PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345532	B. WING _			1	C 08/2018
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		<u>,                                    </u>	00.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  The survey team ent conduct a recertificat and was unable to re due to adverse weath travel conditions. The facility on 1/8/18 and 1/8/18. Event ID #LN Accuracy of Assessm CFR(s): 483.20(g)  §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by:  Based on record rev facility failed to code (MDS) assessment a medications for 1 of 6 reviewed for unneces findings included:  Resident #13 was ad 4/5/16 and most recewith diagnoses that in cancer, and dementiant assessment dated 10 #13 's cognition was N, the Medication Se was administered 0 at The Antipsychotic Medication	dered the facility on 1/2/18 to ion and complaint survey turn to the facility on 1/4/18 her of snow, ice and unsafe e survey team returned to the completed the survey on MK311.  Inents  of Assessments. It accurately reflect the  is not met as evidenced liew and staff interview, the the Minimum Data Set ccurately in the area of 6 residents (Resident #13) is sary medications. The  mitted to the facility on intly readmitted on 9/7/17 included breast cancer, brain a.  Im Data Set (MDS)  of 1/4/17 indicated Resident #13 intipsychotic medications.	F	541	F641 Accuracy of Assessment Based on record review and staff interview, the facility failed to code the Minimum Data Set assessment accura in the area of medications for 1 of 6 residents, Resident #13, reviewed for unnecessary medications. The plan for correcting the specific deficiency and the process that lead to alleged deficiency: On 01/08/18 Minimum Data Set Nurse told the Surveyor that she had incorrect coded resident #13 on section N of the Quarterly Minimum Data Set with the Assessment Reference Date of 10/14/1 as having received 0 antipsychotic medications. While modifying this Minimum Data Set assessment she for to uncheck the section that revealed th resident #13 had received routine antipsychotic medications. The Minimum	tely the	2/5/18
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	F		Data Set was immediately corrected us	sing	(X6) DATE

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

**Electronically Signed** 

01/26/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		345532	B. WING _		0.1	C / <b>08/2018</b>	
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F 641	Continued From pa	age 1	F 6	41			
F 641	A review of Reside Administration Recomposition Resident An interview was consultant. She recomposition Recomposit	ont #13 's Medication ford (MAR) during the 10/14/17 food (10/8/17 through 10/14/17) eved no antipsychotic fooducted with MDS Nurse 18 at 2:40 PM. She indicated sting the facility with completion for a couple of months as a new MDS Nurse. The food for the MDS assessment for the MDS assessment food food food food food food food foo	F	modification request whice to Centers for Medicare as Services data base on 0° All residents on antipsych were audited by the Direct with the assistance of the Consultant on 01/23/18. Who receive antipsychotic were all reviewed for accessection NO410A and that reflected on what basis the was administered. If it was on routine basis, then this coded as such on this see resident received it on as as both and routine basis accurately reflected on some the Minimum Data Set as All current residents on a medications were audited of Nursing with the assist Minimum Data Set Now Responses on section Now Minimum Data Set was a responses on section Now Minimum Data Set was a response on section Now Minimum Data Set was a response on section Now Minimum Data Set was a response on section Now Minimum Data Set was a response on section Now Minimum Data Set was a response on section Now Minimum Data Set was a response on section Now Minimum Data Set was a response on section Now Minimum Data Set was a response on section Now Minimum Data Set was a response on section Now Minimum Data Set was a response on section Now Minimum Data Set was a response on section Now Minimum Data Set was a response on section Now Minimum Data Set was a response on section Now Minimum Data Set Now Response Now Minimum Data Set Now Response Now Minimum Data Set Now Response Now Response Now Response Now Response Now Response Now R	and Medicaid 1/09/18. notic medications ctor of Nursing, MDS Nurse The residents c medications curate coding of t section NO450A ne antipsychotic as administered s should be ction. If the s needed basis or s, this was ection NO450A of esessments. Intipsychotic d by the Director tance of the fultant Nurse and furse on 01/22/18. O410A of the compared to the O450A. None of esessments that to have any  menting the ction for the or of Nursing and furse Consultant fimum Data Set psychotic in the Minimum		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  G	COMPL	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		O1/0	8/2018
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 01/0	6/2016
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F 641	Continued From page	e 2	F 64	Minimum Data Set Nurse should conumber of days the resident receive antipsychotic medications during the day look back of the Assessment Reference Date. If any resident where received antipsychotic medications section NO450A should be coded reflect on what basis the antipsych medications were administered. If were administered, or if some were administered on an as needed base the medications were administered on be routine basis or administered on be routine and as needed basis, the Minimum Data Set should be code accurately to reflect this.  The monitoring procedure to ensure the plan of correction is effective a specific deficiency cited remains of and/or in compliance with the regurequirements:  The Minimum Data Set Nurse and Director of Nursing will complete the Quality Assurance audit tool for medication for 3 residents weekly monthly x 3. Reports will be present the Administrator weekly that in turbe shared with the weekly Quality Assurance committee by the Direct Nursing to ensure corrective action trends or ongoing concerns is initial appropriate. The weekly Quality Assurance Meeting is attended by Director of Nursing, Minimum Data Coordinator, Support Nurse, There Manager, Health Information	red the ne 7 no s, to notic none esis, or if d on a oth ed at that not that corrected latory  ne onitoring ic x 4 then noted to m will to of note at the at the set is Set	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING				08/ <b>2018</b>
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		31	REET ADDRESS, CITY, STATE, ZIP CODE  O COMMERCE DRIVE  ANFORD, NC 27332	1 017	06/2016
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F 641 F 656 SS=D	CFR(s): 483.21(b)(1) §483.21(b) Compreh	Comprehensive Care Plan ensive Care Plans	F 6		Management, Dietary Manager, Administrator and Medical Director. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process.  The title of the person responsible for implementing the acceptable plan of correction:  The Director of Nursing with the assistance of the Minimum Data Set Nurse.  02/05/18	ne	2/2/18
	§483.21(b)(1) The fai implement a compred care plan for each reresident rights set for §483.10(c)(3), that in objectives and timefrimedical, nursing, and needs that are identifiassessment. The cordescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, includ treatment under §483.	cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ied in the comprehensive hprehensive care plan must g-are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 2.25 or §483.40 but are not esident's exercise of rights ding the right to refuse					

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F 656	Continued From pag	e 4	F 6	56				
	rehabilitative service provide as a result o recommendations. If findings of the PASA rationale in the resid (iv)In consultation wiresident's representa (A) The resident's godesired outcomes. (B) The resident's profuture discharge. Fact whether the resident community was assellocal contact agencial contact agencial entities, for this purp (C) Discharge plans plan, as appropriate, requirements set for section.  This REQUIREMENT	s the nursing facility will f PASARR a facility disagrees with the RR, it must indicate its ent's medical record. th the resident and the ative(s)- pals for admission and eference and potential for cilities must document 's desire to return to the essed and any referrals to es and/or other appropriate						
	interviews and recordevelop a comprehe indwelling urinary cat for the use of an anti to treat insomnia (Reresidents reviewed feincluded:  1. Resident #164 wareadmitted 12/23/17 paraplegia. His adm (MDS) dated 6/29/17 intact with no behavior required supervision	on, staff and resident d review, the facility failed to nsive care plan for an theter (Resident # 164) and depressant medication used esident #35) for 2 of 18 or care planning. The findings admitted 6/22/17 and with a diagnosis of ission Minimum Data Set indicated his was cognitively ors. The MDS read he to extensive assistance with living and had an indwelling		F656 Develop/Implement Con Care Plans Based on observation, staff an interviews and record review, the failed to develop a comprehen plan for an indwelling urinary of (Resident # 164) and for the use antidepressant medication used insomnia (Resident #35) for 2 residents reviewed for care plan The plan for correcting the speed deficiency and the process that alleged deficiency:  On 01/02/18 Resident # 164 wobserved by the surveyor as he indwelling urinary catheter.  All his MDS Assessments Res	and resident the facility sive care catheter se of an ed to treat of 18 anning. ecific at lead to the vas aving an			

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		345532	B. WING _		01	/08/2018		
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F 656	Continued From page	e 5	F 6	56				
	dated 6/22/17 and re 12/23/17 read he ma catheter monthly. The Care Area Asses	#164 's admission orders admission orders dated y change his own urinary		had been accurately coded as h urinary catheter. His admission I Data Set assessment that was c with an Assessment Reference I 6/22/17, and his Care Area Asse for Resident #164 for Urinary / Ir	Minimum completed Date of essment ndwelling			
6/29/17 for the urinary catheter The CAA read Resident #164 had an indwelling urinary catheter and was at risk for urinary tract infections and complications related to the catheter. The CAA		n indwelling urinary catheter inary tract infections and to the catheter. The CAA		catheter had the use of the cathe coded and the indication that this be care planned but no care plan been developed to address the i	s would n had indwelling			
	indicated the area of concern would be care planned.  A review the admission care plan dated 6/23/17			catheter. The most recent care prevision had been completed on and did not include the presence industrial units and set of the complete catheter.	09/21/17			
	did not include a care	e plan to the presence of nary catheter. A review of		indwelling urinary catheter.  A full audit for all residents with a indwelling catheter was completed.				
	Resident #164 's mo	st recent care plan last d not include a care plan for		Minimum Data Set Consultant a new Minimum Data Set Nurse of	nd the			
	the presence of a uri			01/23/18.  All the residents in the facility with				
	indicated his was cog	rterly MDS dated 9/29/17 gnitively intact with no		indwelling catheter that had trigg Care Area Assessment were fou	ind to			
	to extensive assistan	read he required supervision ce with his activities of daily welling urinary catheter.		have a comprehensive care plar addressing the indwelling urinary	y catheter.			
	In an observation and	d interview on 1/2/18 at		The procedure for implementing acceptable plan of correction for				
	indwelling urinary cat	#164 was noted to have an heter. He stated he had a		specific deficiency cited: On 01/23/18 the Director of Nurs	•			
	the care involved in h	s young and was aware of his catheter. He stated he		the Minimum Data Set Nurse Corre-educated the Minimum Data S	Set Nurse			
	changed his own cath	neter monthly and had been s stay at the facility.		on accurately ensuring that any Care Area Assessment that had concern indicated to be address	areas of			
	consultant stated Res	3/17 at 2:10 PM, the MDS sident #164 ' s urinary been care planned as		plan must have a care plan deve implemented to address the area comprehensive care plan will be	as. A			
	stated his CAA. She	also stated the lack of his plan should have been		developed / implemented from the relevant Care Area Assessment	he			

Facility ID: 980156

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345532	B. WING				08/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	,		
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F 656	Continued From page	e 6	F	356				
		t quarterly assessment on			that are appropriate and applicable to t	he		
	9/29/17.	t quartony accessment on			resident per the Resident Assessment			
					Instrument guidelines. The care plan w	ill		
	In an interview on 1/8	3/18 at 3:59 PM, the			then be updated / revised with applicat	ole		
		t was her expectation that			new interventions and new goals or go	al		
		a comprehensive care plan			changes.			
including the presence of catheter.		e of his indwelling urinary				. 1		
					The monitoring procedure to ensure the the plan of correction is effective and the			
	On 1/8/18 at 5:45 PM	I, the MDS consultant			specific deficiency cited remains correct			
provided a care plan for the presence of Resident #164's urinary catheter initiated 1/8/18.					and/or in compliance with the regulator			
				requirements:	,			
	2. Resident #35 was	admitted on 6/12/17 and			The Director of Nursing and the Minimu	um		
	readmitted on 12/13/	17 with cumulative			Data Set Nurse will complete the Quali	ty		
	_	I vascular accident and			Assurance audit tool for monitoring			
	-	cent significant MDS dated			comprehensive care plan triggers, wee	kly		
		e was cognitively intact with			x 4 then monthly x 3. Reports will be			
	no behaviors. She rec	with her activities of daily			presented to the Administrator weekly to turn will be shared with the weekly	nat		
		essment Area (CAA) dated			Quality Assurance committee by the			
	11/15/17 indicated sh	` ,			Director of Nursing to ensure corrective	خ		
	antidepressant. The				action for trends or ongoing concerns is			
	medication was to be				initiated as appropriate. The weekly			
					Quality Assurance Meeting is attended	by		
		#35 ' s November 2107			the Director of Nursing, Minimum Data			
	orders to present rea				Set Coordinator, Support Nurse, Thera	ру		
	Trazadone (antidepre	essant) at night for insomnia.			Manager, Health Information			
	A	#05   -  t			Management, Dietary Manager,			
		#35 's last revised care plan			Administrator and Medical Director.	20		
	use of an antidepress	include a care plan for the			Deficiencies that are identified during the monitoring process will be addressed	IC		
	acc of all alliacpiess	ant for mooning.			through the facility Quality Assurance			
	In an interview on 1/8	3/18 at 10:10 AM, Resident			process.			
		recent surgery, she was less			·			
		t night. She confirmed she			The title of the person responsible for			
		n at bedtime to help her			implementing the acceptable plan of			
	sleep.				correction:			
	In an interview on 1/8	3/17 at 2:10 PM, the MDS						

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		345532	B. WING _			1	C / <b>08/2018</b>
NAME OF PR	ROVIDER OR SUPPLIER	*****	<u> </u>	STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 01/	00/2010
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				SA	ANFORD, NC 27332		
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F 656	Continued From page	Continued From page 7		56			
	consultant stated Resident #35 's antidepressant medication prescribed for insomnia should have been care planned as stated her CAA dated 11/15/17.				The Director of Nursing and the Minime Data Set Nurse. 02/05/18	um	
	·	, the MDS consultant for the use of a prescribed sident #35 ' s insomnia					
	In an interview on 1/8/18 at 3:59 PM, the Administrator stated it was her expectation that Resident #35 have a comprehensive care plan including the administration of an antidepressant prescribed for insomnia.						
F 657 SS=D			F6	57			2/2/18
	be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the r An explanation must be medical record if the p	days after completion of seessment. erdisciplinary team, that ited to-resician. e with responsibility for the responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s). The included in a resident's participation of the resident resentative is determined					

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		345532	B. WING		01/08/2018		
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 01/00/2010		
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F 657	disciplines as deter or as requested by (iii)Reviewed and reteam after each assements. This REQUIREMED by: Based on record refacility failed to revirelated to antidepresampled residents included:  Resident #16 was a 11/28/12 and most with diagnoses that with diagnoses that The annual Minimulassessment dated #16 's cognition was have a diagnosis of antidepressant medicated Trazodon was discontinued of A review of Resider Administration Recontinued on 12/1.	the staff or professionals in mined by the resident's needs the resident. Evised by the interdisciplinary sessment, including both the diguarterly review.  In the staff interview, the ewand revise a care plan essant medication for 1 of 18 (Resident #16). The findings admitted to the facility on recently readmitted on 4/21/17 trincluded insomnia.  In Data Set (MDS) 10/20/17 indicated Resident as intact. He was noted to finsomnia and had received dication on 7 of 7 days during riod.  Int #16's physician's orders the (antidepressant medication) on 12/1/17.  Int #16's Medication ord from 12/2/17 through received no antidepressant the discontinuation of 1/17.	F 65	F657 Care Plan Timing and Revision Based on record review and staff interview, the facility failed to review a revise a care plan related to antidepressant medication for 1 of 18sampled residents (Resident #16). The plan for correcting the specific deficiency and the process that lead to alleged deficiency:  The annual Minimum Data Set assessment with Assessment Referer Date of 10/20/17 for resident #16, revealed that the resident had an activity diagnosis of insomnia and was receivity an antidepressant medication daily to assist with the insomnia during the endok back period of the Minimum Data assessment. The physician or orders indicated that the antidepressant medication was discontinued on 12/0. The surveyors reviewed the resident care plan on 01/08/18 and found the antidepressant medication still showing the active care plan. The antidepressant medication should have been resolved from the care plan since it had been discontinued. The Minimum Data Set	o the oce we sing tire o Set  1/17. os og on		
	was reviewed on 1/	e plan of care for Resident #16 /8/18. The plan of care e focus area of antidepressant		Consultant resolved the medication from the active care plan on 01/08/18.  The procedure for implementing the	om		

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F 657	Consultant on 1/8/18 she had been assistir of MDS assessments of months as they had Nurse. The care plar medication for Reside the MDS Nurse Consorder dated 12/1/17 tfor Resident #16 as withrough 1/7/18 that in antidepressant medic was reviewed with the She revealed Reside have been revised to of the focus area relamedication.  An interview was con Administrator and Dir 1/8/18 at 3:51 PM. Tooth indicated they exaccurately reflect the	ducted with the MDS Nurse at 2:40 PM. She indicated ag the facility with completion and care plans for a couple d just hired a new MDS a related to antidepressant ent #16 was reviewed with sultant. The physician 's hat discontinued Trazodone well as the MAR from 12/2/17 dicated he had received no eation during that time frame a MDS Nurse Consultant. Int #16 's care plan should indicate the discontinuation ted to antidepressant ducted with the ector of Nursing (DON) on he Administrator and DON	F	acceptable plan of correction for specific deficiency cited: All residents with the diagnoses of Insomnia were reviewed by the Ending Minimum Data Set Nursing, Minimum Data Set Nursing, Minimum Data Set Consultant or 01/23/18. All the Minimum Data sassessments were reviewed to sagnosis of Insomnia was still and diagnosis for the resident. Any rewith an active diagnosis of Insom their care plan revised and update reflect the current orders.  The procedure for implementing acceptable plan of correction for specific deficiency cited: On 01/23/18 the Director of Nursithe Minimum Data Set Clinical Correducated the new Minimum Data Set Clinical Correction to the care plan revision and updates as a daily practice and conceded basis. All new orders to be reviewed by the Minimum Data Set Clinical Correction daily Quality Assurance and updates made to the care plans and indicated on the orders.  The monitoring procedure to ensithe plan of correction is effective specific deficiency cited remains and/or in compliance with the regrequirements:  The Director of Nursing and the Month Data Set Nurse will complete 3 reusing the Quality Assurance audicare plan revision and update we then monthly x 3. Reports will be presented to the Administrator we in turn will be shared with the we Quality Assurance committee by	of Director of se and on Set ee if the en active esidents on in a solution of set and on sultant ata Set and on as one Set Nurse and eas ever that and that corrected gulatory  Winimum esidents it tool for eekly x 4 eekly that ekly		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _				08/2018	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332			00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From page	e 10		6888	Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended the Director of Nursing, Minimum Data Set Coordinator, Support Nurse, Thera Manager, Health Information Management, Dietary Manager, Administrator and Medical Director. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction:  The Director of Nursing and the Minimum Date Set Nurse.  02/05/18	s by py ne	1/26/18	
SS=D	CFR(s): 483.25(c)(1)- §483.25(c) Mobility. §483.25(c)(1) The factor resident who enters the range of motion does range of motion unless condition demonstrate of motion is unavoidated with the services to increase represent further decreases \$483.25(c)(3) A residence receives appropriate approp	cility must ensure that a ne facility without limited not experience reduction in as the resident's clinical es that a reduction in range ble; and						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O	CODE		
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F 688	Continued From page	e 11	F 6	888			
	reduction in mobility in This REQUIREMENT by:	able independence unless a s demonstrably unavoidable. is not met as evidenced					
	Based on record rev staff interviews, the fa decreased range of n decreased use of the 2 residents (Resident Findings included:			F688 Increase/Prevent De ROM/Mobility Based on record review, re interview, and staff intervie failed to prevent decrease motion which resulted in duthe resident 's left hand fo residents (Resident #20).	esident ews, the facili d range of ecreased use		
	The resident was admitted on 12/11/15.  The annual comprehensive MDS dated 10/25/17 revealed Resident #20 had adequate hearing and vision and an intact cognition. The resident 's ability to make choices was important. The resident required extensive assistant of two-staff members for transfer and toileting, one staff member for personal care and dressing and set up for meals. The resident's diagnoses were osteoporosis and cerebral vascular accident.			The plan for correcting the deficiency and the process alleged deficiency: On 01/10/18 Resident #20 and picked-up for treatmer Occupational Therapist for in Range of Motion. Upon splint was ordered for residurther decline in Range of	s that lead to  ) was screene  nt by the  r managemer  screening, a  dent to preve	ed nt	
	order for occupational check left hand and a views.  X-ray results dated 9, no acute fracture or common was decreased, and degenerative change	dated 9/7/17 revealed an I therapy consultation and in x-ray of the left hand 2  /8/17 revealed left hand had dislocation, the mineralization there was moderate joint is with no suspicious as no focal soft tissue		Therapy automatically screadmissions. Residents adr 01/01/2018 who have had consults since admission of for rehabilitation orders. A identified as having orders rehabilitation will be given Director for follow-up and t necessary.	mitted since outside will be review any resident s for to the Rehab	)	
	findings.  A review of the therap no notes for 2017.	by notes revealed there were dated 11/22/17 revealed		The procedure for implement acceptable plan of correction specific deficiency cited: All residents with outside comonitored by the Director of Support Nurse upon return	ion for the consults will b of Nursing or	•	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE : AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			` ′			E SURVEY PLETED
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				SANFORD, NC 27332		
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F 688	there was an interver and treat as ordered  On 1/2/17 at 12:45 p conducted with Residuated that after here her left hand had decided been declining ever several weeks ago suby the physician who therapy. The resider therapy. The resider she needs therapy a use of her left hand. lost some range of make was admitted.  On 1/8/18 at 1:00 pm with the Rehabilitation that the occupational was not followed, it worders were process inform therapy. RD obtained a notice from Resident #20 had not occupational therapy RD agreed without the motion the range care.  On 1/8/18 at 11:30 a conducted with the DON stated that follow the physician's therapy evaluation to motion.  Provision of Medicalliance in the conducted with the DON stated that follow the physician's therapy evaluation to motion.	m an interview was dent #20. The resident creased movement and has since. The resident stated he requested and was seen ordered an x-ray and int had an x-ray but no int stated that she believed and some exercises to retain. The resident stated she had notion to her left hand since in an interview was conducted in Director (RD). RD stated if therapy order dated 9/7/17 was missed. RD stated new led by nursing who was to does not recall having m nursing. RD stated that it received ordered in services for her left hand. Interapy services for range of in be decreased.	F 6	ensure any follow-up orders are in the appropriate department for for and treatment as necessary.  The monitoring procedure to ensure the plan of correction is effective specific deficiency cited remains and/or in compliance with the regrequirements:  The Director of Nursing or Suppowill report daily in the Quality Assimeeting on residents who had condourned new orders resulting in need Rehabilitation Services or others needed. Deficiencies that are ideal during the monitoring process will addressed through the facility Quantum Assurance process.  The title of the person responsible implementing the acceptable plant correction: The Director of Nursing or the Sunurse.  02/05/18	ure that and that corrected ulatory  rt Nurse urance nsults for ervices entified I be ality  e for	2/2/18
SS=D	GFK(S): 483.4U(d)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 745	Continued From page	e 13	F 7	45		
	maintain the highest and psychosocial we This REQUIREMENT by: Based on record rev	ial services to attain or practicable physical, mental ll-being of each resident. is not met as evidenced iew, family interview, and		F745 Provision of Medically Related Social Service	ted	
	for an oncology appo on her hospital discha the resident missing to one residents reviews social services. The	nsportation arrangements intment that was indicated arge instructions resulting in the appointment for one of ed for medically related findings included:		Based on record review, family int and staff interview, the facility faile ensure Resident #62 had transport arrangements for an oncology appointment that was indicated or hospital discharge instructions rest the resident missing the appointm	ed to rtation n her sulting in	
	Resident #62 was ad 7/19/17 with diagnost cancer.	mitted to the facility on es that included bone		one of one residents reviewed for medically related social services.		
	included the hospital 7/19/17. The dischar follow up appointmen	#62 's medical record discharge summary dated ge instructions included a t with Resident #62 's ecialist) physician on 7/26/17.		The plan for correcting the specific deficiency and the process that leadleged deficiency: Appointments for Resident#62 for oncology and orthopedics were rescheduled.	ad to the	
	#62 's cognition was behaviors and no rejet had an active diagnost A Grievance Report F	26/17 indicated Resident intact. She had no ection of care. Resident #62		The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Resident appointments from 01/07 were reviewed by the Director of Nand Transportation aide for the poof any missed appointments or transportation issues. There were	ne 1/18 Nursing ssibility	
	Resident #62 missed and an oncology app review of the investig had missed the appo	arty (RP). The form stated an orthopedic appointment ointment on 7/26/17. A ation revealed Resident #62 intment with her oncology that was indicated on her		The monitoring procedure to ensu the plan of correction is effective a specific deficiency cited remains cand/or in compliance with the regu	and that corrected	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 745	Continued From page	e 14	F 7	45			
	discharge instructions investigation also revimissed an orthopedic indicated on her discharge instruction.  A phone interview wa #62 's RP on 1/8/18 the information in the Form.  An interview was con Administrator on 1/8/16 Grievance Report For Resident #62 was revided and the Administrator. The AT/26/17 oncology app #62 's discharge instruction with the appointment of the AT/26/17 oncology app #62 's discharge instruction with the appointment of the AT/26/17 oncology app #62 is discharge instruction with the AT/26/17 oncology app #62 is discharge instruction with the AT/26/17 oncology app #62 is discharge instruction.	s from the hospital. The ealed Resident #62 had appointment that was not narge instructions and was y staff. Both appointments facility staff.  s conducted with Resident at 9:30 AM. She confirmed 8/4/17 Grievance Report  ducted with the 18 at 10:33 AM. The rm dated 8/4/17 related to viewed with the dministrator confirmed the cointment noted on Resident ructions was missed by the ngements had not been on resulting in the resident ent. She explained that she dic appointment had been int #62 's family and the ware of the appointments.		requirements: The Transportation Aide will bring appointment schedule to the daily Assurance meeting for review and validation by the Director of Nursi Administrator of scheduled appoin and transportation arrangements.  The title of the person responsible implementing the acceptable plant correction: The Director of Nursing and Supp Nurse.  02/05/18	Quality d ng and ntments e for		
F 758 SS=E	She indicated her exp to ensure transportati made for all appointm knowledge of.	chotropic Meds/PRN Use	F 7:	58		2/2/18	
	§483.45(e) Psychotro §483.45(c)(3) A psych	opic Drugs. notropic drug is any drug that					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 758	processes and behabut are not limited to categories: (i) Anti-psychotic; (ii) Anti-psychotic; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehesident, the facility of the second se	s associated with mental vior. These drugs include, drugs in the following the sassessment of a must ensure that— ents who have not used are not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic all dose reductions, and ons, unless clinically in effort to discontinue these ents do not receive oursuant to a PRN order on is necessary to treat a condition that is documented and orders for psychotropic drugs is. Except as provided in attending physician or her believes that it is ern order to be extended or she should document their ent's medical record and	F 758		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 758	Continued From pag	e 16	F 7	758			
	drugs are limited to 1 renewed unless the a prescribing practition the appropriateness. This REQUIREMENT by:  Based on record revent Pharmacy Consultant to administer antipsy (Resident #7) and fail orders for as needed medications were time for residents (Resident reviewed for unnecess). The findings included 1a. Resident #7 was facility on 6/2/16 and 11/20/17 with diagnot psychotic disorder, a The significant change assessment dated 10 's cognition was sev was assessed with not care. She receive on 7 of 7 days and at 7 days.  A physician 's order Zyprexa (antipsychology by mouth in the Resident #7.	riew, staff interview, and to interview, the facility failed chotic medication as ordered filed to ensure physician 's (PRN) psychotropic file limited in duration for 4 of ts #7, #14, #35, and #60) assary medications.  d:  initially admitted to the most recently admitted on sees that included dementia,		F758 Free from Unnecessary Psychotropic Meds/PRN Based on record review, staff in and Pharmacy Consultant intenfacility failed to administer antipmedication as ordered (Resider failed to ensure physician's ordereded psychotropic medication time limited induration for 4 of 6 (Residents #7, #14,#35, and #6 reviewed for unnecessary medication time limited induration for 4 of 6 (Residents #7, #14,#35, and #6 reviewed for unnecessary medication or unnecessary medication or unduration limit as pregulation or unduration limit as pregulation.  All as needed Psychotropic Medication or unduration limit as pregulation.  All as needed Psychotropic Medication or unduration limit as pregulation.  All as needed Psychotropic Medication of the 14 day durand review for unnecessary medication of the 14 day durand review for unnecessary medication of the 14 day regularion of the	view, the sychotic of #7) and ders for a ns were resident (a) cations cations cation the 1 per dication ector of eart on ders mee ation limitedications for udit of the d by the	d as ts ts tat tit s.	
		onstituted 5 mg to be injected		orders are correctly reflected on		vv	

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F 758	Continued From page	e 17	F 7	758	
	intramuscularly (IM) a	as needed (PRN) for		Medication Administration Record a	nd
		structions stated, "Give if		that the prior order has been	
	patient refuses to tak			discontinued. As needed Psychotro	ppic
	·	·		Medication orders will be reviewed	
	A review of Resident	#7 's Medication		of the Daily Quality Assurance Mee	ing to
		d (MAR) for December 2017		assure ongoing compliance with the	
		2/29/17 Resident #7 received		day maximum duration limit. The Di	
	, ,,	morning as ordered. On		of Nursing will review every 14 days	
	12/29/17 at 4:58 PM			as needed psychotropic medication	
	administered Zyprexa	a 5 mg IM PRN by Nurse #1.		bring to the attention of the physicia	n
	Δn interview was con	iducted with Resident #7 's		those that need to be addressed.  All as needed Anti-Psychotic Medic	eation
		at 11:45 AM. The physician '		orders will be audited to ensure that	
	' '	#7 dated 12/19/17 for routine		orders meet the regulation of the 14	
		ed with the physician. The		duration limit. An audit of the corre	-
		r Resident #7 dated 12/19/17		orders will be completed by the Dire	
		that indicated it was to be		Nurses to ensure that the new orde	rs are
	given if Resident #7 r	refused to take "the pill" was		correctly reflected on the Medication	ا ا
		ysician. The December 2017		Administration Record and that the	·
		that indicated she received		order has been discontinued. As no	
		exa and the PRN Zyprexa on		o psychotropic orders will be review	ed as
		ed with the physician. The		part of the Daily Quality Assurance	
	written the Zyprexa P	Nurse Practitioner (NP) had PRN IM order on 12/19/17 for		Meeting to assure ongoing complian	
		cated it was his belief she		The procedure for implementing the	
		Zyprexa to be administered		acceptable plan of correction for the	;
		ad refused the routine		specific deficiency cited:	
		He reported expected his		On 01/23/18 the Director of Nursing	
	orders and his NP's o	orders to be followed.		began re-education of all nurses an nurse practitioner regarding regulati	
	An interview was con	iducted with the NP on		related to the limit in duration of prn	
		The physician 's order for		anti-psychotic medications orders to	
		2/19/17 for routine Zyprexa		days. All nurses and the Nurse	
		e NP. The physician 's		Practitioner will be re-educated by 1	/
		dated 12/19/17 for Zyprexa		31/18.	
		d it was to be given if			
	Resident #7 refused	to take "the pill" was		The monitoring procedure to ensure	that
	reviewed with the NP	2. The December 2017 MAR		the plan of correction is effective an	
	for Resident #7 that is	ndicated she received both		specific deficiency cited remains co	rected

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		X3) DATE SURVEY COMPLETED	
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		345532	B. WING _			01/	08/2018	
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F 758	the routine Zyprexa at 12/29/17 was reviewed confirmed she had with IM Zyprexa on 12/19/stated the PRN IM Zyadministered only if F Zyprexa by mouth.  An interview was contil/8/18 at 3:02 PM. The Resident #7 dated 12 was reviewed with Nurorder dated 12/19/17 indicated it was to be to take "the pill" was in The December 2017 indicated she receive and the PRN IM Zypreviewed with Nurse in had administered PR on 12/29/17 as the reher evening medications that were had not included rout thought the PRN IM Zadministered if Resid Nurse #1 revealed she Zyprexa order was or Resident #7 had refusion.  An interview was contiled Administrator and Dir 1/8/18 at 3:51 PM. The Image of The	and the PRN IM Zyprexa on and with the NP. The NP ritten the order for the PRN 17 for Resident #7. She apprexa was intended to be desident #7 had refused the ducted with Nurse #1 on the physician 's order for 1/19/17 for routine Zyprexa warse #1. The physician 's for Zyprexa IM PRN that given if Resident #7 refused reviewed with Nurse #1.  MAR for Resident #7 that do both the routine Zyprexa exa on 12/29/17 was 1/1. Nurse #1 confirmed she N IM Zyprexa to Resident #7 sident had refused some of the express order was to be ent #7 had refused any pill. In the was unaware the PRN IM the sed the routine Zyprexa by	F	758	and/or in compliance with the regulator requirements:  The Director of Nursing or Support Nurwill complete the Quality Assurance autools for as needed Anti-psychotic Medication Orders, weekly x 4 then monthly x 3. Reports will be presented the Administrator weekly that in turn wibe shared with the Quality Assurance Committee by the Director of Nursing, ensure that corrective action for trends ongoing concerns are initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Minimum Data Set Coordinator, Support Nurse, Therapy Manager, Health Information Manager, Dietary Manager, Administrator and Medical Director. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process.  The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing and Support Nurse  02/05/18	se dit to II to or		
	1b. Resident #7 was	initially admitted to the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 758	Continued From proceeding facility on 6/2/16 and 11/20/17 with diagonal psychotic disorder. The significant chassessment dated 's cognition was a was assessed with of care. She receon 7 of 7 days and 7 days.  A physician 's ord Zyprexa solution medication) 5 millinitramuscularly (I Resident #7. The patient refuses to stop date for this and I with the continuation of the continuation discontinuation of the continuation of t	page 19 and most recently admitted on gnoses that included dementia, r, and schizophrenia.  ange Minimum Data Set (MDS) d 10/6/17 indicated Resident #7 severely impaired. Resident #7 th no behaviors and no rejection elived antipsychotic medication d antianxiety medication on 1 of der dated 12/19/17 indicated reconstituted (antipsychotic igrams (mg) to be injected M) as needed (PRN) for elinstructions stated, "Give if take the pill". There was no PRN Zyprexa order.  Ing Physician/Prescriber" dated ten by the Pharmacy Consultant tipsychotic medication was a Resident #7 was noted with exa 5 mg PRN IM with no late. The form had not yet been	F 7	DEFICIENCY		
	An interview was 1/8/18 at 9:30 AM regulations relate medications to be A phone interview Pharmacy Consustated she was avegarding PRN psindicated she had	was conducted with the ltant on 1/8/18 at 1:30 PM. She ware of the new regulations sychotropic medications. She				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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F 758	duration of 14 days a stated she had also be recommendations reg for psychotropic med duration as per the reconsultant indicated medication (excluding the prescriber was reartionale and indicate order was to extend pure An interview was con Administrator and Dir 1/8/18 at 3:51 PM. The expected all PRN order medications to have a days as per the regulation of the significant change assessment dated 10 or so cognition was seven was assessed with no of care. She received on 7 of 7 days and ar 7 days.  A physician 's order Lorazepam Powder (needed (PRN) every There was no stop day Powder order.	tions to have a maximum is per the regulations. She been making garding all other PRN orders ications to be time limited in egulations. The Pharmacy for any PRN psychotropic grantipsychotic medications) quired to document a era time limited duration if the boast 14 days.  I ducted with the rector of Nursing (DON) on hey both indicated they lers for antipsychotic a maximum duration of 14 ations.  I initially admitted to the most recently admitted on sees that included dementia,	F	758			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		, ,	ATE SURVEY DMPLETED
		345532	B. WING _		,	C 01/08/2018
	ROVIDER OR SUPPLIER	A BUILDING  345532    B. WING   STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   Ontinued From page 21 2/28/17 and written by the Pharmacy Consultant dicated PRN psychotropic medication was mitted to 14 days and if the prescriber wanted to ktend the order past 14 days a rationale and me limited duration was to be documented in the redical record. Resident #7 was noted with an rider for Ativan Powder every 8 hours PRN with to discontinuation date. The form had not yet been addressed by the physician as of 1/8/18.  In interview was conducted with the physician on 8/18 at 9:30 AM. He stated he expected the explactions to be followed.  In the pharmacy Consultant on 1/8/18 at 1:30 PM. She ated she was aware of the new regulations grading PRN psychotropic medications. She dicated she had been making ecommendations for all PRN orders for ntipsychotic medications to have a maximum uration of 14 days as per the regulations. She ated she had also been making				
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE
F 758	12/28/17 and writter indicated PRN psyclimited to 14 days a extend the order patime limited duration medical record. Re order for Ativan Powno discontinuation obeen addressed by  An interview was consultant and indications related in medications to be formally and interview with the prescriber was regarding PRN psyclimicated she had also recommendations in for psychotropic medication of 14 days stated she had also recommendations in for psychotropic medication (excluding the prescriber was a rationale and indicated order was to extend the prescriber was a rationale and indicated order was to extend the prescriber was a rationale and indicated order was to extend the prescriber was to extend the prescrib	n by the Pharmacy Consultant shotropic medication was and if the prescriber wanted to st 14 days a rationale and a was to be documented in the sident #7 was noted with an order every 8 hours PRN with date. The form had not yet the physician as of 1/8/18.  Inducted with the physician on He stated he expected the to PRN psychotropic collowed.  I was conducted with the ent on 1/8/18 at 1:30 PM. She are of the new regulations chotropic medications. She een making or all PRN orders for sations to have a maximum as per the regulations. She been making egarding all other PRN orders dications to be time limited in regulations. The Pharmacy defor any PRN psychotropic medications) required to document a te a time limited duration if the lipast 14 days.	F 7	58		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345532	B. WING _			C <b>01/08/201</b>	18	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	01/00/201		
				310 COMMERCE DRIVE				
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA	COMPL	(5) LETION ATE	
F 758	Continued From page	e 22	F 7	758				
	they expected the pro- rationale and indicate PRN psychotropic or days. They stated if documented rationale	escriber to document a e a time limited duration if the der was to extend past 14						
	7/13/17 with diagnos	s admitted to the facility on es that included dementia rbance and mood disorder.						
	#14 's cognition was delusions, no behavious of 3 days during the l Resident #14 receive	0/20/17 indicated Resident severely impaired. She had ors, and rejected care on 1 MDS review period. ed antipsychotic medication, cation, and antianxiety						
	Lorazepam (antianxi	•						
	11/28/17 and written indicated PRN psych limited to 14 days an extend the order pastime limited duration medical record. Resorder for Lorazepam The form was address 12/1/17 and indicated PRN twice daily was	Physician/Prescriber" dated by the Pharmacy Consultant otropic medication was d if the prescriber wanted to t 14 days a rationale and was to be documented in the ident #14 was noted with an 0.5 mg PRN twice daily. seed by the physician on d the Lorazepam 0.5 mg to continue for 3 months due cular dementia, depression,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPL	(X3) DATE SURVEY COMPLETED			
		345532	B. WING		01/0	) 08/2018
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332		30/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 758	paranoia. The physi had frequent anxiety outbursts that were r Lorazepam.  A review of the curre Resident #14 on 1/3, order for PRN Lorazenot been updated wi indicated the end da  An interview was cor Nursing (DON) on 1/if a medication had a indicated on the elect Attending Physician/11/28/17 related to R Lorazepam 0.5 mg to the DON. The physi form dated 12/1/17 to Lorazepam 0.5 mg to continued for 3 mont reviewed with the DO's order for Resident no stop date as of 1/DON. The DON indict in charge of reviewing on the "Note to Attenform and updating the accordingly.  An interview was con Nurse on 1/3/18 at 3 to December 2017 swere reviewing the "Physician/Prescriber electronic orders accordingly are reviewed electronic orders accordingly and the state of the physician/Prescriber electronic orders accordingly and the physician/Prescriber electronic orders accordingly.	atted by psychosis and cian indicated Resident #14 exacerbations/behavioral elieved by the PRN  Int physician 's orders for 18 revealed the physician 's epam 0.5 mg twice daily had the astop date. The order the was "indefinite".  Inducted with the Director of 3/18 at 3:05 PM. She stated in end date it was to be tronic order. The "Note to Prescriber" form dated the sident #14 's PRN wice daily was reviewed with cian 's instructions on the inat indicated the PRN wice daily was to be the for Resident #14 was DN. The electronic physician at #14 dated 8/11/17 that had 3/18 was reviewed with cated the Support Nurse was gone the physician's responses ding Physician/Prescriber" electronic orders  Inducted with the Support the and/or the floor nurses	F 75	8		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345532	B. WING			C 01/08/2018	
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	•	11/06/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 758	updating the electrophysician 's respon Physician' Prescribe asked for this respon noticed a "stack" of been completed.  This interview with The "Note to Attend dated 11/28/17 rela Lorazepam 0.5 mg the Support Nurse. on the form dated 1 Lorazepam 0.5 mg continued for 3 moreviewed with the Sphysician's order for PRN Lorazepam no stop date as of Support Nurse. Th Resident #14's Pf daily should have to of 90 days from the "Note to Attend on 12/1/17.  An interview was con 1/8/18 at 9:30 AM. regulations related medications to be for the PRN psy indicated she was awaregarding PRN psy indicated she had to the stack of the stack	primary responsibility of onic orders as per the one on the "Note to Attending or" form. She revealed she onsibility because she had it these forms that had not the Support Nurse continued. Sing Physician/Prescriber" form of the to Resident #14 's PRN twice daily was reviewed with the physician 's instructions 12/1/17 that indicated the PRN twice daily was to be on this for Resident #14 was support Nurse. The electronic for Resident #14 dated 8/11/17 on 0.5 mg twice daily that had 1/3/18 was reviewed with the e Support Nurse revealed RN Lorazepam 0.5 mg twice on updated with an end date of date the physician had signed ing Physician/Prescriber" form on the stated he expected the to PRN psychotropic ollowed.  Was conducted with the ant on 1/8/18 at 1:30 PM. She are of the new regulations chotropic medications. She	F 75	8			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345532	B. WING _				08/2018		
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332			00/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE		
F 758	stated she had also be recommendations reg for psychotropic med duration as per the reconsultant indicated medication (excluding the prescriber was rerationale and indicate order was to extend put the prescriber was con Administrator and Dir 1/8/18 at 3:51 PM. The expected all PRN order medications to have at the regulations. They they expected the prescribinate and indicate PRN psychotropic order and prescribed as a rational duration for a PRN psychotropic order accordingly.  2b. Resident #14 was 7/13/17 with diagnose with behavioral disturbing the recommendation of the prescribed and the results of the electronic duration for a PRN psychotropic order accordingly.	s per the regulations. She been making garding all other PRN orders ications to be time limited in egulations. The Pharmacy for any PRN psychotropic grantipsychotic medications) quired to document a era time limited duration if the exast 14 days.  ducted with the rector of Nursing (DON) on hey both indicated they lers for psychotropic artime limited duration as per a additionally both indicated escriber to document a era time limited duration if the der was to extend past 14 the physician had ale and a time limited escriber to be updated escriber to december they are the facility on the est that included demential bance and mood disorder.	F 7	· ·					
	#14 's cognition was delusions, no behavio to 3 days during the N Resident #14 receive	n/20/17 indicated Resident severely impaired. She had ors, and rejected care on 1 MDS review period. d antipsychotic medication, eation, and antianxiety							

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			C <b>01/08/20</b>	18	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	<b>--</b>	01/00/20		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) PLETION DATE	
F 758	Ativan (antianxiety m 0.5 milligrams (mg) a #14 unwillingly/uncomedication. There were proposed and interview was cornected to medications related to medications to be followed by the present of the pr	dated 12/14/17 indicated redication) crème topically is needed (PRN) if Resident operative with oral was no stop date for this order.  Inducted with the physician on the stated he expected the PRN psychotropic lowed.  Inducted with the expected the PRN psychotropic lowed.  Inducted with the expected the PRN psychotropic medications. She expected the regulations hotropic medications. She expected the regulations. She expected the regulations is per the regulations. She expected the regulations to be time limited in expected in the psychotropic grantipsychotic medications) exquired to document a expected to document a expected in the poast 14 days.  Inducted with the rector of Nursing (DON) on they both indicated they	F7					
	the regulations. The they expected the prorationale and indicate	a time limited duration as per y additionally both indicated escriber to document a e a time limited duration if the der was to extend past 14						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			01/0	08/2018	
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP COI 310 COMMERCE DRIVE SANFORD, NC 27332	DE	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE	
F 758	7/17/17 and most red with diagnoses that in behavioral disturband. A physician 's order Ativan (antianxiety mas needed (PRN) ev. There was no stop d. The admission Minimassessment dated 9/#60 's cognition was behaviors and no rejreceived antipsychot medication, and antiadays.  A "Note to Attending 11/28/17 and written indicated PRN psychlimited to 14 days an extend the order pastime limited duration medical record. Resorder for Ativan 1 mg form was addressed and indicated the Atiwas to continue for 3 dement, depression, physician indicated Fanxiety/agitation/beh the PRN Ativan was	admitted to the facility on cently readmitted on 9/12/17 included dementia with ce and anxiety.  dated 9/12/17 indicated dedication) 1 milligram (mg) ery 6 hours for Resident #60. ate for this PRN Ativan order.  Thum Data Set (MDS) (19/17 indicated Resident intact. She had no dection of care. Resident #60 ic medication, antidepressant anxiety medication on 7 of 7  Physician/Prescriber" dated by the Pharmacy Consultant otropic medication was diff the prescriber wanted to the tax of the prescriber wanted to the tax of the prescriber wanted to the ident #60 was noted with an and PRN every 6 hours. The by the physician on 12/1/17 wan 1 mg PRN every 6 hours months due to chronic anxiety, and insomnia. The desident #60 had frequent avioral outbursts for which deffective.	F7	758				
	indicated Resident #	ssessment dated 12/18/17 60 's cognition was intact. riors on 1-3 days during the 7						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345532	B. WING				C <b>08/2018</b>
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		310	COMMERCE DRIVE NFORD, NC 27332	1 011	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	e 28	F	758			
	Resident #60 receive antidepressant medic medication on 7 of 7	•					
	Resident #60 on 1/3/ order for PRN Ativan	nt physician 's orders for 18 revealed the physician 's 1 mg every 6 hours had not stop date. The order e was "indefinite".					
	Nursing (DON) on 1/3 if a medication had a indicated on the electindicated the Support reviewing the physicia to Attending Physicia	ducted with the Director of 3/18 at 3:05 PM. She stated in end date it was to be tronic order. The DON thurse was in charge of an's responses on the "Note in/Prescriber" form and ic orders accordingly.					
	Nurse on 1/3/18 at 3: to December 2017 sh were reviewing the "New Physician/Prescriber' electronic orders accaround the beginning asked to take over prupdating the electronic physician 's response Physician/Prescriber' asked for this response	r forms and updating the ordingly. She indicated of December she had imary responsibility of					
		ducted with the physician on le stated he expected the PRN psychotropic					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		01/08/2018
	ROVIDER OR SUPPLIER	REHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 310 COMMERCE DRIVE SANFORD, NC 27332	1 0110012010
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F 758	Pharmacy Consulta stated she was awa regarding PRN psycindicated she had be recommendations for antipsychotic medication of 14 days stated she had also recommendations refor psychotropic meduration as per the Consultant indicated medication (excluding the prescriber was reationale and indicated order was to extend An interview was conditionally and interview was conditionally and indicated all PRN or medications to have the regulations. The they expected the prationale and indicated PRN psychotropic conditions to the prescriber was a state of the prescriber was a state	vas conducted with the int on 1/8/18 at 1:30 PM. She are of the new regulations chotropic medications. She een making or all PRN orders for rations to have a maximum as per the regulations. She been making egarding all other PRN orders dications to be time limited in regulations. The Pharmacy difference for any PRN psychotropic and antipsychotic medications) required to document a te a time limited duration if the past 14 days.  Inducted with the director of Nursing (DON) on They both indicated they arders for psychotropic at time limited duration as per ey additionally both indicated rescriber to document a te a time limited duration if the order was to extend past 14	F 75	58	
	readmitted on 12/13 diagnoses of cerebr	s admitted on 6/12/17 and 3/17 with cumulative ral vascular accident, recent amputation (AKA) and			

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345532	B. WING _				08/2018		
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY	•	31	REET ADDRESS, CITY, STATE, ZIP CODE  O COMMERCE DRIVE  ANFORD, NC 27332	, , ,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 758	Continued From page	e 30	F	758					
	11/15/17 indicated show to behaviors. She re-	cent significant MDS dated e was cognitively intact with quired supervision to with her activities of daily							
	readmission orders d read she was to take	#35 's December 2107 ated 12/13/17 to present Lorazepam (antianxiety) 1 eded twice daily for anxiety.							
	medication administra she received Lorazep from 12/1317 to 12/3	#35 's December 2017 ation record (MAR) indicated barn 1 mg one 8 occasions 1/17 and her January 2018 eceived Lorazepam 1 mg on 1/18 to 1/8/18.							
	dated 12/15/17 read								
	12/28/17 read Reside (antianxiety) 0.5 mg to anxiety rather than the twice daily as needed. The recommendation as needed psychotro include her antianxiet limited to 14 days unli	cy recommendation dated ent was prescribed Ativan wice daily as needed for e ordered Lorazepam 1mg I for anxiety on 12/13/17. I read that Resident #35 's pic medications which by medications were to be ess a rationale and indicated ented in Resident #35 's							
	dated 1/2/18 included	#35 's last revised care plan I a care plan for her anxiety. d: consultant pharmacist to							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED		
		345532	B. WING_			C 01/08/2018		
	ROVIDER OR SUPPLIER	EHAB CTR OF LEE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CO 310 COMMERCE DRIVE SANFORD, NC 27332	DE	01/00/2010		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 758	review all psychotrop changes, dose reducipotential adverse side behaviors to warrant Lorazepam.  In an interview on 1/8 Director stated he walimit on as needed mowould have expected Lorazepam for anxiet by Resident #35 's and In an interview on 1/8 #35 stated since her less anxious. Nursing since Resident #35 's noted less anxiety and In an interview on 1/8 practitioner stated Reneed for the prescribe should have been addocumentation to sup a new stop date or should have been addocumentation to sup a new stop date or should have been addocumentation to sup a new stop date or should have been addocumentation to sup a new stop date or should have been addocumentation to sup a new stop date or should have been addocumentation to sup a new stop date or should have been addocumentation to sup a new stop date or should have been addocumentation to sup a new stop date or should have been addocumentation to sup a new stop date or should have been addocumentation to sup a new stop date or should have been addocumentation to sup a new stop date or should have been addocumentation after 14.  In a telephone interview on 1/8 practitioner stated Resident #35 's pres read her prescribed Lessident #35	ic medications for possible tions and staff to monitor for e effects and any observed the administration of the 1/18 at 9:30 AM, the Medical s aware of the 14-day time edications for anxiety and he the continued use of the y to have been addressed ttending physician.  1/18 at 10:10 AM, Resident recent left AKA, she was a Assistant (NA) #1 stated as recent surgery, she had donfusion in Resident #35.  1/18 at 1:15m PM, the nurse esident #35 's continued and Lorazepam past 14 days dressed either with apport the continued use with about have been days.  1/18 at 1:30 PM the the the expected any as the ex	F	758				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345532	B. WING _				C / <b>08/2018</b>
NAME OF PROVIDER OR SUPPLIBERTY COMMONS NSG		EHAB CTR OF LEE COUNTY		31	REET ADDRESS, CITY, STATE, ZIP CODE O COMMERCE DRIVE ANFORD, NC 27332	1 01/	00/2010
PREFIX (EACH D	EFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
physician on to contact the there was no  In an interview stated Reside on anxiety but recent left AK.  In an interview Resident #35 evidence of all In an interview Administrator Resident #35 have a time lis support contins specified time  F 825 Provide/Obtain CFR(s): 483.65 (a) Provide/Obtain CFR(s): 483.65 (a) Provide/Obtain CFR(s): 483.65 (a) Provide/Obtain CFR(s): 483.65 (a) (b) pathology, on the temporary, and required in the care, the facility \$483.65(a)(1)  §483.65(a)(1)	all was 1/8/18 a survey return 1 av on 1/3 not as A surge v on 1/3 that a survey or on 1/3 stated v on 1/3 stated v on 1/3 stated v on 1/3 stated us limit d n Special limit don's fallized ovision rehabilities by as see reside ty mus Provident according to the prov	placed to the attending at 2:40 PM with instructions for and at the time of exit, delephone call.  8/18 at 3:05 PM, Nurse #1 continues to have episodes a often since having herery.  8/18 3:07 PM, NA #2 stated of displayed any crying or on second shift in a month.  8/18 at 3:59 PM, the dit was her expectation that azepam for anxiety would 4 days or documentation to be with another order with a curation.  6/2)  1/2)  1/2)  1/2)  1/3)  1/4)  1	F 7				2/2/18

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	100/2010	
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LIBERTY	COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332			
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F 825	F 825 Continued From page 33		F 8	25			
F 825	resource that is a pro rehabilitative services participating in any fe programs pursuant to the Act. This REQUIREMENT by: Based on record rev staff interviews, the fe occupational therapy of two residents reviee (Resident #20). Findings included: The resident was addressident was addressident was addressident was important. The resident was important of two-staff toileting, one staff med dressing and set up for diagnoses were oster vascular accident.  A physicians ' order order for occupational check left hand and a views.  X-ray results dated 9 no acute fracture or contact the resident was a contact the resident	vider of specialized and is not excluded from ideral or state health care of section 1128 and 1156 of a section 1128 and	F 8	F825 Provide/Obtain Specialized R Services Based on record review, resident interview, and staff interviews, the failed to provide occupational theral services as ordered for one of two residents reviewed for range of mot (Resident #20).  The plan for correcting the specific deficiency and the process that lead alleged deficiency: On 1/10/18 Resident #20 was screed and picked-up for treatment by the Occupational Therapist for manage in Range of Motion. Upon screenin splint to prevent further decline in R of Motion was ordered for Resident  Therapy automatically screens all in admissions. Residents admitted sin 01/01/2018 who have had outside consults since admission will be revibetween 01/24/2018 and 01/31/201 orders for rehabilitation. Any reside identified as having orders for rehabilitation will be given to the Re Director for follow-up and treatment necessary. There were no resident identified as having missed orders for Rehab Services.	acility by ion I to the ened ment g a ange #20. ew ce iewed 8 for nt hab as s		
		no focal soft tissue findings.		The procedure for implementing the	:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345532	B. WING _			01//	08/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	 )E	1 01/1	00/2010	
				310 COMMERCE DRIVE				
LIBERTY	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY		SANFORD, NC 27332				
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F 825	Continued From page 34		F 8	325				
	no notes for 2017.  Resident's care plan there was an interver	dated 11/22/17 revealed there were		acceptable plan of correction specific deficiency cited: All residents with outside con monitored by the Director of N Support Nurse upon return to ensure any orders for rebability.	sults will b Nursing or the facilit			
	there was an intervention for therapy to evaluate and treat as ordered.  On 1/2/17 at 12:45 pm an interview was conducted with Resident #20. The resident stated that after her cerebral vascular accident her left hand had decreased movement and has been declining ever since. The resident also stated that a while back she requested and was seen by the physician who ordered an x-ray and therapy. The resident had an x-ray but no therapy.  On 1/8/18 at 1:00 pm an interview was conducted with the Rehabilitation Director (RD). RD stated that the occupational therapy order dated 9/7/17 was not followed, it was missed. RD stated new orders were processed by nursing who was to inform therapy. RD does not recall having			ensure any orders for rehability other are relayed to physical follow-up and treatment as not the plan of correction is effect the specific deficiency cited recorrected and/or in compliant regulatory requirements:  The Director of Nursing or Su will report daily in the Quality meeting on residents who had and new orders resulting in mehabilitation Services or oth services. Deficiencies that are during the monitoring process addressed through the facility Assurance process.	therapy for ecessary.  ensure that tive and the emains ce with the apport Nur. Assurance d consults eed for her needectere identifies will be	at nat e se e		
F 865 SS=D	The DON stated that follow the physician's therapy evaluation to motion.  QAPI Prgm/Plan, Dis CFR(s): 483.75(a)(2)  §483.75(a) Quality as improvement (QAPI)	n an interview was irector of Nursing (DON). it was unacceptable not to order for occupational prevent decreased range of closure/Good Faith Attmpt (h)(i)	F 8	The title of the person respon implementing the acceptable correction: The Director of Nursing or the Nurse will be responsible for implementing this plan of corr 02/05/18	plan of e Support		2/5/18	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
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F 865	Continued From page	ge 35	F 865	5	
	Survey Agency no la promulgation of this	ater than 1 year after the regulation;			
	except in so far as s	tary may not require ords of such committee uch disclosure is related to uch committee with the			
	and correct quality da basis for sanctions	83.75(i) Sanctions.  bood faith attempts by the committee to identify and correct quality deficiencies will not be used as basis for sanctions.  his REQUIREMENT is not met as evidenced			
	Based on record reand staff interviews, Assessment and Assailed to maintain immonitor these interviput into place in 1/20 Minimum Data Set a comprehensive care plan (280), and previmotion (318) was or recertification survey 1/8/18 recertification continued failure of the federal surveys of reserving the staff of the surveys of reserving the staff of the	surance (QAA) Committee plemented procedures and entions that the committee 0/17 recertification survey. Inccuracy (242), develop a explan (279), revision of a care ent decreased range of iginally cited in the 1/20/17 yr and again recited in the 1/complaint survey. The extremely during the two excord showed a pattern of the sustain an effective QA		F865 QAPI Program/Plan, Disclosure/Good Faith Attempt Based on record review, observation resident and staff interviews, the faci Quality Assessment and Assurance Committee, failed to maintain implemented procedures and monito these interventions that the committe into place in 1/20/17 recertification st Minimum Data Set accuracy (641), develop a comprehensive care plan revision of a care plan (657), and pre decreased range of motion (688) was originally cited in the 1/20/17 recertific survey and again recited in the 1/8/18 recertification/complaint survey. The continued failure of the facility during two federal surveys of record shower	r ee put urvey. (656), event s cation s the
	This tag is cross refe F 641 (also known a	erenced to: is [aka] 242) - Based on iaff interview, the facility failed		pattern of the facility's inability to sus an effective Quality Assurance progra Based on record review, observation resident and staff interviews, the faci Quality Assessment and Assurance	tain am , lity's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 865	Continued From p	page 36	F 8	365			
		rately in the area of medications		Committee failed to maintain	-		
		s sampled (Resident #13)		procedures and monitor thes			
	reviewed for unne	cessary medications.		interventions that the commit	•		
	The facility was a	tad for F 242 on the		place in 1/20/17 recertification	-		
		ted for F 242 on the vey of 1/20/17 for failure to		Minimum Data Set accuracy develop a comprehensive ca	•		
	accurately code the			revision of a care plan (657),			
	accuratory code to	io MBG.		decreased range of motion (	•		
	F 656 (aka 279) -	Based on observation, staff and		originally cited in the 1/20/17	,		
	resident interview	s and record review, the facility		recertification survey and aga			
		a comprehensive care plan for		the 1/8/18 recertification/com			
	_	ary catheter (Resident # 164)		The continued failure of the f			
		an antidepressant medication		the two federal surveys of re			
	used to treat insomnia (Resident #35) for 2 of 18 residents reviewed for care planning.			a pattern of the facility's inab	ility to sustain		
	residents reviewe	d for care planning.		an effective QA program.			
	The facility was ci	ted for F 279 on the		The findings included:			
		vey of 1/20/17 for failure to					
	develop a compre	hensive care plan.		This tag is cross referenced			
				F 641 (also known as [aka] 2	•		
		Based on record review and		on record review and staff in			
		e facility failed to review and		facility failed to code the Min			
		related to antidepressant		Set (MDS) assessment accu			
	(Resident #16).	of 18 sampled residents		sampled (Resident #13) revi			
	(INCOIDENT # 10).			unnecessary medications.	SWCG 101		
	The facility was ci	ted for F 280 on the		annecessary medicalions.			
		vey of 1/20/17 for failure to		The facility was cited for F 24	12 on the		
	revise a care plan	-		recertification survey of 1/20			
				to accurately code the MDS.			
	, , ,	Based on record review,					
		, and staff interviews, the facility		F 656 (aka 279) - Based on 6			
	•	lecreased range of motion		staff and resident interviews			
		decreased range of motion of thand for 1 of 2 sampled		review, the facility failed to do comprehensive care plan for	•		
	residents (Reside			urinary catheter (Resident #			
	residents (reside	πε∪ <i>j</i> .		the use of an antidepressant			
	The resident was	cited for F 318 on the		used to treat insomnia (Resid			
		vey of 1/20/17 for failure to		2 of 18 residents reviewed for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED  C 01/08/2018	
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F 865	Continued From pag		F8	65	nlanning		
	prevent decreased ra	ange of motion.			planning.		
	On 1/8/18 at 5:00 pm, the Director of Nursing (DON) was interviewed regarding their QAA program. The DON indicated that she was the contact person for the facility's QAA program. The members were the administrator, medical director, all the department heads, one staff nurse, and one nursing assistant. She indicated that the committee had met monthly and quarterly. The DON indicated that she was new to her position and was not aware that F641, F565, F567, and F688 were repeat citations. The DON stated that she had a new MDS Coordinator and Director of Nursing and changes would be made.				The facility was cited for F 279 on the recertification survey of 1/20/17 for fails to develop a comprehensive care plan.  F 657 (aka 280) - Based on record reviand staff interview, the facility failed to review and revise a care plan related to antidepressant medication for 1 of 18 sampled residents (Resident #16).  The facility was cited for F 280 on the recertification survey of 1/20/17 for fails to revise a care plan.  F 688 (aka 318) - Based on record reviresident interview, and staff interviews, the facility failed to prevent decreased range of motion which resulted in decreased range of motion of the resid 's left hand for 1 of 2 sampled resident (Resident #20).	iew D ure iew,	
					The resident was cited for F 318 on the recertification survey of 1/20/17 for fails to prevent decreased range of motion.  On 1/8/18 at 5:00 pm, the Director of Nursing (DON) was interviewed regard their QAA program. The DON indicated that she was the contact person for the facility's QAA program. The members were the administrator, medical directo all the department heads, one staff nur and one nursing assistant. She indicate that the committee had met monthly an quarterly. The DON indicated that she was new to her position and was not	ure ling d e or, se, ed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
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				SANFORD, NC 27332		
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F 865	Continued From page	38	F8	aware that F641, F565, F567, and F68 were repeat citations. The DON stated that she had a new MDS Coordinator a Director of Nursing and changes would made.  The plan for correcting the specific deficiency and the process that lead to alleged deficiency: Corrective action has been implement for all residents having been identified affected by any deficiency cited in the 2567 for the annual survey conducted from 01/02/2018 through 01/08/2018.  The procedure for implementing the acceptable plan of correction for the specific deficiency cited:  Audits have been completed and reviewed during daily Quality Assurance meeting as stated in the plan of correct to identify residents having the potential have been affected by the alleged deficient practice.  The monitoring procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements:  Daily reporting during the daily Quality Assurance meeting continues indefinite for the individual cited deficiencies.  The title of the person responsible for implementing the acceptable plan of correction:  The Administrator and Director of Nurse.	and dibe withe ed as set tion at the cited cry elly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880 F 880 SS=D	infection prevention designed to provide comfortable environ development and tradiseases and infection program.  The facility must est and control program a minimum, the followard for the followard for the facility must est and control program a minimum, the followard for the facility must est and control program a minimum, the followard for the followard for the followard for the facility must est and control program a minimum, the followard for the followard for the followard for the facility for the facility for the followard	& Control )(2)(4)(e)(f)  control ablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable cons.  prevention and control ablish an infection prevention (IPCP) that must include, at wing elements:  tem for preventing, identifying, ng, and controlling infections diseases for all residents, itors, and other individuals nader a contractual upon the facility assessment to to §483.70(e) and following andards;  In standards, policies, and rogram, which must include, or eillance designed to identify	F 88	0	2/2/18
	communicable disea reported; (iii) Standard and tra	y; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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F 880	resident; including b (A) The type and dure depending upon the involved, and (B) A requirement the least restrictive possicircumstances. (v) The circumstance must prohibit employ disease or infected secontact with resident contact will transmit (vi)The hand hygient by staff involved in designation of the second seco	colation should be used for a cut not limited to: ration of the isolation, infectious agent or organism at the isolation should be the lible for the resident under the ses under which the facility wees with a communicable skin lesions from direct the disease; and the procedures to be followed irect resident contact.  The for recording incidents facility's IPCP and the ken by the facility.  The disease is and the seem for recording incidents facility is IPCP and the seem for process, and the seem for process, and the second incidents facility.	F 88	F880 Infection Control Based on observation and staff the facility failed to properly dis contaminated sharps during 2 o blood draws reviewed during bl glucose testing for 1 of 2 nurse (Nurse#5) The plan for correcting the spec	pose of out of 3 lood s.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	, ,	TE SURVEY MPLETED
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F 880	Continued From pag	e 41	F 88	0		
	address disposal of s	sharps.		alleged deficiency:		
	'	•		On 01/08/18 Nurse #5 was re-e	educated	
	An observation was	done on 1/3/18 at 4:00 pm of		on facility policy for the proper	disposal of	
	medication pass with	Nurse #5. Nurse #5		all sharp safety devices by the	Director of	
		cose monitoring technique for		Nursing and the Nurse Consult		
		se #5 used a lancet to obtain		return demonstration by Nurse		
	•	ne blood glucometer for the		correct safety sharps use and	-	
		ntaminated lancet was		practice was observed by the [		
	_	medication cart garbage.		Nursing and the Nurse Consult		
		ractable sharp that could be the sharp after use. Nurse		The procedure for implementin acceptable plan of correction for	•	
	•	obtain a blood sample for the		specific deficiency cited:	or trie	
		the second resident. The		On 01/09/18 the Director of Nu	rses began	
	_	was thrown away into the		re-education of all full time, par		
		age. The medication cart		per diem nurses on the correct		
	was observed to hav			all sharp safety devices following		
	available. Nurse #5	was asked by the surveyor		facility exposure control plan. A	All full time,	
		or disposing of contaminated		part time and per diem nurses	were	
	-	as then observed to place		re-educated as of 01/20/18.		
		ed sharp in the sharps		The monitoring procedure to en		
	container.			the plan of correction is effective		
	An interview was ser	advated on 1/2/19 at 1:20 nm		specific deficiency cited remain		
		nducted on 1/3/18 at 4:20 pm e #5 stated after being asked		and/or in compliance with the r requirements:	<del>c</del> guiatol y	
		rps process "I guess I should		The Director of Nurses or Supp	ort Nurse	
		e sharps container, it is		will complete the Quality Assur		
	•	ated." Nurse #5 stated that		tool for Lancet Sharp Disposal		
		Il properly dispose of the		weekly x 4 then monthly x 3. The		
		s container. Nurse #5 stated		include direct visual observatio		
	she had been dispos	ing the lancet in the regular		sharp disposal practice by full t	ime, part	
	garbage.			time and per diem nurses on a		
				including weekends. Reports w		
		nducted on 1/3/18 at 5:00 pm		presented to the Administrator	•	
		lursing (DON). DON stated		in turn will be shared with the v	-	
		required to be placed in the		Quality Assurance committee b	-	
		sharps container. Placing		Director of Nursing to ensure c		
	-	in the garbage was not		action for trends or ongoing co- initiated as appropriate. The w		
	acceptable nor facilit	y policy.		Quality Assurance Meeting is a	•	
			1	audinity Assurance infecting is a	ittoriaca by	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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F 880	Continued From page	÷ 42	F8	the Director of Nurses, Minimum Data Coordinator, Support Nurse, Therapy Manager, Health Information Management, Dietary Manager, Administrator and Medical Director. Deficiencies that are identified during monitoring process will be addressed through the facility Quality Assurance process.  The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing and the Suppo Nurse  02/05/18	the		