STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN ST SALISBURY, NC 28147

(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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's abuse/neglect policy and procedure and staff interview, the facility failed to report and to investigate 1 (Resident #10) of 2 sampled residents with allegation of abuse/neglect. The finding includes: The facility's abuse/neglect policy and procedure dated May 1, 2007 was reviewed. The policy under investigation read in part, "The administrator or designee will conduct investigation of any areas of concern. Resident interviews, family interviews and staff interviews may be used to investigate an incident. Investigation will be individualized to determine if abuse, neglect or misappropriation of property has occurred". The policy under reporting read in part, "Any allegations (regardless of whether the allegations are substantiated) against unlicensed personnel, including injuries of unknown origin that appear to involve the conduct of abuse, neglect, misappropriating property of the patient or facility, committing fraud against a patient or facility or diverting drugs belonging to the patient or facility, MUST BE REPORTED to the Health Care Personnel Registry via the 24 hour and 5 day report".	F 226	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 226 Implementation of Abuse Policy Corrective Action: Resident # 10 grievances and concerns have been reported to the State Health Care Personnel Registry via a 24 hour and 5 day Report. All allegations have been investigated and resolved to the resident's satisfaction. Identification of other residents who may be involved with this practice: All residents have the potential to be effected by this alleged practice. All reported Abuse Allegations in the last 2 month were audited for timeliness of reporting to State. All were in compliance with regulations. All grievances for the past 2 months were also reviewed by the Administrator/DON to ensure that no other allegations of abuse or neglect were missed. No other allegations were identified. Systemic Changes: Any Abuse Allegations will be immediately reported to the Administrator or DON verbally and a written report completed. Any employees involved in the allegation will be relieved of duty until investigation completed. The 24 hour report will be submitted to the State by Administrator/ DON/ Designee within 24 hours of notification. An investigation into abuse allegations will be under the direction of Administrator/ DON and 5 day report completed and submitted. All Staff was inserviced on August 5 through the 10, 2011 by the DON. Those who attended/completed these inservices include staff	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Admin	8/11/11

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 226	Continued From page 1 Resident #10 was admitted to the facility on 01/26/11 and was re-admitted on 05/11/11 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus, Hypertension, Anxiety; Congestive Heart Failure (CHF), and Deep Vein Thrombosis (DVT). The quarterly Minimum Data Set (MDS) assessment dated 07/04/11 indicated that the resident's cognition was intact. The assessment further indicated that Resident #10 was usually continent of bowel and bladder and needed extensive assistance for transfers and toilet use. Resident #10 was interviewed on 07/25/11 at 5:50 PM. She stated that she had a lot of concerns with the nursing assistant on the third shift. She was made to wear a diaper instead of pull up and not to wear pajama at night as it is hard for the staff. She stated that when she calls for help, the nursing assistant would stand on the door and would yell at her "what do you want?" They don't want to do anything for you. Resident #10 indicated that these incidents happened on several occasions and she had filed a grievance. She also stated that she had attended the care plan meeting and brought it to the attention of the staff. On 07/27/11 at 4:05 PM, the social worker was interviewed. She stated that she keeps the grievance forms. She stated that if the grievance was for nursing, the Director of Nursing (DON) investigates the allegations and intervenes. The social worker had provided one grievance form from Resident #10. The Grievance Report form dated 07/18/11 was reviewed. The form had several concerns listed	F 226	nurses, nursing assistants, dietary staff, therapy staff, social services, activities and administrative staff. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. Any time an agency nurse/hospice staff is utilized the SDC will verify that they have received this in-service training. If not they will not be allowed to work until they receive the appropriate education. The in-service topics included how to report allegations of abuse and neglect, aspects of an investigation, and notification of DON/Administrator. 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. Monitoring: Monday through Friday at the Morning Department Meeting under the direction of the Administrator and/or the DON will review all grievances and reports of abuse, neglect, mistreatment and misappropriation of resident property to ensure the 24 hour Report and the 5 day Report has been filed appropriately and the investigation has been conducted to include all areas of concerns. This will be accepted standard practice. Any audits, trends or concerns will be reviewed at the weekly Quality of Life meeting. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality of Life Meeting. Date of Compliance: August 15, 2011	

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F 226	Continued From page 2 including nursing assistants do not wipe her after using the potty, when she uses her call light the nursing assistant will say "why didn't you tell me you needed something when I was here earlier" yelling while standing on the door, she feels uncomfortable being made to wear a diaper instead of pull up and no pajama at night because it is easier for the staff and when she asked a nursing assistant to pull her up in bed, the nursing assistant told her that she will be back and never came back. On 07/28/11 at 9:45 AM, the DON had provided a statement with concerns from Resident #10. The DON stated that Resident #10 had brought up this concern during the care plan meeting. Resident #10 had voiced concerns with the third shift staff in how they spoke and treated her. On 07/28/11 at 9:53 AM, administrative staff #1 was interviewed. After reading the grievance form filed by Resident #10, the administrative staff stated that she should have reported and investigated the allegations for abuse/neglect but she didn't. She stated that she had investigated the allegation about not cleaning after using the potty but did not investigate the allegations about being made to wear a diaper, staff yelling at her and the staff never came back when she asked to be pulled up in bed.	F 226		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	F 332 Medication Error Rate Corrective Action: Resident # 45 Medication Administration Record now has written instruction to provide 30cc of water to flush the tube prior to and after medication administration. Resident #12 has been discharged. Resident #1 and #154 med error reports have been completed with appropriate follow up. Resident # 74 did receive their medication.	

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F 332	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain their medication error rate below 5% by not following the manufacturer's specification and by not following the physician's orders. There were 6 errors of 55 opportunities resulting in a 10.9% error rate. The findings include: The facility's policy and procedure (undated) on enteral tube medication administration was reviewed. The policy read in part "Enteral tubes are flushed before administering medications and after all medications have been administered with at least 30 ml (milliliter) of water". The facility's list of medications that should not crushed or chewed was reviewed. The list included Enteric Coated tablets. 1a. Resident #45 was observed during the medication pass on 07/27/11 at 8:42 AM. Nurse #1 was observed to prepare and to crush the medications and dissolved them in water. The nurse was observed to check the tube placement and then flush the tube with 15 ml of water, administered the medications thru the tube and then flushed the tube again with 15 ml of water. When interviewed on 07/28/11 at 10:05 AM, Nurse #1 acknowledged that she made a mistake. She stated that the policy is to flush the tube with 30 ml of water before and after the medications. 1b. Resident #45 was observed during the medication pass on 07/27/11 at 8:42 AM. Nurse	F 332	Identification of other residents who may be involved with this practice: All residents have the potential to be affected by this alleged practice. Administrative Nurses reviewed the resident's MD orders and MAR for accuracy July 29 and 30, 2011. Any identified issues were clarified by the MD. Systemic Changes: RNs and LPNs have been inserviced on Medication Administration including medications that cannot be crushed and MD order transcription by DON on August 5 through the 10, 2011. Any in-house staff nurse who did not receive in-service training will not be allowed to work until training has been completed. A complete list of "Medications not be crushed" has been placed on the front of each station MAR notebook. Monitoring: Five days each week for two weeks then weekly for six weeks then monthly two Nurses will be observed during Med pass using the Medication Pass Observation Form. These observations will be conducted by any of the following: DON, Pharmacy Consultant, SDC, RN Supervisor or Weekend Supervisor. Any issues will be reported to the DON immediately for appropriate follow up. Any observations, trends or concerns will be reviewed at the weekly Quality of Life meeting. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality of Life Meeting. Date of Compliance: August 15, 2011	

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F 332	Continued From page 4 #1 was observed to prepare the medications including Enteric Coated Aspirin 325 mgs (milligram) tablet. Then, she crushed the medications and administered them thru the tube. Resident #45's chart was reviewed. On 06/10/11, there was a physician's order for Aspirin 325 mgs 1 tablet by tube for history of CAD (Coronary Artery Disease). On 07/27/11 at 9:58 AM, Nurse #1 was interviewed. She agreed that she administered enteric coated Aspirin instead of Plain Aspirin as ordered. She stated that she pulled the Enteric Coated Aspirin and crushed it. She further indicated that she was told that she could crush the enteric coated tablets. 2. Resident #12 was observed during the medication pass on 07/28/11 at 9:13 AM. Nurse #1 was observed to prepare and to crush the medications and dissolved them in water. The nurse was observed to check the tube placement, then flushed the tube with 15 ml of water, administered the medications and flushed the tube again with 15 ml of water. When interviewed on 07/28/11 at 10:05 AM, Nurse #1 was interviewed. She acknowledged that she made a mistake. She stated that the policy is to flush the tube with 30 ml of water before and after the medications. 3. Resident # 1 was observed during the medication pass on 07/27/11 at 4:00 PM. Nurse #2 was observed to instill 1 drop of Azoph eye	F 332		

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F 332	Continued From page 5 drop to the resident's left and right eye. Review of the resident's records revealed that on 07/24/10, the physician ordered for Azoph 1% eye drops - 1 drop into right eye twice a day for Glaucoma. When interviewed on 07/27/11 at 4:17 PM, Nurse #2 agreed that it was a medication error and would notify the physician. 4. Resident # 74 was observed during the medication pass on 7/28/11 at 8:00 AM. Nurse #4 was observed dispensing the resident's medications into medication cups. Nurse #4 did not punch the citalopram 40 mg tablet out of the medication punch card, although she had it out on top of the medication cart along with the other medications she was giving to resident #74 that morning. On 7/28/11 at 8:12 Nurse #4 completed dispensing the resident's medications into medication cups and was observed putting the medication punch packs, including the one for the citalopram 40 mg, back inside the medication cart and locked it. On 7/28/11 at 8:14 Nurse #4 was interviewed and asked to count the number of tablets in the medication cup that she had placed all the tablet	F 332		

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F 332	Continued From page 6 medications in and she counted 7 ½. Nurse #4 was asked to obtain the citalopram 40 mg medication punch card and to identify whether the citalopram was inside the medication cup. The citalopram 40 mg tablets in the medication punch pack were observed to be round white tablets with ES 400 imprinted on them. Nurse #4 acknowledged that this medication was not in the medication cup and that she had forgotten to put it in the medication cup but thought she had done it already. She indicated the medication was listed on the Medication Administration Record (MAR) to be given and would have been missed as she thought it was already in the medication cup. On 7/28/11 at 8:16 Nurse #4 checked the MAR and then dispensed the missing citalopram 40 mg into the medication cup and administered the medications. Review of the Medical Record revealed there was an order to give Citalopram 40 mg with Resident #74's 8 AM medications and that the resident had diagnosis including anxiety and mental disorder. 5. Resident #154 was observed during the medication pass on 7/27/11 at 4:54 PM. Nurse #5 dispensed 1 packet of Renvela 0.8 mg powder pack in 2 tablespoons water. Review of the Medical Record revealed an order for Renvela 0.8 mg powder pack in 2 tablespoons water with supper over 30 minutes and that the resident had a diagnosis of End Stage Renal Disease on dialysis.	F 332		

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F 332	Continued From page 7 Review of the Manufacturers Prescribing Information for Renvela (sevelamer carbonate) dated "Issued (3/10) RV382 8/10" revealed "General Dosing Information: Renvela should be given three times a day with meals". On 7/27/11 at 5 PM Resident #154 was observed to take the Renvela provided by Nurse #5. The Resident's supper tray was not in the room. Review of the facility meal time schedule revealed supper is served in the main dinning room at 5:35 -5:45 PM and on hall 100 and 200, where Resident #154 was located at 6:10 - 6:15 PM. Interview with the Director of Nursing on 7/28/11 at 4:40 PM revealed it is her expectation that medications to be given with meals are given with meals.	F 332		
F 425 SS=E	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 Pharmacy Services- Expired and Open/Unlabeled Medications Corrective Action: All identified expired or open unlabeled medications were returned to pharmacy or destroyed. Identification of other residents that may be involved in this practice: All residents have the potential to be affected by the alleged practice. All medications in the med carts and med rooms were inspected for expiration dates on July 28 and 29, 2011 by Nursing Supervisor. No additional expired meds were found.	

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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 record review, observation and staff interview, the facility failed to discard expired medications from 3 of 4 medication carts and failed to date multi dose medications including insulin and Advair. The findings include: On 07/27/11 at 3:28 PM, the medication cart on 400 hall was observed. One bottle of Vitamin E and one bottle of Zyrtec were observed with an expiration date of 03/11. There was also one used Advair Discus inhaler with no date of opening. On 07/27/11 at 3:30 PM, Nurse #1 was interviewed. She acknowledged that both bottles of Vitamin E and Zyrtec were already expired. She also stated that Advair should have been dated once removed from the foil pouch. Nurse #1 also indicated that the medication carts and the medication rooms were checked by the nurses, unit supervisor and the pharmacist for expired medications. On 07/28/11 at 4:10 PM, the staff development coordinator (SDC) was interviewed. She stated that the facility's policy was to date the Advair once it is removed from the foil pouch and then it is good for 30 days.	F 425	Systematic Changes: Pharmacy Consultant will check med carts and med rooms monthly for expired medications also to ensure open medications are dated and labeled. QA Nurse Consultant will inspect quarterly during site visit to ensure compliance. All nursing staff was inserviced August 5 through the 10, 2011 by DON on expired meds and the labeling and dating medication upon opening. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. Any time an agency nurse/hospice staff is utilized the SDC will verify that they have received this in-service training. If not they will not be allowed to work until they receive the appropriate education. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all licensed nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: Med Rooms and Med carts will be checked for expired meds 5 days a week for one month then monthly for 6 months using the Nursing Survey QA Tool. Identified issues will be reported immediately to DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality of Life Meeting. Date of Compliance: August 15, 2011	

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F 425	Continued From page 9 On 7/28/11 at 3:00 PM the medication cart on 100 hall was observed. One medication punch card of hydrocodone-APAP 5-500 tablets was observed with an expiration date of 03/11. Nurse # 3 verified that the medication was expired and should have been removed from the medication cart when it expired. On 7/28/11 at 3:30 PM the medication cart on hall 200 was observed. One Levemir FlexPen was observed opened. There was no date on the flex pen indicating when it was opened. The Nurse Supervisor observed the FlexPen and acknowledged that it was not dated and was supposed to be. Review of the document titled "Recommended Maximum Storage for Insulin and Other Selected Injectables" provided by the Staff Development Coordinator (SDC) revealed that opened Levemir FlexPens can be stored at room temperature for 42 days. On 7/28/11 at 3:35 PM the Nurse Supervisor was interviewed. She stated that expired medications should not be on the medication carts. She also noted that the nurses go through the medication carts weekly to look for expired medications and expiry dates are also checked when new medications arrive. On 7/28/11 at 4:45 PM the SDC was interviewed and stated that the facility policy was to date Levemir FlexPens once they are opened.	F 425		

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K 032 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 8/10/2011 the facility had door release mechanisms in the cooler and freezer designed to drop the locking device if accidently locked in either space. These door release mechanisms were not visible in all levels of light. NOTE: The door releases mechanisms in the spaces did work properly when tested. CFR#: 42 CFR 483.70 (a)	K 032	K 032 THE MAINTENENCE DIRECTOR PLACED A IRIDESCENT STICKER ON THE DOOR RELEASE MECHANISM OF THE WALK IN COOLER AND FREEZER THAT IS VISIBLE IN ALL LEVELS OF LIGHT	8/17/11
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 8/10/2011 the facility had the emergency door release switches which are apart of the North Carolina Special Locking system that are located above 48 inches above the finished	K 038	K 038 WE HAD ELECTRICIAN SUBMIT A BID ON LOWERING EMERGENCY DOOR RELEASES SWITCHES TO 48" ABOVE FINISHED FLOOR. (PLEASE SEE ENCLOSED BID FROM OUR ELECTRICIAN) WORK WILL BE COMPLETED BY 9/23/11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMIN	8/26/11

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REH ROWA	4412 SOUTH MAIN ST SALISBURY, NC 28147

(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
K 038	Continued From page 1 floor at the following locations. 1. The 100 Hallway required exit 2. The 200 Hallway required exit 3. The 300 Hallway required exit NOTE: The emergency door releases at each door did work properly. CFR#: 42 CFR 483.70 (a)	K 038		