

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

PRINTED: 12/09/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345532</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/19/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>310 COMMERCE DRIVE SANFORD, NC 27330</b>		
(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 facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey) recertification investigation survey conducted on 10/19/2011.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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NOV 28 2011


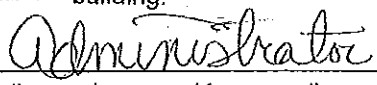
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345532	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED  11/08/2011
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NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27330
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K 018 SS=E	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 8:30 am onward, the following items was observed as noncompliant; specific findings include: refreshment cart blocking door from closing for smoke tight seal (nourishment room at nurse station). Also resident bedroom door number 108 would not latch for smoke tight seal.</p>	K 018	<p><b>F000</b></p> <p><b>Disclaimer</b> The statements made on this plan of correction are not an admission of nor constitute an agreement with the alleged deficiency. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that the alleged deficiency has been or will be corrected by the date or dates indicated or by November 26, 2011</p> <p><b>K018</b></p> <p>For the residents involved, corrective action has been accomplished by: Refreshment cart was removed from blocking Nourishment room.</p>	
K 038 SS=E	<p><b>42 CFR 483.70(a)</b></p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 8:30 am onward, the following items was observed as noncompliant; specific findings include: exit access door on 200 hall would not release on activation of override switch located at nurse</p>	K 038	<p>Resident Room # 108 was repaired by Maintenance ensuring a smoke tight seal.</p> <p>Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: All patient room doors have been inspected to ensure that they have a smoke tight seal.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice does not occur Maintenance Director will monitor doors for smoke tight seal while doing weekly rounds of the building.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  


(X6) DATE  
11/23/11

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K 038	Continued From page 1 station. Also there was not a wiring diagram and system components location map at fire alarm panel at nurse station.	K 038	The facility has implemented a quality assurance monitor: Maintenance Director will submit rounds report to the Monthly Quality of Life (Quality Improvement Committee) Meeting Compliance will be achieved by November 26, 2011	
K 072 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 8:30 am onward, the following items were observed as noncompliant; specific findings include: facility has a flag mounted on wall, that protrudes into corridor more than 2 feet. Also linen cart and lift stored on service hallway reducing corridor width.	K 072	K038  For the residents involved, corrective action has been accomplished by: No residents were adversely affected. Repair order placed.  Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: 200 hall override switch for exit access repaired by Systems Electronics on 11/16/11.  Measures put into place or systemic changes made to ensure that the deficient practice does not occur Maintenance Director will monitor exit doors for override switches working appropriately while doing weekly rounds of the building.	
K 141 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD  Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 18.3.2.4, NFPA 99, 8.6.4.2.  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 8:30	K 141	The facility has implemented a quality assurance monitor: Maintenance Director will submit rounds report to the Monthly Quality of Life (Quality Improvement Committee) Meeting Compliance will be achieved by November 26, 2011	

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K 141	Continued From page 2 am onward,the following items was observed as noncompliant; specific findings include: "No smoking oxygen in use" signs were posted on room 206.	K 141	K072 For the residents involved, corrective action has been accomplished by: Linen carts and patient lift removed from hallways.	
K 147 SS=F	42 CFR 483.60(a) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 8:30 am onward,the following items was observed as noncompliant; specific findings include: resident in room 307 using multi plug outlet for TV and other electrical dices for permanent wiring for power.  42 CFR 483.70(a)	K 147	Decorative flag mounted on wall removed.  Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: Facility staff have been trained to remove linen carts and lifts, etc. from corridors. Reminders to staff will be made at Staff Meeting on December 1, 2011  Measures put into place or systemic changes made to ensure that the deficient practice does not occur Maintenance Director and others will monitor hallways to assure unobstruction while doing daily rounds of the building.  The facility has implemented a quality assurance monitor: Maintenance Director will submit rounds report to the Monthly Quality of Life (Quality Improvement Committee) Meeting Compliance will be achieved by Dec. 1, 2011	

K141

For the residents involved, corrective action has been accomplished by:

No smoking-oxygen in use signs were immediately placed on patient room 206

Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:

All residents who have oxygen in use now have No smoking signs-oxygen in use signs outside of doors.

Measures put into place or systemic changes made to ensure that the deficient practice does not occur

ADON will monitor for No smoking-oxygen in use signs while doing daily rounds of the building.

The facility has implemented a quality assurance monitor:

ADON will submit weekly rounds report to the Monthly Quality of Life (Quality Improvement Committee) Meeting  
Compliance will be achieved by Nov. 26, 2011

K147

For the residents involved, corrective action has been accomplished by:

Multi-plug outlet in Room # 307 was removed

Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by:

All rooms were checked for multi-plug outlets.

Measures put into place or systemic changes made to ensure that the deficient practice does not occur

Maintenance Director will check for unapproved outlet plugs while doing rounds of the building.

The facility has implemented a quality assurance monitor:

Maintenance Director will submit rounds report to the Monthly Quality of Life (Quality Improvement Committee) Meeting  
Compliance will be achieved by Nov. 26, 2011