant Dietary Manager (ADM) on 04/22/21 at 4:02 PM she stated dietary staff were trained to dispose of any compromised kitchenware, including items which were cracked, chipped, or abraded. She reported staff were to count the number of items which were discarded and report it to kitchen leadership so replacement items could be ordered. The ADM commented sloughing plastic from abraded soup bowls could contaminate food and cause a possible choking/swallowing hazard for residents.	F 812	F 812 Corrective Action for Affected Equipment; For 40 abraded bowls facility immediately replaced with new bowls already in stock 4/21/21 by Assistant Dietary Manager, Vent Hood Filters were cleaned by Intracoastal Fire Protection Inc. on 4/27/21, Hot Sauce Container was discarded immediately 4/19/21 by Assistant Dietary Manager, 2 Sautee Pans were replaced immediately with pans that were in stock 4/21/21 by Assistant Dietary Manager, 15 stained coffee mugs were immediately soaked to remove stains 4/21/21 by the Assistant Dietary Manager. Corrective Action for Potentially Affected Equipment; All service ware in the Dietary Department has the potential to be affected by this alleged deficient practice. On 5/26/21 the Assistant Dietary Manager audited all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 76 During an interview with Dietary Aide #1 on 04/22/21 at 4:15 PM she stated dietary staff were in-serviced to throw away compromised kitchenware and inform the Dietary Manager (DM) so she could re-order. She reported abraded surfaces were more likely to harbor bacteria which could possibly make residents sick. 2. During initial tour of the kitchen, beginning at 12:12 PM on 04/19/21, 4 of 8 filter panels above the stove/oven system needed to be cleaned. The two filter panels above and nearest the deep fryer were yellowed with grease, and dust had settled on two other filter panels which were coated with oil. During a follow-up tour of the kitchen, beginning at 9:15 AM on 04/21/21, 4 of 8 filter panels above the stove/oven system needed to be cleaned. The two filter panels above and nearest the deep fryer were yellowed with grease, and dust had settled on two other filter panels which were coated with oil. During an interview with the Maintenance Manager (MM) he stated he thought a contracted company cleaned the filters above the stove and ovens quarterly, but he could increase the frequency to ensure the filters remained free from grease, dirt, and dust. During an interview with the Assistant Dietary Manager (ADM) on 04/22/21 at 4:02 PM she stated filters above the stove and ovens should be kept clean and free of dust and grease. She explained dust could contaminate foods being prepared, and grease posed a fire hazard.	F 812	service ware. Systemic Changes; On 05/20/21 the Assistant Dietary Manager began in-servicing all current Dietary Cooks and Dietary Aides. This in-service included the following topics: Food Storage, Labeling & Dating, Monitoring, Beverage Preparation, Beverage Service, Ware washing, Service ware, Abraded/Stained Service ware Quality Assurance; The CDM or Assistant Dietary Manager will monitor this issue using the Survey Quality Assurance Tool for Monitoring checklist for safe food handling. The monitoring will include reviewing all service ware, equipment, labeling/dating. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 77	F 812		

During an interview with Dietary Aide #1 on 04/22/21 at 4:15 PM she stated a contracted company cleaned the stove/oven filters, but she was not sure about the frequency of the cleaning. She reported the dietary staff did not want dust and dirt to fall from the filter system into food being prepared for residents.

3. During initial tour of the kitchen, beginning at 12:12 PM on 04/19/21, an opened container of hot sauce was being stored under a food preparation counter in the kitchen. The label on the hot sauce documented, "Refrigerate After Opening."

During a follow-up tour of the kitchen, beginning at 9:15 AM on 04/21/21, an opened container of hot sauce was being stored under a food preparation counter in the kitchen. Two thirds of the product had already been used. The label on the hot sauce documented, "Refrigerate After Opening."

During an interview with the Assistant Dietary Manager (ADM) on 04/22/21 at 4:02 PM she stated she did not recall having to educate dietary staff about reading food labeling in the past because it had never been an issue. However, she reported staff should follow labeling instructions including "refrigerate after opening." She commented by not refrigerating foods with labeling which recommended refrigeration after opening the facility risked foods spoiling and making residents sick.

During an interview with Dietary Aide #1 on 04/22/21 at 4:15 PM she stated not following labeling instructions about how to store opened

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 78	F 812		

foods compromised food quality and safety.

4. During initial tour of the kitchen, beginning at 12:12 PM on 04/19/21, 2 of 4 fry/saute pans were compromised. The two small saute pans had a non-stick coating which was scratched.

During a follow-up tour of the kitchen, beginning at 9:15 AM on 04/21/21, 2 of 4 fry/saute pans were compromised. The two small saute pans had a non-stick coating which was scratched.

During an interview with the Assistant Dietary Manager (ADM) on 04/22/21 at 4:02 PM she stated even though the small saute pans were rarely used, they should have been disposed of as soon as the non-stick coating was scratched. She reported dietary staff could use the pans to prepare small amounts of food for a single resident, and then there would be the risk that the coating could flake off into the foods being prepared in the pans.

During an interview with Dietary Aide #1 on 04/22/21 at 4:15 PM she stated any kitchenware which was chipped, cracked, scratched, or abraded needed to be disposed of so it would not be used by accident. She reported the flakes of non-stick coating could get into foods being served to residents and pose a contamination and safety risk.

5. During an inspection of kitchenware, beginning at 9:49 AM on 04/21/21, 15 of 40 coffee mugs had dark brown stains on the inside of them.

During an interview with the Assistant Dietary Manager (ADM) on 04/22/21 at 4:02 PM she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 79 stated the facility did not currently have a de-staining program in which kitchenware was soaked to remove stains on a regular basis. During an interview with Dietary Aide #1 on 04/22/21 at 4:15 PM she stated kitchenware should be kept free of stains because the stains were not appetizing and made residents question whether the kitchen used good sanitation skills.	F 812		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, refrigeration technician interview, staff interview, and record review the facility failed to make repairs in the walk-in freezer which caused a build-up of ice along one wall and into the entrance doorway for the past month. Findings included: Invoices from a refrigeration company documented on 02/12/21 new hinges were placed on the door of the walk-in freezer, and the cam lifts were rotated to alleviate the dragging of the freezer door. During initial tour of the kitchen and food storage areas, beginning at 12:12 PM on 04/19/21, ice was found on the floor of the walk-in freezer extending out approximately one and a half feet from the left wall and about an inch into the doorway entry. The ice build-up was approximately two inches deep in places.	F 908	F 908 Corrective Action for Affected Equipment; The condensate drain for the walk-in freezer was reconfigured using all coper fitting and piping. The electric heat strip was added along with insulating and taping the completed drain figuration. Repairs made by Johnny Well, Maintenance/Environmental Services Director on 5/20/21. Corrective Action for Potentially Affected Equipment; All walk-in freezers have the potential to be affected by this alleged deficient practice. However because the facility only has one walk-in freezer, no other walk-in freezers were affected by this	5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 908	Continued From page 80 During a follow-up tour of the kitchen and food storage areas, beginning at 9:15 AM on 04/21/21, ice was found on the floor of the walk-in freezer extending out approximately one and a half feet from the left wall and about two inches into the doorway entry. The ice build-up was approximately two and a half inches deep in places. At this time the Assistant Dietary Manager (ADM) stated she thought the freezer compressor was dripping/leaking during the defrost cycle and the water it produced was freezing over. She reported maintenance was aware of the problem and was supposed to be working on a solution. She commented the ice build-up in the freezer had been going on for a month. According to the ADM, dietary or maintenance had to break up the ice every couple of days. During an interview with the facility's Maintenance Manager (MM) on 04/21/22 at 10:55 AM he stated he had been working on icing issues in the walk-in freezer for about 3 months. He reported he ordered a heat strip which had arrived, but he had not installed it yet. He explained condensation and melting ice generated during defrost cycle was freezing up before it could drain out of the walk-in. He commented the drain was not thawing enough to allow water to escape before it froze over. During a 04/21/21 11:32 AM telephone interview with the refrigeration technician, who was helping the facility with icing problems in the walk-in freezer, he stated he had been asked to evaluate the ice-build up in the freezer about a month ago. He reported he relayed to the facility that the PVC (polyvinyl chloride--synthetic plastic) drain lines needed to be replaced with copper and insulated,	F 908	deficiency. Systemic Changes; On 5/24/21 the Dietary Manager or designee began in-servicing all current dietary staff. This in-service included the following topics: " Dietary Manager or designee will audit the walk-in freezer for ice buildup along the wall, entrance doorway, condensate drain, piping, boxes, or floor. If you see any of the above or presence of dripping water, you should notify the Dietary Manager or Maintenance Director as soon as possible and report these concerns to the Maintenance Log. The Dietary Manager or designee will ensure that any dietary staff who have not received this training by 5/26/21 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all dietary staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance; The Dietary Manager or designee will monitor this issue using the Survey Quality Assurance Tool for monitoring ice buildup along the wall and into the entrance doorway. The monitoring will include reviewing the QA Daily Checklist. This will be completed weekly for 5 days a week for 4 weeks, 1 day a week for 2 months, then monthly for 3 months or until	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 908	Continued From page 81 the freezer drain needed to be "trapped", and heat tape needed to be installed. He commented he had not been contacted yet to actually complete the work. According to the technician, just installing heat tape alone would not fix the problem. During a follow-up interview with the MM on 04/22/21 at 1:03 PM he stated he ordered the heat strip on 04/08/21, it came in last week, and he had not had time to install it yet. He commented he would probably need to do some other modifications in addition to installing the heat strip to prevent ice build-up in the freezer. During an interview with ADM on 04/22/21 at 4:02 PM she stated no dietary residents had experienced any accidents/incidents related to the ice-build up in the walk-in freezer. During an interview with Dietary Aide #1 on 04/22/21 at 4:15 PM she stated the ice build-up in the walk-in freezer had been much worse in the past couple of weeks, but had not caused any accidents/incidents among dietary staff. She reported dietary staff had to move food away from the left wall so the ice would not compromise the quality of the stored food and to avoid ice causing freezer burn.	F 908	resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	