STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 000	INITIAL COMMENTS The surveyor entered the facility on 11/19/19 to conduct a complaint survey and exited on 11/22/19. Additional information was obtained on 11/25/19 and 11/26/19. Therefore, the exit date was changed to 11/26/19. Four of the sixteen allegations were substantiated.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, and family interview the facility failed to identify a resident had been involved in a fall, was assessed following the fall, and that the incident was investigated to determine if future interventions were needed to prevent falls for one of three sampled residents with a history of falls (Resident # 1). The findings included: Resident # 1 resided at the facility from 10/1/19 to 10/21/19. The resident had a diagnosis of Parkinson's disease (a disease which can cause tremors, muscular rigidity, difficulty in standing, and problems with coordination). Prior to her facility residency, the resident had been hospitalized for a heart attack and transferred to the facility on 10/1/19 for therapy.	F 689	Resident #1 discharged on 10/21/2019. On 12/02/2019, a 100% audit was completed on all current facility residents by the facility Social Worker to ensure there are no additional residents affected by this practice. Residents with a BIMS of greater than 12 were interviewed to identify if any incidents or accidents had occurred. The Lead Support nurse conducted skin assessments for all residents with a BIMS of 12 or less. No areas of concern were identified with these audits. On 11/21/2019, the Staff Development Coordinator provided education to all nursing staff related to reporting any injury	1/4/20

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

Electronically Signed | 12/13/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 689	Continued From page 1 Review of therapy notes revealed upon the therapist's 10/2/19 assessment, Resident # 1 needed a moderate amount of assistance to transfer; requiring 50% physical assistance to transfer. According to Resident # 1's admission Minimum Data Set Assessment, dated 10/8/19, the resident was cognitively intact. She had needed extensive assistance from two people with her transfers and toileting during the assessment period. The resident's 10/1/19 care plan noted the resident was at risk of falls. The care plan directed the resident should wear non skid socks, and physical therapy would be provided. The care plan also noted, "I require staff assistance with transfers." Review of the medical record revealed no documented falls or incidents of the resident sliding from the chair while she resided at the facility. On 11/21/19 at 9:40 AM Resident # 1 was interviewed by phone and reported the following. While she had resided at the facility there was an evening on which she needed to go to the bathroom. She had asked her Nurse Aide (NA #1) if she needed to get help to take her to the bathroom, and the NA had told her she did not need help. She had started sliding out of the wheelchair before she could make it to the bathroom, and the NA left her while she was sliding out of the chair. By the time the NA returned, most of her body was on the floor and the NA did not call for assistance to get her back in the chair. When the NA helped her back up into	F 689	or accident immediately to the nurse, the nurse promptly assesses the resident and then notifies the Medical Provider and the responsible party. Nurses were instructed to complete an Incident Report in Point Click Care (PCC) software which is then reviewed by the DON and clinical team during the daily Quality of Life/QA clinical meeting. This education has been integrated in the standard orientation training for all licensed nurses and medication aides. On 12/12/2019, the facility DON created a reference sheet for all facility halls to identify resident-specific care requirements and preferences to assist direct care givers (CNAs, Nurses, Orderlies, etc.) with daily tasks. This audit tool will be reviewed at each shift-to-shift communication between CNAs and Nurses and will be reviewed by DON and/or Designee during the daily QOL/QA meeting. A quality assurance tool by the Director of Nurses and/or Designee will review communication on the reference sheets for any changes weekly X 4, then monthly X 3 to monitor actual communications to ensure compliance with new tool. Report of the audit wil be given by the DON to the Qualify of Life-QA committee and corrective action initated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Social Worker, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support Nurse and Health	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 689	Continued From page 2 the chair it was rough. She had reported the incident to her family member (the responsible party) on the evening of the incident when her family member visited. The resident's Responsible Party (RP) was interviewed on 11/19/19 at 11:26 AM and again on 11/21/19 at 7:36 PM by phone. The RP reported the following. She had arrived one evening to visit and Resident # 1 had informed her of an incident which had occurred earlier that same evening with a nurse aide. Resident # 1 had described she had needed to go to the bathroom, and NA # 1 had not acted as if she wanted to take her. NA # 1 had wanted her to use the bedpan instead. The resident had told her she did not want to use the bedpan, and the NA decided to try to take her to the bathroom. NA #1 left the resident without getting her to the toilet and she began to start sliding out of the wheelchair while the NA was gone. When the NA returned, she did not have help and it had been rough for the resident when the NA had gotten her back into the chair. The RP stated after hearing about the incident from Resident # 1, the RP went to find and talk to the NA who was assigned to Resident # 1. The RP stated she talked to NA # 1 about her attitude in addition to the resident sliding out of the wheelchair. The RP told NA # 1 she did not want her back in Resident # 1's room. The RP stated Nurse #8 walked up while she was talking to the NA and heard part of the conversation. The RP stated it was made clear to Nurse # 8 that the resident had slid out of her wheelchair, and Nurse # 8 told the RP she would put a note in the record about the incident. The RP stated no one ever talked to her or Resident # 1 about the incident while Resident # 1 resided at the facility. After the resident was	F 689	Information Management and meets at least monthly for formal review of daily QA minutes and compilation of tracking/trending data. Administrator is responsible for implementing an acceptable plan of correction. The target completion date is 01/04/2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 689	Continued From page 3	F 689		

discharged the RP called again to report the incident because the resident complained again about how the NA had been rough getting her back in the chair when she slid out of the chair.

Interview with the Director of Nursing DON on 11/19/19 at 4:00 PM and again on 11/22/19 at 10:40 AM revealed administrative staff had first become aware of the incident involving Resident #1 after the resident's responsible party reported it following Resident # 1's discharge. The RP had let them know the resident had slid out of the chair and was concerned that it was very rough when she had been lifted back into the chair. They had not known about it while the resident resided at the facility. They had verified the date to be 10/12/19 based on who the RP had reported to be working. NA # 1, who was an agency NA, was the NA who had been assigned to care for Resident # 1 that evening.

NA # 1 was interviewed on 11/20/19 at 9:45 AM by phone and reported the following. When she arrived at work at 3:00 PM on 10/12/19, the 7:00 AM to 3:00 PM NA had told her Resident # 1 needed assistance of one person with her care and she could stand. Before the evening meal the resident had needed to go to the bathroom, but she did not appear as if she could bear weight to transfer. NA # 1 asked the resident about using the bedpan as an alternative. The resident did not want to use the bedpan and so she took her to the bathroom and had her grab onto the handicap bar and try to stand up. The resident could not stand up and make a complete transfer to the toilet. She therefore got the resident seated back in the wheelchair after an unsuccessful transfer, took her back into the room, locked her wheelchair, and went to ask the medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 689	Continued From page 4	F 689		

technician to look in the computer about the resident's care needs. While she was talking to the medication technician, she heard the resident yelling for help. She went back to the room. The resident was sliding out of the wheelchair. NA #1 indicated the majority of Resident #1's body was on the floor and her arms were still in the wheelchair. She then eased her down to the floor the rest of the way in order to get up under her arms and lift her back into the wheelchair. After lifting her from the floor to the wheelchair, she then placed her in the bed and helped her use the bedpan. NA #1 explained she did not go to the nurse and report the incident right away. NA # 1 stated she knew she had done wrong in not reporting the incident to the nurse who was on duty at the time of the incident, but she had reported the incident to Nurse # 8 who was working after the evening meal when the resident's family member came and was upset later that evening. No one asked her about the incident until about a month later when someone from the facility called and talked to her about it.

Nurse # 8 was interviewed on 11/21/19 at 9:56 AM by phone and reported the following. On the evening of 10/12/19, Nurse #8 had been giving medications when she heard and saw Resident # 1's RP "up in the face" of NA # 1. She went to inquire what was wrong, and the RP informed her she did not want NA # 1 back in Resident # 1's room. The RP talked about NA # 1 being rude and did not expound. Nurse # 8 explained she switched the assignments for the NAs so that NA # 1 was no longer assigned to Resident # 1 for the rest of the evening. She asked Resident # 1 if she was okay, and the resident told her she had not liked NA # 1's tone but had not indicated she had fallen or slid out of the wheelchair at that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 689	Continued From page 5	F 689		

point. Therefore, she did not physically assess the resident. Nurse # 8 called the lead nurse (Nurse # 6) at home and notified her the daughter had been upset about NA # 1's tone to the resident and she had changed the assignment. She also talked to the DON about the RP being upset with NA # 1 at a later date. Nurse # 8 stated she had not asked NA # 1 what had occurred. Nurse # 8 stated NA # 1 had walked off after the assignment change and as she walked away mumbled she did not know the residents on the unit.

Nurse # 6 was interviewed on 11/22/19 at 12:30 PM and confirmed she was the supervisor on call on the evening of 10/12/19. Nurse # 6 reported the following. Nurse #8 had called Nurse # 6 at home on the evening of 10/12/19 and let her know she had changed NA # 1's assignment with Resident # 1. Nurse #6 stated she perceived from the conversation that Resident # 1 had a personal preference not to have NA # 1, and she asked Nurse # 8 if there had been any concerns or anything wrong, and Nurse # 8 had told her there were no concerns. Nurse #6 stated she had not talked to the resident nor the daughter while the resident was at the facility about any incident or why the assignment had been changed. Nurse # 6 also reported it was the facility's system to assure that any resident who had been involved in an accident was assessed for injury right after the accident occurred. The incident was then to be documented and discussed by their risk management team to determine if there needed to be other interventions put in place to assure the accident did not occur again. According to Nurse # 6 this evaluation never occurred while Resident #1 was at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 689	Continued From page 6 Interview with the Director of Nursing (DON) on 11/20/19 at 10:40 AM and again on 11/22/19 at 10:40 AM revealed the following. While the resident resided at the facility, she had not been informed NA # 1's assignment had to be switched on the evening of 10/12/19 or that Resident # 1 had an incident where she slid from her wheelchair. After the resident was discharged the resident's RP called to report the incident to her. The former Administrator did an investigation after the resident was discharged. During the facility's investigation NA #1 let the facility know she had left the resident because she was having trouble transferring her and went to confirm her transfer status. When she returned the resident was sliding from her chair. The DON stated the NA had not told them she had placed the resident on the floor in order to lift her back to the chair. According to the DON, anytime a resident is on the floor or has an accident then the nurse is to assess them for physical injuries. The DON confirmed that there was nothing about the incident in the resident's record, and she had not known about it until after the resident was discharged. Therefore, the resident had not been checked after the incident for injuries. According to the DON, when an accident or fall occurs then the facility does an accident assessment and prevention assessment to determine if something different needs to be done for the resident.	F 689		
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	F 755		12/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 7 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 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, resident interview, staff interview, family interview, and pharmacist interview, the facility failed to assure their system was working in order that medications be received, accurately administered, and documented for one (Resident # 4) of three sampled residents reviewed for medication administration. The findings included. Resident # 4 was admitted to the facility on 6/12/19 with diagnoses of Lupus (an autoimmune	F 755	On 11/27/2019, the Director of Nursing completed a medication review for Resident #4 to ensure all medications were available and accurately administered. From 11/27/2019 thru 11/29/2019, a 100% audit was conducted for all current resident medications to ensure there are no additional residents affected by this practice. The reviews were completed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 8 disorder which can contribute to joint pain), Autonomic Neuropathy, (a dysfunction of the nerves that regulates nonvoluntary body functions, such as heart rate, blood pressure, and sweating), chronic pain, history of compression fractures, gastroesophageal reflux disease, hypertension, atrial fibrillation, fibromyalgia, anxiety, and a history of psychosis. The resident's quarterly MDS (Minimum Data Set) assessment, dated 10/30/19, revealed the resident was cognitively intact. a. Resident # 4 was initially interviewed on 11/19/19 at 8:45 AM and again on 11/22/19 at 3:10 PM. The resident stated her 11/18/19 bedtime medications were given around 12:40 AM on 11/19/19, and there was a recurrent problem with her medications being late. Some of her medications were for chronic pain. The resident indicated she was never free of pain, and the timing of her medications was very important. Some of her medications were time released and when she got them on time she was better able to handle her pain and rest better. She also liked to go to bed around 9:00 PM and many of her medications helped her rest. Review of Resident # 4's physician orders revealed the following information. On 10/23/19, the resident was ordered the following medications: Morphine Sulfate ER (extended release) 15 mg (milligrams) two times per day. (used for pain) Coreg Tablet 3.125 mg two times per day to be given with food. (used for high blood pressure) Duloxetine HCL Delayed Release 60 mg two times per day. (A delayed release medication	F 755	the Director of Nursing and the Lead Support Nurse and recommendations were communicated to Medical Providers for review. From 11/27/2019 thru 11/29/20119, the Director of Nursing reviewed the medication pass with each nurse and conducted random medication passes on each hall to then coordinate an improved medication pass schedule for each. On 11/21/2019, the Staff Development Coordinator provided education to all FT, PT and PRN licensed nurses and medication aides related to medication administration and prevention of medication errors including proper narcotic count. This education has been integrated in the standard orientation training for all licensed nurses and medication aides. The Director of Nursing and/or Designee will review five randomly chosen residents to ensure medications are received, accurately administered and properly documented. This will be completed weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the monthly Quality Assurance Meeting for three months by the Administrator/Designee. Any trends will be noted and an immediate corrective action plan will be implemented. Administrator is responsible for implementing an acceptable plan of correction. The target date for completion	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 9 used to treat nerve pain and depression) Buspirone HCL 5 mg two times per day. (used to treat anxiety) Seroquel 250 mg one time per day to be given at bedtime. (used for a history of psychosis) Omeprazole Capsule 20 mg give two capsules one time per day (used for GERD) Review of medication administration records revealed the Morphine Sulfate ER, Coreg, Duloxetine HCL Delayed Release, Seroquel, and Omeprazole delayed release were all scheduled to be administered at 8:00 PM on 11/18/19. These 11/18/19 8:00 PM doses were signed as administered by Nurse # 1 at the following times in the digital record. The Seroquel and Omeprazole delayed release capsule were administered on 11/19/19 at 12:44 AM. The Morphine Sulfate ER was administered on 11/19/19 at 12:43 AM. The Coreg and the Duloxetine HCL delayed release capsule were administered on 11/19/19 at 12:55 AM. Review of medication administration records revealed the Buspar was scheduled to be given on 11/18/19 at 9:00 PM. This Buspar dose was signed as administered by Nurse # 1 on 11/19/19 at 12:45 AM. Interview with Nurse # 1 on 11/21/19 at 7:27 PM confirmed the medications had been given late as documented. The nurse stated she was a new nurse and she had about three- and one-half days of orientation. On the night of 11/18/19 there had been a lot of residents who had been wanting their medications at the same time, and this had run her behind schedule in administering medications.	F 755	is 12/20/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 10	F 755		

b. Resident # 4 and her Responsible Party (RP) were interviewed together on 11/20/19 at 12:38 PM and provided more details about medication concerns. The resident's RP (Responsible Party) reported the following. Late medications had been problematic with more than one of her medications. The resident was on multiple medications and many were ordered to be given more than one time per day. Therefore, she was concerned that late administration of one scheduled dose of a medication followed by a timely administration of the same medication at the next scheduled time would affect how much medication was in the resident's system. One of the largest concerns was the resident's Midodrine. The RP stated that because of the resident's autonomic neuropathy, the resident often had problems with her blood pressure dropping during the day. She was ordered the Midodrine to help sustain her blood pressure during the daytime, and timeliness was very important so that she would not have too much drug in her system but have the right amount to help sustain her blood pressure. In addition to having concerns about the late administration of the Midodrine, she was also concerned with the schedule on which the Midodrine had been placed. The family member stated the resident was accustomed to having the Midodrine on an 8:00 AM; 12 PM; and 4 PM schedule prior to her facility admission, and she had shared this information with staff. These were the times the resident was up and prone to having her blood pressure drop. The family member was concerned because the resident had already been up and prone to hypotension before she received her first dose some mornings at the facility because of the scheduling and late

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 11	F 755		

administration. The facility had changed the administration times more than once.

Review of physician orders revealed the resident had an order, dated 8/9/19, for Midodrine 5 mg to be administered three times per day. This was in effect until 10/20/19 when the resident was hospitalized. On the resident's 10/23/19 hospital discharge summary, the notation was made the Midodrine should be given at 8 AM; 12:PM; and 4:00 PM. On the resident's facility readmission 10/23/19 orders there were no specific administration times by the order. Upon the resident's return on 10/23/19 the Midodrine was ordered as 5 mg (two tablets) by mouth three times per day.

A review of FDA (Federal Drug Administration) dosing recommendations for Midodrine revealed the following information. "Dosing should take place during the daytime hours when the patient needs to be upright, pursuing the activities of daily living. A suggested dosing schedule of approximately 4-hour intervals is as follows: shortly before, or upon arising in the morning, midday and late afternoon (not later than 6 P.M.). Doses may be given in 3-hour intervals, if required, to control symptoms, but not more frequently."

According to Resident # 4's October 2019 and November 2019 Medication Administration Records (MARs) the resident's Midodrine schedule had changed multiple times on the MAR. The first dose had been scheduled at 8:00 AM at one point and 9:00 AM at another point. The second dose had been scheduled as early as 12:00 PM at one point and as late as at 2:00 PM; and the third dose as early as 4:00 PM and as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 12	F 755		

late as 9:00 PM. The current schedule was 9:00 AM; 12:00 PM and 5:00 PM.

On 11/21/19 at 1:49 PM the DON (Director of Nursing) printed out a medication audit report for October and November 2019 Midodrine administration. According to the DON the report summarized the times the Midodrine had been administered outside the hour leeway afforded past the scheduled administration time. The Midodrine audit report included the following.
Dose due on 10/7/19 at 8:00 AM was administered on 10/7/19 at 11:52 AM
Dose due on 10/9/19 at 8:00 AM was administered on 10/9/19 at 10:02AM
Dose due on 10/9/19 at 12:00 PM was administered on 10/9/19 at 2:38 PM
Dose due on 10/10/19 at 8:00 AM was administered on 10/10/19 at 10:17 AM
Dose due on 10/12/19 at 8:00 AM was administered on 10/12/19 at 10:07 AM
Dose due on 10/14/19 at 8:00 AM was administered on 10/14/19 at 10:20 AM
Dose due on 10/15/19 at 8:00 AM was administered on 10/15/19 at 10:47 AM
Dose due on 10/18/19 at 8:00 AM was administered on 10/18/19 at 10:19 AM
Dose due on 10/18/19 at 12:00 PM was administered on 10/18/19 at 2:12 PM
Dose due on 10/19/19 at 8:00 AM was administered on 10/19/19 at 11:24 AM
Dose due on 10/21/19 at 12:00 PM was administered on 10/21/19 at 2:37 PM
Dose due on 10/22/19 at 12:00 PM was administered on 10/22/19 at 2:44 PM
Dose due on 10/24/19 at 8:00 AM was administered on 10/24/19 at 11:16 AM
Dose due on 10/24/19 12:00 pm was administered on 10/24/19 at 7:45 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 13	F 755		

Dose due on 10/28/19 8:00 AM was administered on 10/28/19 at 10:56 AM
Dose due on 11/6/19 at 4 PM was administered on 11/6/19 at 6:09 PM.

The DON was interviewed on 11/21/19 at 1:20 PM and again on 11/22/19 at 10:40 AM regarding Resident # 4's medications. She reported the following. Resident # 4 had many medications which were due to be administered at different times though out the day. The nurses had tried to schedule the times of the Midodrine to streamline this medication when other medications were due. To her knowledge the nurses had not discussed the scheduling with their consultant pharmacist. The nurses, who were administering Resident # 4's medications, were responsible for medications on more than one hall. These halls were part of the 300 hall and all the 100 hall. Per her review of the medication tasks required by the nurses, she felt the nurses should be able to give Resident # 4's medications within an acceptable timeframe, which she stated was within one hour before or one hour after the scheduled time. She had not identified any medication administration problems which posed problems to the nurses.

The following nurses were interviewed regarding their ability to administer Resident # 4's medications within an hour of scheduled times.

Nurse # 2 was interviewed on 11/21/19 at 4:40 PM. According to the MAR, Nurse # 2 had been been responsible for eight of the Midodrine late doses administered in October 2019. Nurse # 2 reported that she usually started passing medications on the 300 hall and many residents took a long time to swallow medications. It had been difficult to administer Resident # 2's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 14	F 755		

Midodrine medication within the hour timeframe, and the doses had been late.

Nurse # 3 was interviewed on 11/21/19 at 5:00 PM. According to the MAR, Nurse # 3 had been responsible for five of the Midodrine late doses administered in October 2019. Nurse # 3 reported the following. The 300 and 100 halls had several residents with varying needs such as dialysis residents, residents with chronic pain, and other needs. When she first started working at the facility, she typically tried to start administering medications on the 300 hall and move towards the 100 hall residents. She had learned that strategy did not work because of the varying medication needs all along the medication pass. Just within the past month or two she had learned from another nurse a different strategy in starting and completing the medication pass based on the resident's medication needs and typical requests, but this had not been shown to her when she first started. The nurse confirmed that some of the Midodrine doses which showed up on the audit sheet as late were late. In other cases, the documented administration time was not the true administration time. The nurse stated this was because she had learned she needed to give the Midodrine early, and then she would go back and document the administration of the doses when she had time to do so.

Nurse # 4 was interviewed on 11/22/19 at 2:15 PM. According to the MAR audit sheet, Nurse # 4 had been one of the nurses who had been responsible for a late dose of Midodrine. Nurse # 4 reported the following. It had been difficult to get the Midodrine in on time, and it had been late. She had found that she needed to get to work early because there was inconsistency in how the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 15	F 755		

nurses left the medication carts. Sometimes they were stocked with the medications she needed and other times they were not. Sometimes medications from the pharmacy had not arrived also. These things contributed to difficulty in completing the medication pass on time.

On 11/22/19 at 8:30 AM Nurse # 5 was observed to administer medications on Resident # 4's hall. While administering medications to three residents, the nurse was observed to have to leave the cart or clarify orders on three different occasions because medications were not available on the cart.

Interview with the Director of Nursing on 11/26/19 at 10:45 AM revealed her expectation was that every nurse should assure the medication cart was stocked for the oncoming nurse with medications, and that medications would be available from the pharmacy to be administered to residents on time.

C. Resident # 4 and her responsible party were interviewed together on 11/20/19 at 12:38 PM and spoke of concerns regarding a weekly medication that had been ordered for Resident # 4's Lupus but had never been obtained and given as of 11/20/19. The RP was also interviewed again on 11/25/19 at 10:19 AM regarding the Lupus medication. The responsible party reported the following. The medication was Benlysta, and was originally prescribed and administered by the resident's Rheumatologist. Prior to the resident residing at the facility, the resident had received an infusion of this medication at the Rheumatology office. The Benlysta was available in an injectable form. In September 2019 the Rheumatology office had worked with Resident #

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 16	F 755		

4's insurance company to receive approval for the injectable form of the medication so that it could be administered at the facility. The RP provided a letter, dated 9/11/19, noting the Benlysta was approved by the insurance company as a covered medication through 9/10/2020. The RP had taken the letter showing the medication was approved to the facility and given it to the facility administrative assistant. She had talked to different nurses in September and October 2019 about the resident needing the medication. She had also mentioned in care plan meeting on 11/12/19 she was concerned because the resident was not getting her Lupus medication although her insurance would pay for it. She had been told the medication could not be acquired and been given different reasons. One was related to the expense of the medication and another was that it needed to be obtained from a specialty pharmacy. At one point, although she had provided a letter noting the medication was covered by the insurance company, she had been told the resident would need to pay upfront the cost of the medication in order to acquire it.

Review of Resident # 4's record revealed an order on 10/14/19 for Benlysta Solution Prefilled Syringe 200 mg/ml (milligrams/ milliliters) inject 200 mg subcutaneously one time a day every seven days. Following the resident's hospitalization from 10/20/19 to 10/23/19, the Benlysta was reordered on 10/23/19 at the same dosage and to be given weekly. On 11/20/19 a review of the October and November 2019 MARs (Medication Administration Records) revealed the Benlysta had never been administered, although it showed as scheduled to be given on multiple occasions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 17	F 755		

A clinical pharmacist from the Rheumotogy office was interviewed on 11/22/19 at 1:41 PM and reported the following. When the resident was last seen by the Rheumatologist, her Lupus was noted to be slightly flaring. They had worked to help Resident # 4 and her responsible party receive approval from the insurance company for an injectable form of Benlysta which could be administered by the facility staff to the resident. The approval was obtained in September 2019. On 10/7/19 the Rheumatology records showed their office had faxed the resident's Rheumatology notes to the facility on 10/7/19. Their records showed the first time the facility called to talk to them about obtaining the medication was on 11/20/19. The clinical pharmacist stated he was unsure of what the issue had been for the facility in obtaining the medication, and if Resident # 4 had not been receiving the medication then the facility needed to have figured that out on their end.

Interview with the Administrative Assistant on 11/25/19 at 11:29 AM revealed any paperwork given to her by a family member for Resident # 4 would have been placed in Nurse # 6's unit manager box.

The DON was interviewed on 11/26/19 at 10:45 AM and reported the following. Resident # 4's family member had brought a concern to them about the resident needing the Benlysta medication at some point. The concern alerted them they needed the Rheumatology notes. On 10/7/19 they had called and obtained notes from the Rheumatology office. On 10/14/19 the DON had called the Rheumatology office and obtained the exact order for the medication and received approval from the resident's primary physician to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 18	F 755		

administer the medication. She had asked Nurse # 6 to look into acquiring the medication. On 11/19/19 she had been informed that Resident # 4's family member had been concerned in the 11/12/19 care plan meeting that the resident had still not been getting the Benlysta.

Nurse # 6 was interviewed on 11/25/19 at 3:15 PM. Nurse # 6 reported the following. She did not recall the insurance paper being placed in her unit manager box in September 2019. On 10/7/19 the facility had called and obtained the Rheumatology notes because of the family member's prompting to do so. They did not have a copy of the last notes as of that date. An order was obtained through the resident's primary physician on 10/14/19 to administer the Benlysta. The medication was placed on the MAR to start on 10/21/19. She did not know what efforts had been made between 10/14/19 and 10/21/19 to acquire and give the medication, and why it had been placed on the MAR to start on 10/21/19 although it was ordered on 10/14/19. The resident was hospitalized from 10/20/19 to 10/23/19 and returned with the weekly Benlysta order again on 10/23/19. Because Resident # 4 had an infection while hospitalized, the Benlysta medication was to start back on 10/31/19. The medication did not come from the pharmacy and was never given on 10/31/19. The pharmacy called the facility on 11/2/19 and told them it would arrive on 11/4/19. It did not arrive. On 11/4/19 the facility talked to the pharmacy again, and the facility was told it was a specialty medication which they could not acquire. On 11/6/19 she left a message for the Rheumatology office. She did not hear back. The next time the facility called the Rheumatology office was on 11/19/19, and she left a message. She talked to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 19	F 755		

them on 11/20/19 and the facility was provided another pharmacy's name which could send the medication. Nurse # 6 validated that as of 11/25/19 the resident still had never received any of the Benylsta injections since it had been ordered on 10/14/19.

On 11/25/19 at 9:30 AM a manager at the facility's pharmacy was interviewed. The Pharmacy Manager stated their notes showed they called the facility on 10/23/19 to let them know Benlysta was a high cost specialty medication and asked for more information. The pharmacy notes did not show any further information about correspondence between them and the facility regarding the Benlysta. While being interviewed the Pharmacy Manager checked the insurance reimbursement for the Benlysta, and verified Resident # 4's insurance company would pay 100% of the cost of the Benlysta.

On 11/25/19 at 5:00 PM a customer service representative from the specialty pharmacy, which was to dispense the medication for Resident # 4, was interviewed. The Customer Service Representative reported it takes 24 to 72 hours after they receive a prescription to verify it with the physician. They then enroll the resident in their drug program and mail the drug. Information is found online regarding their services. Their records showed the first time Resident # 4 had an account set up with them for pharmacy services was on 11/20/19.

d. According to Resident # 4's November 2019 MAR, Morphine Sulfate 15 mg was scheduled to be given at 8:00 AM and 8:00 PM. Resident # 4's Narcotic Count Sheet for Morphine Sulfate 15 mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 20 extended release was reviewed. This review revealed the Morphine was not signed out as given on 11/5/19 at 8:00 AM. Nurse # 7 signed on the MAR she administered the 8:00 AM Morphine on 11/5/19 although there was no record it was removed from the narcotic storage. On 11/5/19 Nurse # 8 signed on the Morphine Narcotic Count Sheet she removed the scheduled 8:00 PM Morphine dose from the narcotic storage on 11/5/19 at 8:45 PM, and she signed she administered it on the MAR. On 11/6/19 at 12:15 AM, Nurse # 8 signed on the Morphine Narcotic Count Sheet she removed another dose of Morphine. According to Resident # 4's MAR, there was no Morphine due on 11/6/19 at 12:15 AM or administered at 12:15 AM. Nurse # 7 could not be reached during the survey for interview. Nurse # 8 was interviewed on 11/21/19 at 2:49 PM and reported she did not recall giving Morphine at 12:15 AM on 11/6/19 and did not know why her signature would be on the narcotic sheet at 12:15 AM signifying she had removed a dose. Interview with the DON on 11/21/19 at 2:49 revealed it was her expectation that the MAR administration doses of Morphine should match the times on the Narcotic Count Sheet signifying a dose of Morphine was removed from storage, and she was not sure what had happened on 11/5/19 and 11/6/19. She had not been aware there was an issue with the reconciliation of the MAR and the Narcotic Count Sheet.	F 755		
F 806	Resident Allergies, Preferences, Substitutes	F 806		1/4/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 806 SS=D	Continued From page 21 CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview the facility failed to assure one (Resident # 4) of three sampled residents reviewed for dietary needs received foods according to their preferences or were offered meals of similar nutritive value when the resident chose not to eat food that was initially served. The findings include: Resident # 4 was admitted to the facility on 6/12/19. The resident's quarterly MDS (Minimum Data Set) assessment, dated 10/30/19, revealed the resident was cognitively intact. A review of orders on 11/19/19 revealed Resident # 4 was currently prescribed to have a regular cardiac diet. On 11/19/19 at 8:45 AM Resident # 4 was observed in her room and had her breakfast tray before her. Her toast was on top of her grits and a portion of the toast was covered with grits when she picked it up. The toast visibly appeared soggy	F 806	Resident #4 interviewed regarding dietary preferences and confirmed details are correct on diet cards. Menu is announced daily and posted at each dining room, on the 300-hall and at each nurse station. In addition, the menu will be provided to any resident with vision and/or hearing impairment and to all residents on the rehabilitation unit. Facility Administrator and Director of Nursing met with the President of Gallins Dining and Nutrition, the facility contracted dietary provider. Upon investigation, it was determined that the replacement meal was not provided in a timely manner. All involved were properly counseled and notified this practice is unacceptable. Selection sheets are now distributed at breakfast for the following day's meals which will allow proper time for response and food preparation based on preferences. Gallins will also provide pre-made salads	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 806	Continued From page 22 with the moisture it had absorbed. Resident # 4 stated the toast usually came in that condition, and she preferred to have stiff toast or otherwise she could not eat it. Nurse Aide (NA) # 7 entered the resident's room while the resident was talking about the toast. NA # 7 was interviewed regarding whether a replacement piece of toast could be obtained for Resident # 4. NA # 7 stated she would go check with the dietary department. On 11/19/19 at 8:55 AM, interview with NA # 7 revealed she had tried to get a replacement piece of toast for Resident #4 but the dietary department had told her there was no more toast. NA # 7 said she had just let the resident know that there was no more toast to replace hers. Resident # 4 was again observed on 11/19/19 at 12:42 PM in her room. At this time the resident had her lunch tray before her. The resident was not eating her meal which was observed to be sesame chicken, zucchini, an egg roll, and gelatin with fruit. Resident # 4 was observed to put on her call bell to ask if the facility had an alternative to the hot meal. The resident was interviewed further about her meals while she waited to see if there was an alternative to her 11/19/19 lunch. She looked through a stack of papers and pulled out a piece of paper which was entitled "Alternate Menu." The resident reported that when she was admitted she had been told she could choose from the "Alternate Menu " meals listed on the paper if she did not like the meal being offered each day. The resident also reported she had trouble knowing whether she would need an alternate meal for the day because she did not always know what was to be served. The scheduled daily meals were posted outside the dining room each day and she did not have the energy to roll her wheelchair each day to look and	F 806	and sandwiches for quick-fix alternatives in the event someone changes their mind from the prior day's selections or if they do not want the primary or alternate meal prepared for that day. This will also accommodate any late-day admissions. Gallins and Dietary Manager along with Facility Administrator will plan to attend the next Resident Council meeting (scheduled for 12/17/2019) to discuss progress of new system and review potential menu changes. Dietary Manager will plan to be available for all future Resident Council meetings based on future invitation to provide updates to our residents regarding our dietary program. Administrator is responsible for implementing an acceptable plan of correction - targeted completion date is 01/04/2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 806	Continued From page 23	F 806		

see what was being offered. The facility also announced the menu in the mornings, but she often kept her door shut, and she was not able to hear the menus being announced. In order to get an alterative meal, she had to notify the dietary department by 10:00 AM, and most of the time she did not know what she was going to be served until it arrived. On occasion the NAs might tell her before 10:00 AM if they remembered to do so, but this was not consistent. Therefore, she did not have the opportunity to choose an alternative from the alternate menu. The resident finished talking about the menus, and no one had come to check on her food. The resident stated her daughter had left a sandwich earlier, and she would just eat the sandwich for lunch. On 11/19/19 at 1:14 PM, NA # 8 entered Resident # 4's room and asked if she needed something. NA # 8 was interviewed regarding whether there was an equitable hot meal that Resident # 4 could obtain since she did not like the hot meal served to her. NA # 8 stated the resident could have a sandwich and soup, but there was no other hot meal to be offered. NA # 8 stated in order for the resident to have obtained an alterative hot meal, she would have needed to let the dietary department know by 10:00 AM and therefore it was too late.

The dietary manager was interviewed on 11/19/19 at 3:50 PM regarding the resident's breakfast toast and lack of alternative at lunch. The dietary manager reported the following. The resident's toast should never have been placed under the lid by the dietary staff when the breakfast was plated. Therefore, it would not have been mushy. Her staff may have told NA # 7 that the resident could not have more toast because the NA may have not told them what type of diet she was on.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 806	Continued From page 24	F 806		

Her staff did not send food out of the kitchen unless they knew the resident could be served the food being requested. It also may have been that they were indeed out of toast, and it took time for the staff to heat the toaster back up if they were finished making toast. This also could have been the reason Resident # 4 was not provided more toast. Regarding the lunch meal, there had been an equitable hot meal alternative for 11/19/19 which could have been served to Resident # 4 if NA # 8 had asked. The dietary department had prepared hamburger steak, mashed potatoes, and stewed tomatoes. This would still have been available on 11/19/19 at 1:14 PM. In regards to the piece of paper noting routine "Alternate Menus", the resident would have needed to request the items on the "Alternate Menu" by 10:00 AM. There was currently only one person in the facility who received the menus in advance in their room to know if they wanted to order from the routine list of alternatives. Other residents would need to go to the hallway where the menu was posted, be able to hear the announcements, or rely on the nurse aides to tell them the menu.

During an interview with Resident # 4 on 11/19/19 at 4:00 PM, Resident # 4 stated she would have liked to have tried the hamburger steak meal as an alternative to her lunch meal on 11/19/19 if it had been offered to her.

During a follow up interview with NA # 7 on 11/22/19 at 3:00 PM it was clarified with NA # 7 that she had told the dietary department on the morning of 11/19/19 that she was seeking a replacement piece of toast for Resident # 4 because it had grits on it and therefore it had been clear to them that the toast was an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. BUILDING _____ B. WING _____	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH JOHN	2315 HIGHWAY 242 NORTH BENSON, NC 27504

(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 806	Continued From page 25 acceptable item for her to receive. According to NA #7, the dietary department had informed her they had thrown out all the toast and did not offer to make more for the resident.	F 806		