STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R CTR OF COLUMBUS CTY	1402 PINCKNEY STREET WHITEVILLE, NC 28472

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to develop a comprehensive care plan for one of nineteen residents (Resident #32) whose care plans were reviewed. Findings included: Review of the clinical record indicated Resident #32 was admitted 2/29/2016 with diagnoses of heart failure, Diabetes, anxiety and depression. Review of the admission Minimum Data Set (MDS), dated 3/7/2016 noted Resident #32 was	F 279	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.	7/29/16

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

Electronically Signed | 07/29/2016

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F 279	Continued From page 1 cognitively intact and needed extensive assistance for all Activities of Daily Living (ADLs). Resident #32 could feed herself with supervision. The MDS noted Resident #32 was occasionally incontinent for urine. The Care Area Assessment (CAA) highlighted Resident #32 was occasionally incontinent for urine and this area would be care planned. A review of Resident #32 ' s care plan dated 6/16/2016, revealed no plan of care for urinary incontinence. On 07/13/2016 at 2:53:31 PM, in an interview, the MDS nurse stated she did not know why there was no care plan for urinary incontinence and would check with her assistant who updated care plans. On 7/13/2016 at 3:10 PM, the MDS nurse stated the care plan had been updated for urinary incontinence for Resident #32. On 7/14/2016 at 4:15 PM, in an interview, the Director of Nursing (DON) stated her expectation was the MDS would be accurate and complete.	F 279	For resident #32, the MDS Coordinator updated the resident's care plan on 07/13/2016 to reflect his current incontinence status. Interventions were initiated as indicated. On 07/26/2016, the MDS Nurse audited all current MDS assessments section H0300 and H0400 for coding of 1, 2, or 3 for incontinence. If 1, 2, or 3 was coded, the care plan was audited to ensure the incontinence was care planned with interventions included as indicated. This process will be completed by 07/27/2016. See attachment #1. On 07/28/2016, the IDT was in-serviced by the Administrator on care planning requirements, and updating care plans. This information has been integrated into the standard orientation training for MDS Coordinators and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. See attachment #2. The Director of Nursing will monitor this issue using the Care Plan Quality Assurance Tool for monitoring care planning for incontinence. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as	

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F 279	Continued From page 2	F 279	appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, ADON, SDC, HIM, Dietary Manager and the Administrator. See attachment #3.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record reviews, facility staff and consultant pharmacist interviews, the facility failed to ensure monthly Medication Regimen Reviews (MRR) were conducted each month by a licensed pharmacist for 1 of 5 resident records reviewed for unnecessary medications (resident #142). Findings included: Review of the clinical record indicated resident #142 was admitted to the facility on 10/10/2014 with diagnoses to include Hypertension, Anemia and Peripheral Vascular Disease. A clinical review of the consultant pharmacist ' s monthly MMR ' s revealed hand written reviews from the month of the facility ' s last recertification	F 428	For resident # 142, the Consultant Pharmacist reviewed the drug regimen on 7/22/16. See attachment #4. On 07/22/2016, the HIM audited all current residents' charts for current monthly MRR. This process will be completed by 07/27/2016. See attachment #5. On 07/26/2016, the Consultant Pharmacists were in-serviced by the Administrator on monthly MRR completion and the process to prevent missing resident reviews. This information has	7/27/16

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F 428	Continued From page 3 survey (August 2015) through January 2016. The next MMR was dated April 25, 2016. An interview was conducted with the Director of Nursing (DON) on 7/13/2016 at 2:00 PM. The DON reported the consultant pharmacist was notified by telephone, and the pharmacist indicated awareness of the omitted MRR ' s. A telephone interview was conducted with the facility pharmacist on 7/13/2016 at 5:30 PM. The pharmacist reported every resident in the facility was reviewed monthly. The pharmacist indicated the facility provided a copy of the updated census on the date of each monthly visit. The pharmacist stated the residents were checked off the list when the MRR ' s were completed. The pharmacist was unable to indicate why the MMR ' s were not completed for resident # 142 in February or March of 2016. The pharmacist reported the February and March MRR ' s were missing when the April MRR was completed for resident # 142. The pharmacist indicated when the missing MRR ' s were discovered, a review of the physician ' s orders for February and March was completed. The pharmacist indicated no new medication orders were written during February and March. The pharmacist stated she had no explanation for the missing MRR ' s. An interview was conducted with the facility Administrator on 7/14/2016 at 10:30 AM. The Administrator indicated the missing MRR ' s were discovered during the facility ' s Quality Assurance meeting in April. The Administrator stated it was her expectation the consultant pharmacist would conduct a MRR each month on every resident in the facility.	F 428	been integrated into the standard orientation training for Pharmacist Consultants and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. See attachment #6. The HIM will monitor this issue using the Pharmacy Log QA tool for monitoring completion of monthly reviews. This will be completed monthly x 3 months or until resolved by Quality Assurance Committee. Reports will be presented to the Monthly QA committee by the HIM to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the DON, ADON, SDC, HIM, Dietary Manager and the Administrator. See attachment #7.	