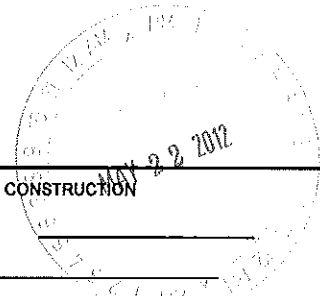


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/11/2012
FORM APPROVED
OMB NO. 0938-0391




STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 346496	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2012
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NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS N&R ALAMANCE	STREET ADDRESS, CITY, STATE, ZIP CODE 791 BOONE STATION DRIVE BURLINGTON, NC 27215
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(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
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F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to report 1 of 2 allegations of abuse to the appropriate agencies within the State's required timeframe. Resident #93.</p> <p>Findings included:</p> <p>A review of the facility's policy on "Abuse Prohibition" (revised 5/1/07) included: "Reportable Incidents: 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. A 24-Hour investigation and report must be completed and faxed in to DHHS (fax number is on DFS-4501 form-revised 8/16/00) Facilities will use the 24-Hour Initial Report form and follow the guidelines for completion that are on the instruction sheet provided with the form. " Further review of the policy documented: " Allegations occurring after hours or on weekends: It is the SUPERVISOR '</p>	F 226	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</p> <p>Corrective Action for Resident Affected For Resident #93 the facility allegedly failed to report an allegation of abuse to the appropriate agencies within the State's required timeframe on 4/23/12.</p> <p>Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this alleged deficient practice. All abuse investigations were reviewed by the Director of Nursing on 5/1/12 to ensure that failure to report allegations of abuse to the appropriate agencies within the State's required timeframe were present for those residents with an allegation of abuse. Also all staff were interviewed to ensure that all allegations of abuse were reported and followed up in a timely manner.</p>	5/22/12
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 5/17/12
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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	<p>Continued From page 1</p> <p>S RESPONSIBILITY to review the information via in person or by phone with the initiating nurse, and ensure that the completed 24-hour report is faxed into DHHS AND to notify management for appropriate follow-up the next business day."</p> <p>During an interview on 4/23/12 at 4:47pm, Resident #93 (identified by the facility as cognitively, moderately impaired) alleged that a nursing assistant was recently, physically and verbally abusive to her. Resident #93 revealed that on the previous early morning of Thursday or Friday, a nursing assistant came into her room to provide incontinent care or to assist her in preparing for the day. The resident stated that the nursing assistant asked her in a hateful tone of voice, if she still had "that same gown on, that's nasty! I'm gonna get it and you ' re not gonna get it back anymore". The resident indicated the nightgown was her favorite gown and the facility ' s laundry department would wash it for her everyday. Resident #93 further revealed that the nursing assistant grabbed and twisted her left arm, three times. The resident stated that she then told the nursing assistant if she didn't release her arm, she (the resident) would slap her. The resident stated that when the nursing assistant released her arm, it was bruised and sore. During this interview, Resident #93 pulled back the sleeve of her pullover top revealing a purplish bruise on her left arm (near elbow). The resident revealed that she reported the incident to the Head Nurse after breakfast on day of the alleged abuse. The resident also revealed that she had not seen the nursing assistant since she reported the incident.</p> <p>Review of facility ' s records revealed Resident</p>	F 226	<p>Systemic Changes An in-service was conducted on 5/14/12 for all RN supervisors and on 5/16/12, 5/17/12 and 5/22/12 by the Director of Nursing for all additional nursing staff. Those who attended were all RNs, LPNs, and CNAs, FT, PT, and PRN. Hospice providers were included because they do provide resident care in the facility. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included timely completion of the 24-hr report when there is an allegation of abuse, neglect, misappropriating property of the patient and facility, or diverting drugs belonging to the patient or facility, or injury of unknown origin. 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.</p> <p>Quality Assurance The Director of Nursing or Unit Managers will monitor this issue using the "Survey QA Tool for timely notification to DHHS of any alleged abuse". The monitoring will include verifying that the 24 hr report was completed timely and faxed to DHHS. All RN supervisors and 5 staff members will be reviewed with the audit tool each time. See attached monitoring tool. This will be done daily (Monday thru Friday) for four weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.</p>	
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F 226	<p>Continued From page 2</p> <p>#93 ' s allegation of verbal and physical abuse by a nursing assistant was documented as a Grievance Report on 4/20/12 by NS#2 (Nursing Supervisor). However, the 24-Hour Initial Report was not submitted to the appropriate state agencies until 4/23/12 by the DON (Director of Nursing).</p> <p>During an interview on 4/26/12 at 10:12am, NS#2 (Nursing Supervisor) revealed that on Friday, 4/19/12, she was informed about a confrontation between Resident #93 and a 11:00pm-7:00am nursing assistant. NS#2 stated that the nursing assistant told her that the resident had been combative with her while she was conducting a blood pressure check. NS#2 revealed she then interviewed Resident #93 who told her that a nursing assistant " called her a liar " and grabbed her arm causing a painful bruise. NS#2 stated that she did observe a large dark bruise on the resident ' s upper left arm (where the blood pressure cuff would be placed). The resident refused to have the arm bandaged or iced. NS#2 stated that she completed an incident report, and notified the resident ' s Responsible Party and her Physician. She also interviewed, via telephone, the Night Nurse, and the two nursing assistants who were in the resident ' s room at the time of the incident. NS#2 stated that she reported the incident to the DON via telephone. The accused nursing assistant was assigned to a different resident ' s hall on Friday, Saturday, and Sunday. No further instructions were given by the DON. The NS#2 revealed that she did not complete a 24-Hour Report of the incident because she did not consider the episode a case of abuse after interviewing a second nursing assistant who was a present during the incident.</p>	F 226		

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F 226	Continued From page 3 During an interview on 4/26/12 at 11:15am, the DON confirmed that on Friday, 4/19/12, NS#2 notified and discussed with her the incident involving a nursing assistant and Resident #93; and they concluded there was no abuse. However; the following Monday, after discussing the incident with the Administrator, the decision was made to submit a 24-Hour Report to the State Agency and to conduct an investigation of the incident.	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 dates indicated.	5/22/12
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	Corrective Action for Resident Affected No specific resident was identified that based on facility observation and staff interviews the facility allegedly failed to remove expired medications from medication storage areas and assure that medications and biological's were stored at the proper temperature. All expired medication was discarded from the medication storage areas and the temperature of the refrigerator was adjusted to meet facility policy and procedure on 4/26/12. Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this alleged deficient practice. All resident medication storage areas and medication refrigerators were reviewed by RN supervisor's on 4/26/12 and 4/27/12 to ensure that there were no expired medication in the storage areas and the medication refrigerators were at the correct temperatures.	

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F 431	<p>Continued From page 4</p> <p>controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility observations and staff interviews the facility failed to remove expired medications from 3 of 6 medication storage areas (100 hall medication storage cart, 100-300 medication storage room, 400/500 medication storage room) and assure that medications and biological's were stored at the proper temperatures.</p> <p>Findings Include:</p> <p>1. On 04/25/12 at 12:00 PM an observation of the 100, 200, 300 hall medication storage room was conducted with Staff member #1. The following expired Over The Counter (OTC) medications were observed in wooden cabinets, wooden drawers, and on wire shelves in the medication room:</p> <p>Guaifenesin 400mg tablets (1 bottle unopened) lot # S0905002 - Expired 05/2011 Bacteriostatic 0.9% solution bottle for injection (unopened) Lot # 86-460DK - Expired 02/01/2012 Bacteriostatic 0.9% solution bottle for injection (unopened) Lot # 84-301DK - Expired 01/12/2011 Gelocast 4in x 10yd bandage wrap - (12 Boxes)</p>	F 431	<p>Systemic Changes An in-service was conducted on 5/16/12, 5/17/12 and 5/22/12 by the Director of Nursing. Those who attended were all RNs, LPNs, and CNAs, FT, PT, and PRN. Hospice providers were not included because they do not provide medication in the facility. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included monitoring of the medication storage areas for expired medications and monitoring of the medication refrigerators for proper temperatures. 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.</p> <p>Quality Assurance The Director of Nursing or Unit Managers will monitor this issue using the "Survey QA Tool for medication storage and medication refrigerators". The monitoring will include verifying that there are no expired medications in the medication storage areas and the temperatures of all medication refrigerators are correct within facility policy. See attached monitoring tool. This will be done daily for two weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.</p>	

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F 431	<p>Continued From page 5</p> <p>Lot# 8178 - Expired 12/2011</p> <p>An interview was conducted with staff member # 1 (floor nurse) on 04/25/2012 at 12:10 PM. Staff member # 1 indicated all the medications listed above and found in the 100-300 medication storage room were expired and should have been pulled from the storage room. Staff member #1 stated that it was each nurse's responsibility to check the expiration dates of the medications in the medication room. Staff member #1 also stated the facility had an OTC stock person who also assisted in checking the medications for expiration dates.</p> <p>An interview was conducted with the Director of Nursing (DON) on 04/27/2012 at 1:44 PM. The DON was asked her expectation for checking the medications in the medication storage rooms and medication carts for expiration dates. The DON stated the nursing staff was supposed to check the expiration dates of the medications in the medication rooms and the medication carts and remove the medications when expired.</p> <p>2. The 100 hall medication cart was observed on 04/25/2012 with staff member # 3 at 12:15 PM. In the cart the following medications were found to be expired: 1 unopened Glucagon Emergency Kit - for Low Blood Sugar treatment Lot# A693325D - Expired 11/2011 9 unopened Albuterol and Ipratropium Bromide breathing treatment medication solution package kits containing 5-3ml vials in each packet and 1 opened packet containing 3-3ml vials Lot #B8K025 - Expired 10/2010.</p>	F 431		

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F 431	<p>Continued From page 6</p> <p>An interview was conducted with staff member #3 on 04/25/2012 at 12:25 PM. Staff member #3 indicated the medications listed above and found in the 100 hall's medication cart were expired. Staff member # 3 also stated that it was each nurse's responsibility to check the expiration dates of the medications in the medication carts.</p> <p>An interview was conducted with the Director of Nursing (DON) on 04/27/2012 at 1:44 PM. The DON was asked her expectation for checking the medications in the medication storage rooms and medication carts for expiration dates. The DON stated the nursing staff was supposed to check the expiration dates of the medications in the medication rooms and the medication carts and remove the medications when expired.</p> <p>3. On 4/25/2012 at 10:00 am an observation was made in the medication room for the 400-500 halls of Colace with an expiration date of 3/2012. When asked who checked the stock medications for expiration dates, Nurse # 7 responded that the nurses and the nurse supervisor checked. Nurse # 7 stated that the medications were checked at least once a month. Nurse # 7 also removed the Colace from the medication room shelf for disposal.</p> <p>At 1:45 pm on 4/27/2012 the Director of Nurses (DON) was asked her expectations for checking the medications in the medication storage rooms for expiration dates. The DON stated the nursing staff were supposed to check the expiration dates of the medication in the medication rooms and the medication carts and remove medications when expired.</p>	F 431			

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F 431	Continued From page 7 4. Manufacturer's recommendations for Novolog pen by Nova Nordisk, Lantus pen by Sanofi Aventis, and Phenadoz by Paddock all indicated these medications should be stored at refrigerator temperatures between 36 degrees and 46 degrees when unopened. Turbinol (Purified Protein Derivative [PPD] tuberculin test) by Sanofi Pasteur was to be stored at 36-46 degrees even after opening and was to be discarded if exposed to freezing temperatures as the freezing temperature changed the chemical makeup of the medication. At 10:15 am on 4/25/2012 the medication refrigerator located in the medication room for the 400-500 halls was observed to have a temperature of 32 degrees. There was also a large piece of ice hanging out of an open freezer compartment at the top of the refrigerator's interior. Observation of the temperature log for this refrigerator found that temperatures were checked at midnight each day. The temperature for 4/23/2012 was documented at 26 degrees, for 4/24/2012 at 20 degrees, and for 4/25/2012 at 30 degrees. On 4/25/2012 the log indicated the temperature control was turned to #4. There were no other changes noted. Inside the refrigerator the following medications were observed: 1. Opened Turbinol PPD manufactured by Sanofi Pasteur 2. Unopened Novolog pen manufactured by Nova Nordisk 3. Unopened Lantus pen manufactured by Sanofi Aventis 4. Unopened individual Phenadoz manufactured by Paddock	F 431			

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F 431	<p>Continued From page 8</p> <p>Nurse # 7 was asked who checked the temperatures for the medication refrigerator. Her reply was that the night shift did. Asked what the acceptable range was Nurse # 7 said the log indicated temperatures should be between 32 degrees and 42 degrees. The log was observed to have this range printed at the top of the page. Asked what should be done if the temperatures were out of range, Nurse # 7 stated she didn't really know as she did not work night shift.</p> <p>At 1:15 pm on 4/25/2012 Nurse # 7 stated she had turned the temperature up on the medication refrigerator and the thermometer now read 39 degrees. The temperature was observed to be 39 degrees. Nurse #7 when asked for the policy related to the medication temperatures was not able to find it in the facility's online policy manual.</p> <p>In an interview on 4/25/2012 at 1:30 pm the nurse supervisor for the 400-500 halls stated that she checked the temperature log each morning to be sure it had been signed off for the previous shift. When asked what should happen if the temperature is out of the acceptable range, the nurse supervisor stated that the nurse checking the temperature should notify maintenance by either a verbal communication or written work order.</p> <p>At 2:05 pm on 4/25/2012 an interview was conducted with the facility's maintenance manager in his office. He explained the process for repairs that needed to be done in the facility was for the staff to fill out a work order for the needed repair and turn it in to his office. The maintenance manager identified the turned-in work orders that were kept in a cardboard box on</p>	F 431		

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F 431	Continued From page 9 a shelf in his office. The maintenance manager was asked if there had been a work order turned in for repair of the 400-500 halls' refrigerator due to it being logged with temperatures colder than those required for medication storage. The maintenance manager reviewed the work orders and stated he did not have a work order for the refrigerator and was not aware that there was a problem with the refrigerator being too cold. The nurse supervisor for the 400-500 halls on 4/25/2012 at 2:46 pm provided an updated medication storage facility policy. The policy indicated that the medication refrigerators should be maintained with temperatures from 36-46 degrees.	F 431	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	5/22/12
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441	Corrective Action for Resident Affected For Residents # 141, # 59 and #11 the facility allegedly failed to ensure residents treatment equipment was stored in a manor to prevent possible contamination. On 4/26/12, all oxygen tubing was replaced with new tubing and then stored in plastic bags. Corrective Action for Resident Potentially Affected All residents that use oxygen concentrators and nasal cannulas have the potential to be affected by this alleged deficient practice. All residents on oxygen were identified and reviewed by the two RN supervisors on 4/25/12 and 4/26/12 to ensure that all nasal cannula tubing was in plastic bags attached to the oxygen concentrators.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345496	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2012
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NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS N&R ALAMANCE	STREET ADDRESS, CITY, STATE, ZIP CODE 781 BOONE STATION DRIVE BURLINGTON, NC 27215
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F 441	<p>Continued From page 10</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility observations, resident and staff interviews, and record reviews the facility failed to ensure resident treatment equipment was stored in a manor to prevent possible contamination for 3 of 9 residents (#141, #59, #11) observed to be using oxygen concentrators and nasal cannulas.</p> <p>Findings Include:</p> <p>1. On 04/23/2012 at 12:05 PM an observation and interview was conducted with resident # 141. During the interview it was observed that the resident's oxygen tubing/cannula attached to his oxygen concentrator was laying unprotected on the floor. During interview the resident stated he used the oxygen/nasal cannula at night but did not know how long the tubing and cannula had been on the floor. A review of the resident's</p>	F 441	<p>Systemic Changes An in-service was conducted on 5/16/12, 5/17/12 and 5/22/12 by Director of Nursing. Those who attended were all RNs, LPNs, and CNAs, FT, PT, and PRN. Hospice providers were included because they do provide resident care in the facility. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included storing oxygen tubing in a plastic bag attached to the side of the oxygen concentrator and if the tubing is on the floor unprotected it will be replaced with new tubing. 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.</p> <p>Quality Assurance The Director of Nursing or designee will monitor this issue using the "Survey QA Tool for proper handling of oxygen concentrators and tubing". The monitoring will include verifying that any resident with an oxygen concentrator and tubing has a plastic bag attached and the tubing is correctly placed inside the bag and not unprotected. All residents with an oxygen concentrator and oxygen tanks in use and tubing will be reviewed. See attached monitoring tool. This will be done daily for four weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.</p>	
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NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS N&R ALAMANCE			STREET ADDRESS, CITY, STATE, ZIP CODE 791 BOONE STATION DRIVE BURLINGTON, NC 27215	
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F 441	<p>Continued From page 11</p> <p>medical record indicated the resident was to be receiving oxygen via nasal cannula at night.</p> <p>A second observation was made on 04/25/2012 at 2:55 PM of resident # 141's nasal cannula with staff member # 4. The oxygen tubing was observed connected to the resident's concentrator and the nasal cannula was laying unprotected on the floor under the concentrator. An interview was conducted with staff member # 4 at 2:58 PM. Staff member #4 recognized the resident's nasal cannula was lying unprotected on the floor and stated, "It needs to be changed before the resident receives oxygen from the concentrator."</p> <p>A third observation of resident # 141 was conducted with staff member # 3 on 04/25/2012 at 3:10 PM. The resident's nasal cannula was observed to be still laying unprotected on the floor. Staff member # 3 stated the nasal cannula was not supposed to be laying unprotected on the floor and removed the oxygen tubing/nasal cannula from the resident's concentrator. After removing the tubing/cannula staff member # 3 stated, "The next shift is here and they will now have to put on a new cannula before they can give the resident his oxygen tonight."</p> <p>A fourth observation was made of resident # 141 on 04/26/2012 at 2:35 PM with the 100 hall PM nurse, staff member # 5. The resident's nasal cannula was observed by staff member # 5 laying unprotected on the floor. Staff member # 5 stated, "The cannula was supposed to be wrapped up and placed on the oxygen concentrator by the night shift to prevent it from becoming contaminated."</p>	F 441		

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F 441	<p>Continued From page 12</p> <p>2. On 04/23/2012 at 1:30 PM an observation and interview was attempted with resident # 59. During the interview attempt it was observed that the resident's oxygen tubing/nasal cannula was laying unprotected on the floor. A review of the resident's medical record indicated the resident was to be receiving continuous oxygen via nasal cannula.</p> <p>A second observation of resident # 59 was made on 04/25/2012 at 2:50 PM. The resident's nasal cannula was observed still laying unprotected on the floor next to the resident's bed. The resident could not communicate how long the cannula had been on the floor. An interview was conducted with staff member # 4 who could not state how long the oxygen tubing and nasal cannula had been on the floor.</p> <p>3. On 04/25/2012 at 2:42 PM an observation was made of resident # 11 and her room. The resident's oxygen tubing and nasal cannula were observed to be laying on the floor unprotected and under the resident's bed. Staff member # 6 was observed in the room. Staff member # 6 was asked about the resident's oxygen tubing/nasal cannula being on the floor. Staff member # 6 stated, "It should be on the resident." At that time staff member # 6 was observed to pick up the oxygen tubing/nasal cannula off the floor and place it on resident # 11. A review of the resident's medical record indicated the resident was to be receiving continuous oxygen via nasal cannula.</p> <p>An interview was conducted with staff member # 6 on 04/25/2012 at 2:45 PM When asked about</p>	F 441			

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F 441	Continued From page 13 placing the possibly contaminated nasal cannula which was observed on the floor back on the resident staff member # 6 stated, "I should not have placed the nasal cannula back on the resident, I should have replaced the nasal cannula with a new clean cannula and tubing."	F 441	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	5/22/12	
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on facility observation, staff interviews, and maintenance record reviews the facility failed to ensure all handrails were firmly secured to the walls for 1 of 5 (500 hall) resident hallways. Findings Include: On 04/25/2012 at 1:53 PM an observation was made of the facility's 400/500 hall's handrails. The handrail on the 400 hall (nearest the nurses station by room 403 and the entry point to the nurses station) was found to be loose and could be easily moved at least 1/2 inch from the wall with one finger's pressure. An interview with staff member # 7 (400 hall nurse) was conducted on 04/25/2012 at 1:57 PM. The nurse observed the loose handrail and stated, "It is not supposed to be loose, this hall is the facility's rehabilitation hall and the residents used the handrails a lot." The nurse also indicated she was not aware the handrail had become loose.	F 468	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Resident Affected No specific resident was identified. The facility allegedly failed to ensure all handrails were firmly secured to the wall for resident hallways. The handrail was tightened on 4/25/12. Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this alleged deficient practice. All handrails were reviewed by the Maintenance Director on 4/25/12 and 4/26/12 to ensure that all handrails were secured firmly to the wall on all hallways.		

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F 468	<p>Continued From page 14</p> <p>On 04/25/2012 at 2:00 PM the facility's maintenance manager was observed to come to the 400 hall and observe the identified loose handrail. An interview was conducted with the maintenance manager at 2:02 PM who indicated the handrail was supposed to be secure to the wall and observed that it only took 1 finger pressure to bring the handrail approximately 1/2 inch away from the wall. The maintenance manager stated, "I was not aware that the handrail was loose and I do not recall having a work order for the loose handrail." The maintenance manager was asked to describe the facility's process for requesting work once a deficiency was identified. The maintenance manager stated, "There are file boxes on the walls at each nurse's station with blank work orders in them. Any staff member that identifies an issue requiring repairs will fill out and sign a work order and either place it on the file box for me to pick up on my rounds as I make 3-4 rounds daily, or place it in my office inbox. I will inspect and review the item that needs repair, let the administration know if necessary, and then file the work order in priority for repair. If it is something that needs immediate attention I will start repairs immediately."</p> <p>On 04/25/2012 at 2:10 PM a second interview was conducted with the facility's maintenance manager in his office. The maintenance manager pulled out the turned in work orders he had which he kept in a cardboard box on the shelf in his office. The work orders on hand were reviewed by the maintenance manager and he stated, "I have no work order for the loose hand rail."</p>	F 468	<p>Systemic Changes An in-service was conducted on 5/16/12, 5/17/12 and 5/22/12 by the Director of Nursing. Those who attended were all staff members in all departments, FT, PT, and PRN. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included proper way to complete a maintenance work order and how to notify maintenance if a problem is identified with the handrails. 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.</p> <p>Quality Assurance The Director Maintenance or Floor Technician will monitor this issue using the "Survey QA Tool for monitoring handrails". The monitoring will include verifying that no handrails are loose on resident hallways. See attached monitoring tool. This will be done weekly for four weeks and then monthly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.</p>		

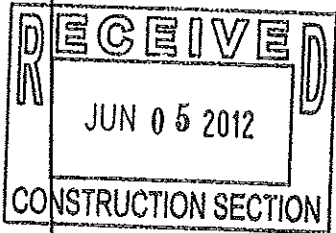
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345496	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
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NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS N&R ALAMANCE	STREET ADDRESS, CITY, STATE, ZIP CODE 791 BOONE STATION DRIVE BURLINGTON, NC 27215
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K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 5/17/12 at approximately noon the following hazardous areas were non-compliant, specific findings include soiled linen was stored in the 300, 400, & 500 Hall bathrooms.</p>	K 029	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</p> <p>Corrective Action for the deficient practice: The soiled linen was removed from 300, 400 and 500 hall bathrooms on 5/17/12 at 12:30 pm.</p> <p>Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this alleged deficient practice. The Administrator and Director of Nursing did walking rounds and checked 300, 400 and 500 hall bathrooms to ensure no soiled linen was in these rooms on 5/18/12 and 5/23/12.</p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 6/1/12
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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 15 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 5/17/12 at approximately noon the following hazardous areas were non-compliant, specific findings include soiled linen was stored in the 300, 400, & 500 Hall bathrooms.</p>	K 029	<p>Systemic Changes An in-service will be conducted on 6/6/12, 6/7/12 and 6/8/12 by the Staff Development Coordinator. Those who will attend are all housekeeping personal, RNs, LPNs, and CNAs, FT, PT, and PRN. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included proper way to handle soiled linen. All soiled linen will be place in a plastic bag and placed in a laundry barrel on the hall, when the container must be removed off the hall and stored in 300, 400 and 500 hall bathrooms the housekeeper assigned to the hall will collect the soiled linen and take to laundry and the empty barrel will be placed in the hall bathrooms. 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.</p> <p>Quality Assurance The Director of Maintenance or Floor Technician will monitor this issue using the "Survey QA Tool for monitoring soiled linen". The monitoring will include verifying that no soiled linen is stored in 300, 400, and 500 hall bathrooms. See attached monitoring tool. This will be done daily for four weeks and then monthly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined the 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 1- 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.