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

PRINTED: 12/10/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	11/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to secure care related information by posting residents' name, room number and the type of care services required for 3 of 3 residents (Resident #30, #52, #90) on the	F 164	**Disclaimer** The statements made on this plan of correction are not an admission of nor constitute an agreement with the alleged deficiency. 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 the alleged deficiency has been or will be corrected by the date or dates indicated or by Dec. 26, 2012 **F164** **For the residents involved, corrective action has been accomplished by:** Resident's # 30, 52 and 90, the information displaying the type of bath the residents were to receive was pulled down from the bulletin board by the ADON on 11/28/12. **Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:** All residents have the potential to be affected by the alleged deficient practice. On 11/28/12, a review of all bulletin boards on 100, 200 and 300 halls was conducted to ensure that the nursing facility has not exposed any protected health information. This review was completed by the DON and ADON and no negative findings were noted.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Andrews — TITLE: Administrator — (X6) DATE: 12/19/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 hallway information bulletin board. The findings included: A review of the facility privacy policy in part read, "Our residents have entrusted their personal and clinical information to us. This information contains highly sensitive material and requires thoughtful and attentive management by those who have access to it. The nursing facility is committed to protecting our residents' right to privacy and safeguarding their protected health information." On 11/28/12 at 10:44 am during an observation on the 300 hall, located on the information bulletin board included Residents' #30, #52 and #90 name, room number, and that each resident required a "Bed Bath" that could be viewed by the public. On 11/28/12 at 11:40 am the Assistant Director of Nursing (ADON) walked down the 300 hall passed the bulletin board and did not identify that care related information was posted on the bulletin board for Resident #30, #52 and #90. On 11/28/12 at 11:45 am, Nursing Assistant (NA) #1 passed the bulletin board on the 300 hall and did not identify that care related information was posted on the bulletin board for Resident #30, #52 and #90. On 11/28/12 at 12:30 pm, during an observation on the 300 hall "Bed bath" continued posted on the information bulletin board for Resident #30, #52 and #90.	F 164	**Measures put into place or systemic changes made to ensure that the deficient practice does not occur** An in-service was conducted on 12/3/12 by the ADON. Those who attended all RNs, LPNs, and CNAs, FT, PT, and PRN. The facility specific inservice was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included a review of the confidentiality policy and specifically securing private information on nurse and CNA report sheets. 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 Quality Assurance Process to verify that the change has been sustained. **The facility has implemented a quality assurance monitor:** The Assistant DON will monitor this issue using the HIPPA Quality Assurance Tool for monitoring residents protected health information. The monitoring will include verifying that no protected health information is posted on bulletin boards with public access.	

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	345592	A. BUILDING _____ B. WING _____	11/28/2012

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F 164	Continued From page 2 In an interview on 11/28/12 at 12:40pm, the ADON and NA #1 indicated that they were not aware that residents' care information was visible so that persons could read the type of care that each resident required on the 300 hall information bulletin board. The ADON concluded that she expected the information that read "Bed bath" not to have been visible for the public view. In an interview on 11/28/12 at 1:41 pm, the Director of Nursing stated care services that residents received which identified residents should not be posted on the information bulletin board.	F 164	See attached monitoring tool. This tool will be completed weekly times four weeks then monthly times two months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the weekly Quality of Life- QA committee by the Director of Nursing and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Business Office Manager, Dietary Manager, Social Worker, MDS Coordinator and others as assigned.	
F 309 SS=D	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 by: Based on record review and staff interviews, the facility failed to administer sliding scale insulin as ordered for 2 of 4 sampled diabetic residents receiving sliding scale insulin (residents # 178, #180). Findings include: 1. Review of the facility policy titled "Diabetes Mellitus, Guidelines for Nursing Care," dated October 1, 2001, revealed no policy for documenting the administration of sliding scale	F 309	**F309** **For the residents involved, corrective action has been accomplished by:** For resident's # 178 and 180, on 11/29/12 the DON and ADON assessed both residents for any adverse reactions from the alleged deficient practice. No adverse reactions were noted. **Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:** All residents receiving sliding scale insulin have the potential to be affected by the alleged deficient practice. On 11/29/12 the DON and ADON assessed all identified at risk residents for any adverse effects from the alleged deficient practice.	Dec. 26, 2012

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F 309	Continued From page 3 insulin. Resident #180 was admitted to the facility on 11/15/12 with multiple diagnoses including diabetes. Review of the resident's clinical record revealed physician orders dated 11/15/12 for FSBS (fingerstick blood sugar) monitoring before meals and at bedtime. FSBS tests involve sticking the resident's finger for a blood sample, which is then placed on a strip. The strip goes into a machine that reads the blood sugar level. Record review revealed physician orders dated 11/15/12 for Novolog (short-acting insulin for treatment of diabetes) for FSBS results above 150 mg/dL (milligram/deciliter) according to the following sliding scale: 81-150 = 0 units, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, greater than 401 = 12 units. The resident's Diabetic Monitoring Flow Sheet read in part: "instructions - use this form to document glucose test results for either diet controlled or sliding scale controlled diabetic residents...for each entry include the type and amount of insulin administered." Review of the resident's Diabetic Monitoring Flow Sheet revealed FSBS results of 204 on 11/19/12 at 9:30PM, 310 on 11/20/12 at 8PM, 190 on 11/21/12 at 4PM, and 156 on 11/25/12 at 4PM. Review of the flow sheet revealed no documentation that sliding scale insulin had been given. Review of the nursing notes revealed no documentation that sliding scale insulin had been	F 309	Assessment included a review of the residents current MAR and Diabetic Monitoring Flow Sheet for any sliding scale errors; such as the resident not getting the ordered amount of insulin. Findings revealed no adverse reactions noted. **Measures put into place or systemic changes made to ensure that the deficient practice does not occur** An in-service was conducted on 12/3/12 by the ADON. Those who attended all RNs and LPNs, , FT, PT, and PRN. The facility specific inservice was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included discontinued use of current diabetic flowsheet as of 12/21/2012. Diabetic monitoring will be done on the medication administration record.	

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F 309	Continued From page 4 given. Review of nursing notes dated 11/20/12 at 10:52PM revealed FSBS results of 408 with "s/s (sliding scale) as ordered." In an interview on 11/28/12 at 2:40PM, nurse # 2 stated she was trained at orientation by the assistant director of nursing and other nurses. She reviewed the resident's medication administration record (MAR) and stated the nurses' initials on the MAR indicated the FSBS was checked. FSBS results and the units of sliding scale insulin administered were documented on the diabetic monitoring flow sheet. She stated "that's our tool for monitoring." FSBS results could also be in the nursing notes. Nurse #2 reviewed the diabetic flow sheet and stated a blank space or "zero" indicated no sliding scale coverage was given. In an interview on 11/28/12 at 3:42PM, nurse #3 stated she was oriented when hired by the nurses on the halls. Her training included review of the facility policy for documenting FSBS. Nurse #3 stated FSBS results were charted on the diabetic flow sheet. If the resident required coverage, the MAR was checked to see what dose of sliding scale insulin was ordered. Nurse #3 stated she documented the units of insulin given on the flow sheet and in the nursing notes. She stated zeros or blanks on the flow sheets indicated no sliding scale insulin was given. In an interview on 11/28/12 at 5:26PM, the director of nursing (DON) stated the staff documented sliding scale insulin on the MAR. The nurses' initials on the MAR indicated the	F 309	Sliding scale will be documented as well as blood glucose result, amount of insulin given and initials by the nurse at that given time. 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 Quality Assurance Process to verify that the change has been sustained.	Dec. 26, 2012

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F 309	Continued From page 5 dose of insulin was given based on the FSBS results and sliding scale. The DON stated "that's what I believe is the policy." The FSBS results were documented on the diabetic flow sheets as well and sent to the physician for evaluation of trends. The DON stated she expected FSBS results to be documented on the diabetic flow sheets but the MAR was documentation that the insulin had been given. 2. Review of the facility policy titled "Diabetes Mellitus, Guidelines for Nursing Care," dated October 1, 2001, revealed no policy for documenting the administration of sliding scale insulin. Resident #178 was admitted to the facility on 11/16/12 with multiple diagnoses including diabetes. Review of the resident's clinical record revealed physician orders dated 11/16/12 for FSBS (fingerstick blood sugar) monitoring before meals and at bedtime. FSBS tests involve sticking the resident's finger for a blood sample, which is then placed on a strip. The strip goes into a machine that reads the blood sugar level. Record review revealed physician orders dated 11/16/12 for Lantus (long-acting insulin for treatment of diabetes) 20 units at bedtime and Regular Insulin (short-acting insulin) for FSBS results above 129 mg/dL (milligram/deciliter) according to the following sliding scale: 71-129 = 0 units, 130-160 = 2 units, 161-200 = 4 units, 201-250 = 6 units, 251-300 = 9 units, 301-350 = 12 units, 351-400 = 15 units.	F 309	**The facility has implemented a quality assurance monitor:** The Assistant Director of Nursing will monitor this issue using the SSI Quality Assurance Tool for Monitoring residents who receive sliding scale insulin for appropriate documentation of sliding scale use on the MAR (medication administration record.) The monitoring will include verifying that if the blood sugar indicated sliding scale insulin was needed, that it was documented according to policy. See attached monitoring tool. This tool will be completed weekly times four weeks then monthly times two months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the weekly Quality of Life- QA committee by the Director of Nursing and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Business Office Manager, Dietary Manager, Social Worker, MDS Coordinator and others as assigned.	Dec 26, 2012

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F 309	Continued From page 6 The resident's Diabetic Monitoring Flow Sheet read in part: "instructions - use this form to document glucose test results for either diet controlled or sliding scale controlled diabetic residents...for each entry include the type and amount of insulin administered." Review of the resident's Diabetic Monitoring Flow Sheet revealed FSBS results of 143 on 11/19/12 at 9PM, 136 on 11/25/12 at 7AM, 133 on 11/27/12 at 4PM, and 140 on 11/28/12 at 7AM. Review of the flow sheet revealed no documentation that sliding scale insulin had been given. Review of the nursing notes revealed no documentation that sliding scale insulin had been given. In an interview on 11/28/12 at 2:40PM, nurse # 2 stated she was trained at orientation by the assistant director of nursing and other nurses. She reviewed the resident's medication administration record (MAR) and stated the nurses' initials on the MAR indicated the FSBS was checked. FSBS results and the units of sliding scale insulin administered were documented on the diabetic monitoring flow sheet. She stated "that's our tool for monitoring." FSBS results could also be in the nursing notes. Nurse #2 reviewed the diabetic flow sheet and stated a blank space or "zero" indicated no sliding scale coverage was given. In an interview on 11/28/12 at 3:42PM, nurse #3 stated she was oriented when hired by the nurses on the halls. Her training included review of the facility policy for documenting FSBS. Nurse #3 stated FSBS results were charted on the diabetic flow sheet. If the resident required coverage, the	F 309		

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F 309	Continued From page 7 MAR was checked to see what dose of sliding scale insulin was ordered. Nurse #3 stated she documented the units of insulin given on the flow sheet and in the nursing notes. She stated zeros or blanks on the flow sheets indicated no sliding scale insulin was given. In an interview on 11/28/12 at 5:26PM, the director of nursing (DON) stated the staff documented sliding scale insulin on the MAR. The nurses' initials on the MAR indicated the dose of insulin was given based on the FSBS results and sliding scale. The DON stated "that's what I believe is the policy." The FSBS results were documented on the diabetic flow sheets as well and sent to the physician for evaluation of trends. The DON stated she expected FSBS results to be documented on the diabetic flow sheets but the MAR was documentation that the insulin had been given.	F 309		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of	F 425	F 425 For the residents involved, corrective action has been accomplished by: The resident's affected by the two undated insulin pens had their pens discarded and a new pen was initiated on 11/27/12 by hall nurse and DON. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: All residents receiving insulin via a flex pen have the potential to be affected by the alleged deficient	

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F 425	Continued From page 8 a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to date opened Lantus and Novolog insulin pens that were stored at room temperature located on 1 of 3 medication carts (300 hall medication cart). The findings included: A review of the facility guideline for insulin storage titled "Recommended Maximum Storage for Insulin" indicated that novolog insulin flex pen and lantus solostar insulin pen after opened could be stored at room temperature for 28 days. On 11/27/12 at 11:20 am accompanied by Nurse #1, an inspection of the medication cart on the 300 hall revealed one lantus insulin pen, and 1 novolog insulin pen both opened with no date. In an interview on 11/27/12 at 11:58 am, Nurse #1 indicated that insulin pens were usually dated when opened by the nurse who administered the insulin initially. Nurse #1 did not know how long the insulin pens had been opened. In an interview on 11/27/12 at 3:00 pm, the Director of Nursing stated she expected insulin pens located on the medication cart to be dated when opened.	F 425	practice. On 11/29/12 a review of all med carts was completed by the DON and ADON. The review consisted of checking each insulin pen for the date open documentation. Findings were consistent with policy. **Measures put into place or systemic changes made to ensure that the deficient practice does not occur** An in-service was conducted on 12/3/12 by the ADON. Those who attended all RNs, LPNs, and CNAs, FT, PT, and PRN. The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included review of pharmacy recommendation for use and storage of certain medications. Education was also provided for proper labeling of insulin pens when removed from refrigerator. 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 Quality Assurance Process to verify that the change has been sustained.	

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			The facility has implemented a quality assurance monitor: The Assistant Director of Nursing will monitor this issue using the Clinical Quality Assurance Tool for Monitoring residents who receive insulin via a flex pen. The monitoring will include verifying that all flex pens on the med card have documentation of the date the pen was put into use. This tool will be completed weekly times four weeks then monthly times two months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the weekly Quality of Life-QA committee by the Director of Nursing and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Business Office Manager, Dietary Manager, Social Worker, MDS Coordinator and others as assigned.	Dec. 26, 2012

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	345532	A. BUILDING 01 - MAIN BUILDING B. WING _____ JAN 22 2013	12/18/2012

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LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 New Health Care section of the LSC and its referenced publications. This building is Type V construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	F000 Disclaimer The statements made on this plan of correction are not an admission of nor constitute an agreement with the alleged deficiency. 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 the alleged deficiency has been or will be corrected by the date or dates indicated or January 17, 2013	
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 By observation on 12/18/12 at approximately noon the following automatic sprinkler system was non-compliant, specific findings include a gate valve was without a tamper to the sprinkler accelerator. A distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. NFPA 72, 9.7.2.1	K 061	K061 For the residents involved, corrective action has been accomplished by: The gate valve identified without a tamper for the sprinkler has been outfitted with a tamper. Compliance has been achieved January 11, 2013 Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: The gate valve identified without a tamper for the sprinkler has been outfitted with a tamper. Compliance has been achieved January 11, 2013 Measures put into place or systemic changes made to ensure that the deficient practice does not occur This was the only gate valve identified without a tamper for the sprinkler accelerator. The facility has implemented a quality assurance monitor: Maintenance Director will assure compliance while doing sprinkler checks on weekly rounds report to the Monthly Quality of Life (Quality Improvement Committee) Meeting that gate valves are in place.	
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A	K 067		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nilda Andrews — TITLE: Administrator — (X6) DATE: Jan. 17, 2013

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.

DRS

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING 01 - MAIN BUILDING B. WING _____	12/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

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K 067	Continued From page 1 This STANDARD is not met as evidenced by: 42 CFR 483.70 By observation on 12/18/12 at approximately noon the following Heating, Ventilation, and Air Conditioning (HVAC) system was non-compliant, specific findings include duct detector sampling tube had lint/dust covering the intake holes. (attic access near the nurses station)	K 067	K067 **For the residents involved, corrective action has been accomplished by:** The dust and lint on the sampling tube for the HVAC system; the air handling unit accessible from the laundry access door and just on the other side of the hatch at the smoke wall has been cleared. **Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:** All sampling tubes for HVCA systems were checked and cleaned of any dust or lint as of January 11, 2013 **Measures put into place or systemic changes made to ensure that the deficient practice does not occur** Maintenance Director has added cleaning sampling tubes of HVAC system to the quarterly checklist. **The facility has implemented a quality assurance monitor:** Maintenance Director will submit quarterly rounds report to the Monthly Quality of Life (Quality Improvement Committee) Meeting confirming that sampling tubes have been cleaned.	January 11, 201