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 _____	01/16/2014

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 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility failed to do a gradual dose reduction recommended by the pharmacist for 1 of 5 residents (Resident# 123) reviewed for a dose reduction by the physician agreeing to the dose reduction but failing to write an order. The findings included: Resident #123 was admitted to the facility on	F 329	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. **F 329** **Corrective Action for Resident Affected** For resident # 123, Dr. Pence was contacted for an order to decrease the Reglan dose to QD. The order was then transcribed to the MAR to be carried out. This was completed by DON on 1-17-14. The order was not changed due to abdominal discomfort of the resident and her refusal to have it changed. **Corrective Action for Resident Potentially Affected** All residents have the potential to be affected by the alleged deficient practice. On 1-27-14 a complete chart audit was initiated for all current residents for pharmacy recommendations that have not been carried out. This will be completed by reviewing the last six months of pharmacy notes and recommendations and comparing them to the most recent physician's orders. Any discrepancies noted will be reconciled by contacting the	2-7-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: J. Gabriel Jenn. | TITLE: ADMINISTRATOR | (X6) DATE: 1/31/14

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 329	Continued From page 1 4/21/11 with multiple diagnoses including dysphasia, and gastro pareses. A review of the resident ' s most recent Medication Administration Record dated January 2014 revealed Resident #123 received Reglan 5 milligrams (mg) 1 tablet by mouth twice a day. Review of the pharmacy notes dated 7/19/13 revealed the last gradual dose reduction for Reglan 5 mg twice a day was in February 2013. There were no problems noted per nurse ' s notes and the pharmacist requested the physician evaluate for a dose reduction. Review of the pharmacy notes dated 10/15/13 revealed there was no response noted for the Reglan gradual dose reduction for the 7/19/13 recommendation. Review of the pharmacy notes dated 11/15/13 revealed there had been no response to the gradual dose reduction. A memo from the pharmacist recommendation 7/19/13 was resent on 10/15/13. A review of the pharmacy notes dated 12/19/13 revealed the physician agreed to the pharmacy consult to decrease Reglan 5 mg twice a day to Reglan 5 mg once a day. Review of Resident #123's medical record revealed medication administration records from 7/19/13 documented Resident #123 continued receiving Reglan 5 mg twice a day until 1/16/14. During an interview on 1/16/14 at 10:15 am with the Director of Nursing (DON) she stated the physician did agree to the dose reduction but	F 329	attending physician. The chart audit was completed by the Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator on 1-30-14)**(See Attachment #1 for findings.)** **Systemic Changes** The QA Nurse Consultant discussed with the Consultant Pharmacist on 01/24/14 the need for notifying the Director of Nursing monthly after each pharmacy audit of any pharmacy recommendations that have not been carried out from the previous month's audit. This will documented on QA Form and will begin with the February 2014 visit and will be an on-going process. In addition to this, the process for reconciling the monthly pharmacy review report was discussed with the Director of Nursing on 01/27/14 by the QA Nurse Consultant. **See Attachment #2.** In addition to this, on 1-28-14 in-service training began for all full-time, part-time and PRN Nurses by the Staff Development Coordinator on the following: Daily the physician's rounds book should be checked for signed pharmacy consult recommendations by the 7-3 and 3-11 nurses before the end of your shift. When a signed recommendation is received, if the MD agrees with the recommendation then a telephone order will be written, the new order noted on the appropriate Medication or Treatment Administration Record and the new order faxed to the pharmacy. A copy of the signed recommendation is then placed in the Director of Nursing's box for review and the original filed in the	

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F 329	Continued From page 2 failed to write an order. When the pharmacist does her notes the facility staff do not read always review all the notes. The pharmacist failed to write her recommendation on the correct form. When the pharmacist did write the recommendation the physician did agree but he failed to write the order and the dose reduction did not occur.	F 329	resident's chart under consults. If the recommendation is declined, then the original recommendation is filed in the chart under consults and a copy is placed in the Director of Nursing's box for review. Any in-house Nurse who did not receive in-service training will not be allowed to work after **02/07/14** until training has been completed. The Staff Development Coordinator will ensure this. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The QA Nurse Consultant will monitor this issue using the "Survey Quality Assurance Tool for Monitoring Pharmacy Consults. **See Attachment # 3.**The monitoring will include verifying that the monthly pharmacy review report recommendations were carried out as outlined above. This will be completed on a sample of 10 resident's a month for 3 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,	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain sanitary conditions in the kitchen by failing to clean the face of a floor fan blowing towards the dish machine drying area, and dietary staff wash hands before going from soiled to clean dishware when operating the dish machine to prevent cross contamination of dishware. The findings include: The facility policy for Sanitation, Ware Washing reads: Policy: All service ware, pots, pans and utensils are to be cleaned and sanitized.	F 371		

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F 371	Continued From page 3 Dishwashing-Machine Operation Check each rack as it comes out of the machine for soiled items Check temperatures and pressures (record temperatures at each washing period) after each meal) · Air-dry all items · Keep your dishwashing machine in good repair During the initial tour on 1/14/14 at 10:40 AM the dish machine area was observed. A large industrial floor stand fan was observed standing near the dish machine pointed towards the empty dish machine blowing on the drying shelf. The front of the fan cage was observed covered with gray dust particles and one dust bunny cluster ¼ inch size in diameter. During the dish machine observation on 1/15/14 at 9:38 AM the industrial floor stand fan was observed standing near the dish machine pointed and blowing towards the dish machine drying shelf. A rack of clean trays and one rack of clean insulated dome lids were observed on the dish machine drying shelf with the dirty fan blowing towards the drying shelf. During an interview on 1/15/14 at 9:51 the Certified Dietary Manager stated " No it should not blow onto clean dishes, I will call the maintenance man right now to remove the fan. " During the dish machine observation on 1/15/14 at 9:38 AM the dietary staff was observed loading dirty trays on a rack. The staff was observed to move from the dirty dishware to pull clean dishware out of the dish machine without washing her hands between. At 9:40 AM the staff was	F 371	Dietary Manager and Social Worker. **F371** **Corrective Action for Resident Affected** Fan was cleaned and removed from area and repositioned to not blow on clean dishes on 1-15-14 by Dietary Manager and Maintenance Man, respectively. Also, on 1-15-14, affected dish rack was immediately run through dishwasher again, and staff member retrained to wait for appropriate staff member with clean hands to remove clean dishes from dishwasher, or to remove gloves and wash hands between handling of dirty dishes and of clean dishes when necessary to do so. **Corrective Action for Resident Potentially Affected** All residents have the potential to be affected by the alleged deficient practice. The corrective action taken for any single resident possibly affected also serves as the corrective action taken for all residents possibly affected. **Systemic Changes** The Dietary Manager and Dietary Consultant developed the Dietary QA Audit Form **(attached)** to document daily checks to assure that staff follow the Dish Machine Ware Washing Process and Proper Hand Washing and the Cleanliness of Fans in Kitchen. This began on 1-20-14. In addition to this, on 1-23-14 in-service training **(presentation notes attached)** began for all full-time, part-time and PRN dietary staff by the Dietary Manager on the following:	2-7-14

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F 371	Continued From page 4 observed using a dirty rack to push a clean rack of dishes out and used her hand to pull the clean dishware out of the dish machine without washing her hands when moving from the dirty to clean side. During an interview on 1/15/14 at 9:43 AM the dietary staff stated that " the third person is supposed to pull the dishes out of the machine, I am just quick today. No, I was not trained that way. " During an interview with the CDM on 1/15/14 at 9:58 AM he stated, " Staff all know what each position is on the dish line and how to wash dishes. She needs to wait for the third person to pull the clean dishes out. She is just in a hurry today and will have to slow down. After you leave I will go out and tell them to wait for the third person to pull the clean dishes out of the dish machine. "	F 371	Maintaining Sanitary Conditions during Ware Washing, Including Dishwasher Operation; Kitchen Fans; and Handwashing. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all dietary staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Staff will not be able to work after 2-7-14 without this training. **Quality Assurance** The Dietary QA Audit Form **(attached)** that documents daily checks to assure that staff follow the Dish Machine Ware Washing Process and Proper Hand Washing and the Cleanliness of Fans in Kitchen 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.	
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by:	F 428	**F428** **Corrective Action for Resident Affected** For resident # 123, Dr. Pence was contacted for an order to decrease the Reglan dose to QD. The order was then transcribed to the MAR to be carried out. This was completed by Director of Nursing on 1-17-14. The order was not changed due to abdominal discomfort and the resident's refusal to	2-7-14

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F 428	Continued From page 5 The facility failed to act on the pharmacist recommendation for a gradual dose reduction for 1 of 5 residents (Resident #123) reviewed for unnecessay medication . The findings included: Resident #123 was admitted to the facility on 4/21/11 with multiple diagnoses including dysphasia, and gastro pareses. A review of the resident ' s most recent Medication Administration Record dated January 2014 revealed Resident #123 received Reglan 5 milligrams (mg) 1 tablet by mouth twice a day. Review of the pharmacy notes dated 7/19/13 revealed the last gradual dose reduction for Reglan 5 mg twice a day was in February 2013. There were no problems noted per nurse ' s notes and the pharmacist requested the physician evaluate for a dose reduction. Review of the pharmacy notes dated 10/15/13 revealed there was no response noted for the Reglan gradual dose reduction for the 7/19/13 recommendation. Review of the pharmacy notes dated 11/15/13 revealed there had been no response to the gradual dose reduction. A memo from the pharmacist recommendation 7/19/13 was resent on 10/15/13. A review of the pharmacy notes dated 12/19/13 revealed the physician agreed to the pharmacy consult to decrease Reglan 5 mg twice a day to Reglan 5 mg once a day.	F 428	have order changed. **Corrective Action for Resident Potentially Affected** All residents have the potential to be affected by the alleged deficient practice. On 1-27-14 a complete chart audit was initiated for all current residents for pharmacy recommendations that have not been carried out. This will be completed by reviewing the last six months of pharmacy notes and recommendations and comparing them to the most recent physician's orders. Any discrepancies noted will be reconciled by contacting the attending physician. The chart audit was completed by the Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator on 1-30-14.**(See Attachment #1 for findings.)** **Systemic Changes** The QA Nurse Consultant discussed with the Consultant Pharmacist on 01/24/14 the need for notifying the Director of Nursing monthly after each pharmacy audit of any pharmacy recommendations that have not been carried out from the previous month's audit. This will documented on QA Form and will begin with the February 2014 visit and will be an on-going process. In addition to this, the process for reconciling the monthly pharmacy review report was discussed with the Director of Nursing on 01/27/14 by the QA Nurse Consultant. **See Attachment #2.** In addition to this, on 1-28-	

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F 428	Continued From page 6 Review of Resident #123's medical record revealed medication administration records from 7/19/13 documented Resident #123 continued receiving Reglan 5 mg twice a day until 1/16/14. During an interview on 1/16/14 at 10:15 am with the Director of Nursing (DON) she stated the physician did agree to the dose reduction but failed to write an order. When the pharmacist does her notes the facility staff do not read always review all the notes. The pharmacist failed to write her recommendation on the correct form. When the pharmacist did write the recommendation the physician did agree but he failed to write the order and the dose reduction did not occur.	F 428	14 in-service training began for all full-time, part-time and PRN Nurses by the Staff Development Coordinator on the following: Daily the physician's rounds book should be checked for signed pharmacy consult recommendations by the 7-3 and 3-11 nurses before the end of your shift. When a signed recommendation is received, if the MD agrees with the recommendation then a telephone order will be written, the new order noted on the appropriate Medication or Treatment Administration Record and the new order faxed to the pharmacy. A copy of the signed recommendation is then placed in the Director of Nursing's box for review and the original filed in the resident's chart under consults. If the recommendation is declined, then the original recommendation is filed in the chart under consults and a copy is placed in the Director of Nursing's box for review. Any in-house Nurse who did not receive in-service training will not be allowed to work after **02/07/14** until training has been completed. The Staff Development Coordinator will ensure this. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The QA Nurse Consultant will monitor this issue using the "Survey Quality Assurance Tool for Monitoring Pharmacy Consults.	

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

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	345468	A. BUILDING 01 - BUILDING 0101 B. WING _____	02/26/2014

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a), using the 2000 Existing 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 area as follows:	K 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: Sprinkler heads installed in the kitchen(in front of stove) smoke compartment were a mixture of quick response heads and green heads. Sprinkler heads in a smoke compartment must be of same temperature. 42 CFR 483.70(a)	K 062	**K 062** **Correction of Deficient Practice:** Quick response heads were replaced with green heads. **Correction of Other Issues with Potential to Affect Residents by Same Deficient Practice:** Inspected facility's other sprinkler heads to assure they met this requirement; they did. **Systemic Changes to Prevent Recurrence:** Trained Maintenance staff to assure knowledge of this requirement, so that in the case of future sprinkler head installation, new sprinkler heads meet this requirement. **Monitoring through Quality Assurance Program:** Environmental Services Director shall report to the Quality Assurance Committee, which meets monthly, any new sprinkler head installations, whether the sprinkler	4/12/14
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply	K 067		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
G. Gabriel Lew	ADMINISTRATOR	3/14/14

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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K 067	Continued From page 1 with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: the following Heating, Ventilating, and Air Conditioning system (HVAC) did not shut down with fire alarm activation.(on 100 Hall). 42 CFR 483.70(a)	K 067	heads installed are green or quick response. **K 067** **Correction of Deficient Practice:** Switch installed to cause HVAC system on 100 Hall to shut down with fire alarm activation. **Correction of Other Issues with Potential to Affect Residents by Same Deficient Practice:** Checked facility's other HVAC systems to assure they shut down with fire alarm activation; they did. **Systemic Changes to Prevent Recurrence:** HVAC systems shall be checked monthly to assure they shutdown with fire alarm activation. **Monitoring through Quality Assurance Program:** Environmental Services Director shall report to the Quality Assurance Committee, which meets monthly, the results of the monthly checks that HVAC systems shut down with fire alarm activation.	4/12/14