-		ND HUMAN SERVICES					NTED: 12/10/2012 FORM APPROVED
STATEMENT	DEFICENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) M			(X3) DA	B NO. 0938-0391 TE BURVEY MPLETED
		348532	8. WN	KS		11/28/2012	
NAME OF PR	OVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		1 (1/20)20 1/2
LĬBERTY	COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY		31	O COMMERCE DRIVE ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATÉMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFY NG INFORMATION)	IO PREF TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION 3HO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	DATE COMPLETION (VS)
F 164 SS=D	The resident has the confidentiality of his or records.  Personel privacy inclimedical treatment, we communications, permeetings of family andoes not require the room for each resident except as provided in section, the resident except as provided in section, the resident except as provided in section, the resident except as provided in the resident is transferred individual outside the or record of the facility must keep contained in the resident is transferred institution; or record or release is required by healthcare institution; contract, or the resident institution; contract, or the residen	right to personal privacy and or her personal and clinical adeas accommodations, ritten and telephone sonal care, visits, and directed a private at the area of personal and clinical records to any facility.  I paragraph (e)(3) of this may approve or refuse the and clinical records to any facility.  I refuse release of personal oes not apply when the district of the another health care elease is required by law.  I confidential all information lent's records, regardless of tethods, except when the law, third party payment	F	164	Disclaimer The statements made on this correction are not an admission constitute an agreement we alleged deficiency. To recompliance with all federal arregulations, the facility has the will take the actions set forth plan of correction. The correction constitutes the allegation of compliance such alleged deficiency has been of corrected by the date of indicated or by Dec. 26, 2012	n of nor not not the main in the main in the state aken or in this plan of facility's that the r will be r dates volved, been been the with by the eficient w of all and 300 that the sed any it is a DON	
ABORATORY	DIRECTORS OR PROMISER	SUPPLIER REPRESENTATIVE 8 BIGNAYUR	£		1 Ann HRE A A		AN DATE
(J <sup>1</sup> /	TURM M	<u>KUUUY</u>		(	19/DAMANAMOR		10/14/10

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

DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES					D: 12/10/2012 MIAPPROVED	
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					0.0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	(X2) MULTIPLE CONSTRUCTION A BUILDING			(XS) DATE SURVEY COMPLETED	
		345532	B. WIN	(G		11/2	8/2012	
NAME OF PR	OVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, 21P CODE			
HRESTV	- - - กหนุ่งการ มระ งหม	SAR CTR OF LEE COLUMN		1	COMNERCE DRIVE			
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY				SA	NFORD, NC 27330			
(X4) ID Prefix Tag	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER 6 PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE	
F 164	Continued From page hallway information be.  The findings included A review of the facility. "Our residents have exhibited information to contains highly sensition thoughtful and attention who have access to incommitted to protecting privacy and safeguare information."  On 11/28/12 at 10:44 on the 300 hell, locate board included Residiname, room number, required a "Bed Bath" public.  On 11/28/12 at 11:40 Nursing (ADON) walk passed the bulletin becare related information bulletin board for Residination and the safe the bulletin did not identify that care.	o 1  ulletin board.  r privacy policy in part read, and usted their personal and	-	164	Measures put into pla systemic changes made to that the deficient practice of occur. An in-service was conducted an in-service was conducted and in-service was conducted all RNs, LPNs, and FT, PT, and PRN. The specific inservice was sent to Providers whose employe residents care in the fact provide training for staff returning to the facility to care. Any in-house staff who did not receive in training will not be allowed until training has been con The in-service topics increview of the confidentiality and specifically securing information on nurse and CN sheets. This information is	ensure loss not cted on ose who of CNAs, facility Hospice es give polity to prior to provide member asservice to work inpleted haded a y policy private (A report as been standard in the courses will be assurance ange has ented a		
,	#52 and #90. On 11/28/12 at 12:30 on the 300 half "Bed I	pm, during an observation bath" continued posted on in board for Resident #30,	Annah mir sarah managar man dan sakin da da manan man	1	issue using the HIPPA Assurance Tool for monitoring residents protecte information. The monitori include verifying that no p health information is po- bulletin boards with public a	Quality d health ng will protected sted on		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES  MEDICAID SERVICES				RM APPROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDERSUPPLIERICLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		NO, 0938-0391 SURVEY ETEO
		345532	B. WING	·	1 11	/28/2012
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2/P CODE		
LIBERTY	COMMONS HSG AND I	REHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY XUSY BE FRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	iò Prefix Tag	PROVIDER'S PLAN OF CORP (EACH CORRECTIVE ACTION S CROBS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	COMPLETION DATE
F 164	In an interview on 1 ADON and NA #1 in aware that residents so that persons cou each resident requir bulletin board. The expected the inform to have been visible in an interview on 1 Director of Nursing residents received v	1/28/12 at 12:40pm, the adicated that they were not so care information was visible lid read the type of care that red on the 300 hell information ADON concluded that she sation that read "Bed bath" not of or the public view.  1/28/12 at 1:41 pm, the stated care services that which identified residents	F 1	See attached monitoring tool will be completed we four weeks then monthly months or until resolved Of Life/Quality Committee. Reports will the weekly Quality of committee by the Director and corrective action is appropriate. The Quality Committee consists Administrator, Director of Assistant DON, Busing Manager, Dietary Manager,	eekly times times two by Quality Assurance be given to Life- QA of Nursing nitiated as y of Lifa of the of Nursing, ess Office	
F 309 \$S=D	should not be posted on the Information bulletin board.  483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced		F3	Worker, MDS Coordinator		Dec. 26, 2012
					involved, been 180, on d ADON for any	
	by: Based on record re facility failed to adm ordered for 2 of 4 so receiving sliding see #180). Findings inc  1. Review of the fact Mellitus, Guidelines October 1, 2001, re	view and staff interviews, the inister aliding scale insulin as ampled diabetic residents le broulin (residents # 178, lude:  for Nursing Care," dated		Corrective action has accomplished on all residents the potential to be affected alleged deficient practice in the potential have the potentiaffected by the alleged practice. On 11/29/12 the ADON assessed all identifications for any adverse of the alleged deficient	ents with ed by the by: ling scale al to be deficient DON and ied at risk fects from	

		ND HUMAN SERVICES			FORM	): 12/10/2012 1 APPROVED
STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:	(XZ) MULTIPLE CONSTRUCTION A BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY	31	EET ADDRESS, CITY, STATE, ZIP COOE 10 COMMERGE DRIVE ANFORD, NC 27330		, , , , , , , , , , , , , , , , , , ,
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F 309	Continued From page inculin.		f 309	Monitoring Flow Sheet for sliding scale errors; such a	iabetic any s the	
	11/15/12 with multiple diabetes.	·		resident not getting the o amount of insulin. Findings re no adverse reactions noted.		
	physician orders date (fingerstick blood sug and at bedtime. FSB resident's finger for a placed on a strip. The that reads the blood sug and at bedtime. FSB resident's finger for a placed on a strip. The that reads the blood suggested that reads the blood suggested for the place of the final reads the blood suggested for most of the resident's Diabet read in part. "Instruct document glucose tecontrolled or sliding suggested for suggested for suggested for suggested for the resident suggested for the flow suggested for the	ar) monitoring before meals S tests involve sticking the blood sample, which is then e strip goes into a machine sugar level.  ad physician orders dated (short-acting Insulin for ) for FSBS results above //deciliter) according to the e: 81-150 = 0 units, 151-200 4 units, 251-300 = 6 units, 1-400 = 10 units, greater  ic Monitoring Flow Sheet tions - use this form to st results for either diet cale controlled diabetic ntry include the type and ninistered."  at S Diabetic Monitoring Flow S results of 204 on 11/19/12 //20/12 at 8PM, 190 on I 156 on 11/25/12 at 4PM.		Measures put into place systemic changes made to exthat the deficient practice do occur. An in-service was conduct 12/3/12 by the ADON. Those attended all RNs and LPNs, I and PRN. The facility inservice was sent to H. Providers whose employees residents care in the facility returning to the facility to preturning to the facility to preturning to the facility to preturning to the facility to preturn did not receive intraining will not be allowed the until training has been come to discontinued use of current of flowsheet as of 12/21/2012. Immitted the materials will be done medication administration.	ensure es not  ed on te who T, PT, pecific lospice give lity to rior to provide nember service o work pleted neladed diabetic on the	

DEPART	MENT OF HEALTH A	ND HUMAN SERVICES				ED: 12/10/2012 RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				IO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIACATION NUMBER:	(XX) MULY A BUILDIN	TIPLE CONSTRUCTION	(X3) DATE S CONPLI	
		345532	B, WING _		11	/28/2012
	OVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	sı	TREET ADDRESS, CITY, STATE, ZIP COOE 310 COMMERCE DRIVE SANFORD, NC 27330	~_ <del></del>	2012012
(X.1) ID PREFIX TAG	FIX (EACH DERCIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERSICED TO THE AP DEFICIENCY)	KULD BE	(XS) COMPLETION EATE
F 309	gíven.  Review of nursing no 10;52PM revealed For (eliding scale) as ord.  In an interview on 11 stated she was traine assistant director of nurses' initials on the was checked. FSBS silding scale insuling adocumented on the casheet. She stated 'till FSBS results could a Nurse #2 reviewed the stated a blank space scale coverage was silding scale insuling an interview on 11 stated she was orien on the halls. Her traifacility policy for door stated FSBS results flow sheet. If the results flow sheet. If the results flow sheet and in the nurse or blanks on the flow scale insulin was given in an interview on 11 director of nursing (Director of nursing (Dire	sides dated 11/20/12 at SBS results of 408 with "s/s ered."  //28/12 at 2:40PM, nurse # 2 and at onentation by the nursing and other nurses, sident's medication if (MAR) and stated the MAR indicated the FSBS results and the units of administered were diabetic monitoring flow hat's our tool for monitoring." also be in the nursing notes, he diabetic flow sheat and or "zero" indicated no silding given.  //28/12 at 3:42PM, nurse #3 ted when hired by the nurses ining included review of the umenting FSBS. Nurse #3 were charted on the diabetic ident required coverage, the passes what dose of sliding lered. Nurse #3 stated she is of insuling given on the flow sing notes. She stated zeros is sheats indicated no sliding en.	F 30	Sliding scale will be doct well as blood glucose rest of insulin given and initi nurse at that given to information has been interested the standard orientation to in the required in-service courses for all employees reviewed by the Quality Process to verify that the been sustained.	alt, amount als by the ime. This grated into aming and c refresher md will be Assurance	Dec. 26, 2012

		ND HUMAN SERVICES				FORM	D: 12/10/2012 A APPROVED
TATEMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDERSUPPLIERICLIA IDENTIFICATION NUMBER:	(XX) MULTIPLE CONSTRUCTION A BUILDING B, WING			CMB NO. 0938-0391 (XS) DATE SURVEY COMPLETED	
		345532				11/2	8/2012
NAME OF PR	OWDER OR SUPPLIER	M		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1	
LIBERTY	COMMONS NSG AND RU	EHAB CYR OF LEE COUNTY			0 COMMERCE DRIVE ANFORD, NC 27330		
(X4) ID PREFIX YAG	(EACH DEFICIENC	AYEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	₩ BE	COMPLETION DATE
F 309	dose of Insulin was g results and sliding so what I believe is that were documented on well and sent to the p trends. The DON starsults to be docume sheets but the MAR vinsulin had been give.  2. Review of the fact Melitus, Guldelines from Cotober 1, 2001, revidocumenting the adminsulin.  Resident #178 was a 11/16/12 with multiple diabetes.  Review of the resider physician orders date (fingeretick blood sug and at bedtime. FSB resident's finger for a placed on a strip. The that reads the blood sug and review reveal 11/18/12 for Lentus (treatment of diabetes Regular Insulin (short results above 129 mg according to the follor 0 units, 130-160 = 2 mg.)	iven based on the FSBS ale. The DON stated "that's bolicy." The FSBS results the diabetic flow sheets as shysician for evaluation of sted she expected FSBS inted on the diabetic flow was documentation that the sin.  Illy policy titled "Diabetes or Nursing Care," dated ealed no policy for ninistration of sliding scale  dmitted to the facility on e diagnoses including  it's clinical record revealed ad 11/16/12 for FSBS par) monitoring before meals is tests involve sticking the blood sample, which is then e strip goes into a machina sugar level.  led physician orders deted long-acting insulin for c) 20 units at bedtime and t-acting insulin) for FSBS gidL (milligram/deciliter) wing sliding scale: 71-129 = units, 181-200 = 4 units, in-300 = 9 units, 301-350 =	F3	809	The facility has implementality assurance monitor: The Assistant Director of will monitor this issue using Quality Assurance To Monitoring residents who sliding scale insulin for application of sliding scale the MAR (medication admirrecord.) The monitoring will verifying that if the blood indicated sliding scale insumeded, that it was doctording to policy. See monitoring tool. This tool completed weekly times for then monthly times two muntil resolved by Qual Life/Quality Assurance Cor Reports will be given to the Quality of Life-QA committed Director of Nursing and caction initiated as appropriate Quality of Life Committee control that the Administrator, Director Mursing, Assistant DON, Office Manager, Dietary Monitoring as assigned.	Nursing the SSI of for receive propriate le use on histration linclude of sugar alin was numented attached will be attached will be at weeks onths or lity. Of mmittee, weekly ee by the corrective ate. The onsists of ctor of Business Manager,	Dec 26, 20

DEPARŢ	MENT OF HEALTH AI	ND HUMAN SERVICES					ED: 12/10/2012 RM APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					VO. 0938-0391	
•	DF DEFICIENCIES CORRECTION	(X1) PROMDERSUPPLIERICLA IDENTIFICATION NUMBER:	1' '	LOING	LE CONSTRUCTION		(XS) DATE SURVEY COMPLETED	
	•	<b>245532</b>	B. Wi	1¢		11	/28/2012	
NAME OF PR	OVIDER OR SUPPLIER		•	S710	EET ADDRESS, CITY, STATE, ZIP CODE	<del>``</del>		
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		3.	10 COMMERCE DRIVE ANFORD, NC 27330			
0(4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LEC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X3) COMPLETION: DAYE	
F 309	Continued From page	a 6	F	309	, 4			
	The resident's Diabet read in part "instruct document glucose te controlled or sliding stresidents for each e amount of insulin adra Review of the resident Sheet revealed FSBS at 9PM, 136 on 11/27/12 at 4PM, and Review of the flow sh documentation that s given. Review of the documentation that s given.  In an interview on 11 stated she was trained assistant director of the She reviewed the resident administration record nurses' initials on the was checked. FSBS sliding scale insulin a documented on the disheet. She stated 'the FSBS results could a Nurse #2 reviewed the stated a blank space scale coverage was given on the halls. Her trained she was orient on the halls. Her trained she was orient on the halls.	tic Monitoring Flow Sheet tions - use this form to st results for either diet cale controlled diabetic mitry include the type and ministered."  It's Diabetic Monitoring Flow 5 results of 143 on 11/19/12 5/12 at 7AM, 133 on 140 on 11/28/12 at 7AM, eact revealed no liding scale insulin had been nursing notes revealed no liding scale insulin had been nursing and other nurses. Ident's medication (MAR) and stated the MAR indicated the FSBS results and the units of idministered were illabetic monitoring flow nat's our tool for monitoring." Iso be in the nursing notes. We diabetic flow sheet and or "zero" indicated no sliding						
	stated FSBS results	were charted on the diabetic ident required coverage, the		1	•			

DEPART	MENT OF HEALTH A	ND HUMAN SERVICES					D: 12/10/2012
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					M APPROVED O. 0938-0391
	OF DERCIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING	3		11/28/2012	
NAME OF PR	OMDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1112	2012
LIBERTY	H THA DEK ZUDÚKOD	PHAR CTO OF LEE COLINTY			O COMMERCE DRIVE		
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY				SA	NFORD, NC 27330		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(A) COMPLETION DATE
F 309	Continued From page	a 7					
. 550	- a (4), pag.	see what dose of sliding	r.	309			1
		ered. Nurse #3 stated she		İ			<b> </b>
		s of insulin given on the flow					1
		ing notes. She stated zeros					1
		sheets indicated no sliding					
	scale Insulin was give	en.	1				
	<b>(</b>		1				
ŀ		/28/12 at 5:26PM, the	1				Ì
	director of nursing (D	Cala insulin on the MAR.					
	The nurses' initials or						
	dose of insulin was g	iven based on the FSBS		- 1			
	results and sliding so	ale. The DON stated "that's		- 1			
	what I believe is the p	oolicy." The FSBS results		- 1			
		the diabetic flow sheets as					
		hysician for evaluation of		-			
		ited she expected FSBS		Į			
		nted on the diabetic flow was documentation that the					
	insulin had been give			-			
F 425	· ·		l F	425	T coe		
ss≃o			'		F 425		
				l	For the residents invo	olved,	
		ride routine and emergency		l	corrective action has	been	
	-	to its residents, or obtain			accomplished by:		
	them under an agree	ment described in rt. The facility may permit		-	The resident's affected by the		
	<del>-</del>	I to administer drugs if State			undated insulin pens had their		
	law permits, but only	<del>-</del>			discarded and a new pen was in		
	supervision of a licen				on 11/27/12 by hall nurse and D	ON.	
	,				Corrective action has	been	
		e pharmaceutical services			accomplished on all residents	s with	
		that assure the accurate		ļ	the potential to be affected by	y the	1
	acquiring, receiving,				alleged deficient practice by:		
		rugs and biologicals) to meet					j [
	the needs of each res	SIQ8III.			All residents receiving insulin		Ţ <b> </b>
	The facility must own	loy or obtain the services of			flex pen have the potential		
	THE INVESTIGATION OF THE PROPERTY OF THE PROPE	**** *** ***** *** **** **** **** **** ****	1 .	E	areasted by the alleged As	HOME	1

## PRINTED: 12/10/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (XZ) MULTIPLE CONSTRUCTION (X3) DAYE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING 345532 11/28/2012 NAME OF PROVIDER OR SUPPLIER STREET ADORESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY SANFORD, NC 27330 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (XA) OOMPLETKIK (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY Continued From page 8 F 425 practice. On 11/29/12 a review of all a licensed pharmacist who provides consultation med carts was completed by the DON on all aspects of the provision of pharmacy and ADON. The review consisted of corvices in the facility. checking each insulin pen for the date open documentation. Findings were consistent with policy. Measures put into place This REQUIREMENT is not met as evidenced systemic changes made to ensure that the deficient practice does not Based on observation, record review, and staff occur interviews, the facility failed to date opened An in-service was conducted on Lantus and Novotog Insulin pens that were stored 12/3/12 by the ADON. Those who at room temperature located on 1 of 3 medication attended all RNs, LPNs, and CNAs, carts (300 hall medication cert). PT, PT, and PRN. The facility specific in-service was sent to The findings included: Hospice Providers whose employees give residents care in the facility to A review of the facility guideline for insulin storage provide training for staff prior to titled "Recommended Maximum Storage for returning to the facility to provide Insulin" Indicated that novolog insulin flex pen and care. Any in-house staff member lantus solostar insulin pen after opened could be who did not receive in-service stored at room temperature for 28 days. training will not be allowed to work until training has been completed. On 11/27/12 at 11:20 am accompanied by Nurse The in-service topics included review #1, an inspection of the medication card on the of pharmacy recommendation for use 300 hall revealed one lantus insulin pen, and 1 and storage of certain medications. novolog insulin pen both opened with no date. Education was also provided for proper labeling of insulin pens when In an interview on 11/27/12 at 11:58 am, Nurse #1 indicated that insulin pens were usually dated removed from refrigerator. This when opened by the nurse who administered the information has been integrated into insulin initially. Nurse #1 did not know how long the standard orientation training and the insulin pens had been opened. in the required in-service refresher courses for all employees and will be In an interview on 11/27/12 at 3:00 pm, the reviewed by the Quality Assurance Director of Nursing stated she expected insulin Process to verify that the change has

when opened,

pens located on the medication cart to be dated

been sustained.

		ND HUMAN SERVICES			FOR	D: 12/10/2012 M APPROVED
STATEMENT	S FOR MEDICARE & OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:	(X2) MULTIPI	LE CONSTRUCTION	OMB NO. 0938-0391  (A3) DATE SURVEY  COMPLETED  11/28/2012	
		345532	B. WNG			
	ROVIDER OR SUPPLIER COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY	25	EET ADDRESS, CITY, STATE, ZIP CODE 10 COMMERCE DRIVE ANFORD, NC 27330	, ,,,,	WEU 12
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL (SC )DENTIPYING INFORMATION)	io Prefix Yag	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD RE	COMPLETION DATE
				The facility has implemed quality assurance monitor: The Assistant Director of will monitor this issue may clinical Quality Assurance Monitoring residents who insulin via a flex pen, monitoring will include verified flex pens on the med of documentation of the date was put into use. This took completed weekly times for then monthly times two mountil resolved by Qualife/Quality Assurance Confector of Nursing and condition initiated as appropriated Quality of Life Committee control i	Nursing Sing the Tool for receive The ying that and have the pen will be ur weeks onths or lity of manittee. Weekly see by the corrective te. The maists of tor of Manager, Worker,	Dec. 26, 201

GES Jan. 22. 2013 11:23AM

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/02/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR' COMPLETE A BUILDING 01 - MAIN BUILDING				
		345532	B. WI	1G_	IAN 2	2 2013 <b>12/</b> 1	8/2012
	ROVIDER OR SUPPLIER COMMONS NSG AN	D REHAB CTR OF LEE COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27330				
(X4) ID PREFIX TAG	(EACH DEFIGIENC)	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000 K 061 SS=F	conducted as per Tat-42CFR 483.70(a Care section of the publications. This because story, with a consystem.  The deficiencies deare as follows: NFPA 101 LIFE SAR Required automatic valves supervised as	ode(LSC) survey was the Code of Federal Register ); using the 2000 New Health LSC and its referenced pullding is Type V construction, emplete automatic sprinkler etermined during the survey after CODE STANDARD as sprinkler systems have so that at least a local alarm e valves are closed. NFPA			Disclaimer The statements made on this correction are not an admission constitute an agreement with the deficiency. To remain in compliant all federal and state regulations, the has taken or will take the actions a in this plan of correction. The correction constitutes the allegation of compliance such the allegation of compliance such the allegation of compliance such the surface of the corrected by the date or dates indictionally stated by the date or dates indictionally stated by the gate valve identified without at for the sprinkler has been outfitted the tamper. Compliance has been achiliance in the sprinkler has been achilianc	of nor alleged co with efacility efacility's nat the will be ated or effective comper with a	
K 067 SS=D	42 CFR 483.70 By observation on noon the following was non-compliant gate valve was with accelerator. A dist be provided to indicimpair the satisfact system. NFPA 72, NFPA 101 LIFE SATING With the provisions in accordance with	is not met as evidenced by:  12/18/12 at approximately automatic sprinkler system, specific findings include a nout a tamper to the sprinkler incive supervisory signal shall cate a condition that would ory operation of the sprinkler 9.7.2.1  IFETY CODE STANDARD  , and air conditioning comply of section 9.2 and are installed the manufacturer's 2, 18.5.2.1, 18.5.2.2, NFPA	Ķ (	067	Corrective action has accomplished on all residents we potential to be affected by the deficient practice by: The gate valve identified without a life for the sprinkler has been outfitted without a life for the sprinkler has been outfitted without a life for the sprinkler has been achied January 11, 2013  Measures put linto place or synchanges made to ensure that the deficient practice do occur. This was the only gate valve is without a tamper for the substance of the substance monitors.  The facility has implemented a assurance monitors. Maintenance Director will compliance while doing sprinkler on weekly rounds report to the industry of Life (Quality improdumented) Meeting that gate valve place.	alleged amper with a eved  /stemic  es not  lentified prinkler  quality  assure checks vionthly vement	
ADODATOR	V DIDEAYAble on Books	PERISTIPP) IER REPRESENYATIVE'S SIG	TATIOE		TITLE (	`	(X6) DATE

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.

Facility (D: 880156

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A BUILDING 01 - MAIN BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	Ð. WII	iG		12/	18/2012	
	ROVIDER OR SUPPLIER COMMONS NSG A	ND REHAB CYR OF LEE COUNTY	<del></del>	31	EET ADDRESS, CITY, STATE, ZIP CODE 10 COMMERCE DRIVE ANFORD, NG 27330			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DAYE	
K 067	This STANDARD 42 CFR 483.70 By observation on noon the following Conditioning (HVA specific findings in	is not met as evidenced by:  12/18/12 at approximately Heating, Ventilation, and Air C) system was non-compliant, clude duct detector sampling covering the intake holes. (attic	. K (	067	For the residents involved, compaction has been accomplished by: The dust and lint on the sampling tut the HVAC system; the air handling usecessible from the laundry access of and just on the other side of the hatch the smoke wall has been cleared.  Corrective action has accomplished on all residents with potential to be affected by the addictent practice by: All sampling tubes for HVCA system checked and cleaned of any dust or of January 11, 2013  Measures put into place or system deficient practice does not occur.  Maintenance Director has added sampling tubes of HVAC system quarterly checklist.  The facility has implemented a assurance monitor: Maintenance Director will submit or ounds report to the Monthly Qualit (Quality Improvement Committee) confirming that sampling tubes had cleaned.	be for nit door hat been the the lieged s were lint as stemic at the cleaning to the quality y of Life Meeting	January 11, 201	