STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	C 05/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

(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 No deficiencies were cited as a result of the Recertification/complaint investigation in the event ID #1J2V11, dated May 17, 2013	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.

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345498	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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K 000	INITIAL COMMENTS Surveyor: 10904 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action K029 The Maintenance Director acquired a contractor on 6/7/13 and had the dry storage room door in the kitchen repaired so that it would close, latch and seal. Corrective action for identifying other potential life safety issues All residents have the potential to be affected by this alleged deficient practice. Every door in the building was checked by the Maintenance Director to ensure the standard for one-hour fire rated construction and all doors are self-closing and latching that protect hazardous areas is functioning correctly. Systemic Changes Monthly the Maintenance Director will check all fire doors to ensure they meet standards for all life safety guidelines as evidenced by self-closing and latching properly. Quality Assurance The Maintenance Director will check all fire doors monthly to ensure they are functioning properly. This will be done monthly times 3 months and reported	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Surveyor: 10904 Based on observation on Tuesday 6/4/13 at approximately 11:00 AM onward the following was noted: 1) The dry storage room door in the kitchen did not close latch and seal. 42 CFR 482.41(a)	K 029		6-7-13

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JUN 21 2013
CONSTRUCTION SECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6/19/13

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	345496	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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K 038 SS=D	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: Surveyor: 10904 Based on observation on Tuesday 6/4/13 at approximately 11:00 AM onward the following was noted: 1) When questioned the staff were not familiar with the master override switch for the mag lock door. 42 CFR 482.41(a)	K 038	to the QOL committee. If any violations are found the maintenance director will contact the contractor for service to the door. Corrective Action K038 The Maintenance Director, Director of Nursing and Administrator in serviced all staff on June 6, 2013 on the locations of emergency exit door override switch locations and their function. Corrective action for identifying other potential life safety issues All residents have the potential to be affected by this alleged deficient practice. All staff was in-serviced on the function of the override switch and the reasons to use the override in case of an emergency. Systemic Changes Effective immediately the function and use of the override switch will be incorporated into the facility orientation process and will be in-serviced annually with all staff. Quality Assurance The Maintenance Director will periodically and randomly ask staff the function of the override switch and how it would be used in an emergency. If any violations are found the maintenance director will conduct additional in-	6-6-13
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by:	K 076	services. All findings will be reported to the QOL committee. Corrective Action K076 The Maintenance Director, Director of Nursing and Administrator in serviced all staff on June 6 and 17, 2013 on the proper method of storage of oxygen cylinders.	6/6/13

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K 076	Continued From page 2 Surveyor: 10904 Based on observation on Tuesday 6/4/13 at approximately 11:00 AM onward the following was noted: 1) An oxygen cylinder in the oxygen storage room was not properly chained or supported in a proper cylinder stand or cart. [NFPA 99 4-3.5.2.1b(27)] 42 CFR 482.41(a)	K 076	Corrective action for identifying other potential life safety issues All residents have the potential to be affected by this alleged deficient practice. The O2 storage room was checked and all O2 tanks were secured. All staff was in-serviced on the proper storage of oxygen cylinders according to life safety regulations. Systemic Changes Effective immediately the proper storage of oxygen cylinders will be incorporated into the facility orientation process and will be in-serviced annually with all staff. Quality Assurance The Maintenance Director and supply clerk will periodically and randomly check the O2 storage rooms to ensure all tanks are properly secured. If any violations are found the maintenance director will conduct additional in-services. All findings will be reported to the QOL committee.	6-17-13 6-6-13
K 141 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Surveyor: 10904 Based on observation on Tuesday 6/4/13 at approximately 11:00 AM onward the following was noted: 1) For resident room 208 there was not a no smoking sign posted on the door while oxygen was in use. 42 CFR 482.41(a)	K 141	Corrective Action K141 The Director of Nursing and Administrator in serviced all staff on June 6 and 17, 2013 on the proper signage for oxygen while in use. Corrective action for identifying other potential life safety issues All residents have the potential to be affected by this alleged deficient practice. All residents that use O2 were checked to ensure the proper signage was displayed. All staff was in-serviced on the proper signage required for oxygen use.	6/6/13 6/17/13

Systemic Changes
Effective immediately all residents that use oxygen will have a "No Smoking" sign placed outside of their room. This practice will be incorporated into the facility orientation process and will be in-serviced annually with all staff.

Quality Assurance
The Director of Nursing, and RN supervisors will periodically and randomly check all rooms of residents that use O2 to ensure the proper signage is in use. If any violations are found the Director of Nursing will conduct additional in-services for all staff. All findings will be reported to the QOL committee.