STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility on 1/2/18 to conduct a recertification and complaint survey and was unable to return to the facility on 1/4/18 due to adverse weather of snow, ice and unsafe travel conditions. The survey team returned to the facility on 1/8/18 and completed the survey on 1/8/18. Event ID #LMK311.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of medications for 1 of 6 residents (Resident #13) reviewed for unnecessary medications. The findings included: Resident #13 was admitted to the facility on 4/5/16 and most recently readmitted on 9/7/17 with diagnoses that included breast cancer, brain cancer, and dementia. The quarterly Minimum Data Set (MDS) assessment dated 10/14/17 indicated Resident #13 ' s cognition was severely impaired. Section N, the Medication Section, indicated Resident #13 was administered 0 antipsychotic medications. The Antipsychotic Medication Review indicated Resident #13 had received routine antipsychotic medication. This section of the MDS was completed by the MDS Nurse Consultant.	F 641	F641 Accuracy of Assessment Based on record review and staff interview, the facility failed to code the Minimum Data Set assessment accurately 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 the alleged deficiency: On 01/08/18 Minimum Data Set Nurse told the Surveyor that she had incorrectly coded resident #13 on section N of the Quarterly Minimum Data Set with the Assessment Reference Date of 10/14/17 as having received 0 antipsychotic medications. While modifying this Minimum Data Set assessment she forgot to uncheck the section that revealed that resident #13 had received routine antipsychotic medications. The Minimum Data Set was immediately corrected using	2/5/18

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

Electronically Signed | 01/26/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 641	Continued From page 1 A review of Resident #13 ' s Medication Administration Record (MAR) during the 10/14/17 MDS look back period (10/8/17 through 10/14/17) indicated she received no antipsychotic medication. An interview was conducted with MDS Nurse Consultant on 1/8/18 at 2:40 PM. She indicated she had been assisting the facility with completion of MDS assessments for a couple of months as they had just hired a new MDS Nurse. The Medication Section of the MDS assessment dated 10/14/17 for Resident #13 was reviewed with the MDS Nurse Consultant. The MAR for Resident #13 during the look back period of the 10/14/17 MDS was reviewed with the MDS Nurse Consultant. She revealed she had incorrectly coded the MDS for routine antipsychotic medication. She confirmed Resident #13 had received no antipsychotic medication during the 10/14/17 MDS review period. An interview was conducted with the Administrator and Director of Nursing (DON) on 1/8/18 at 3:51 PM. The Administrator and DON both indicated they expected the MDS to be coded accurately.	F 641	modification request which was submitted to Centers for Medicare and Medicaid Services data base on 01/09/18. All residents on antipsychotic medications were audited by the Director of Nursing, with the assistance of the MDS Nurse Consultant on 01/23/18. The residents who receive antipsychotic medications were all reviewed for accurate coding of section NO410A and that section NO450A reflected on what basis the antipsychotic was administered. If it was administered on routine basis, then this should be coded as such on this section. If the resident received it on as needed basis or as both and routine basis, this was accurately reflected on section NO450A of the Minimum Data Set assessments. All current residents on antipsychotic medications were audited by the Director of Nursing with the assistance of the Minimum Data Set Consultant Nurse and the Minimum Data Set Nurse on 01/22/18. Responses on section NO410A of the Minimum Data Set was compared to the responses on section NO450A. None of the Minimum Data Set assessments that were audited were found to have any discrepancies. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 01/23 /18, the Director of Nursing and the Minimum Data Set Nurse Consultant re-educated the new Minimum Data Set Nurse on coding the antipsychotic medications accurately on the Minimum Data Set. In section NO410A, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 641	Continued From page 2	F 641	Minimum Data Set Nurse should code the number of days the resident received the antipsychotic medications during the 7 day look back of the Assessment Reference Date. If any resident who received antipsychotic medications, section NO450A should be coded to reflect on what basis the antipsychotic medications were administered. If none were administered, or if some were administered on an as needed basis, or if the medications were administered on a routine basis or administered on both routine and as needed basis, the Minimum Data Set should be coded accurately to reflect this. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Minimum Data Set Nurse and Director of Nursing will complete the Quality Assurance audit tool for monitoring accurate coding of the antipsychotic medication for 3 residents weekly x 4 then monthly x 3. Reports will be presented to the Administrator weekly that in turn will be shared with the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 641	Continued From page 3	F 641	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	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 656	Continued From page 4 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to develop a comprehensive care plan for an indwelling urinary catheter (Resident # 164) and for the use of an antidepressant medication used to treat insomnia (Resident #35) for 2 of 18 residents reviewed for care planning. The findings included: 1. Resident #164 was admitted 6/22/17 and readmitted 12/23/17 with a diagnosis of paraplegia. His admission Minimum Data Set (MDS) dated 6/29/17 indicated his was cognitively intact with no behaviors. The MDS read he required supervision to extensive assistance with his activities of daily living and had an indwelling urinary catheter.	F 656	F656 Develop/Implement Comprehensive Care Plans Based on observation, staff and resident interviews and record review, the facility failed to develop a comprehensive care plan for an indwelling urinary catheter (Resident # 164) and for the use of an antidepressant medication used to treat insomnia (Resident #35) for 2 of 18 residents reviewed for care planning. The plan for correcting the specific deficiency and the process that lead to the alleged deficiency: On 01/02/18 Resident # 164 was observed by the surveyor as having an indwelling urinary catheter. All his MDS Assessments Resident # 164	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 656	Continued From page 5 A review of Resident #164 ' s admission orders dated 6/22/17 and readmission orders dated 12/23/17 read he may change his own urinary catheter monthly. The Care Area Assessment (CAA) also dated 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 indicated the area of concern would be care planned. A review the admission care plan dated 6/23/17 did not include a care plan to the presence of Resident #164 ' s urinary catheter. A review of Resident #164 ' s most recent care plan last revised on 9/21/17 did not include a care plan for the presence of a urinary catheter. The most recent quarterly MDS dated 9/29/17 indicated his was cognitively intact with no behaviors. The MDS read he required supervision to extensive assistance with his activities of daily living and had an indwelling urinary catheter. In an observation and interview on 1/2/18 at 12:15 PM, Resident #164 was noted to have an indwelling urinary catheter. He stated he had a catheter since he was young and was aware of the care involved in his catheter. He stated he changed his own catheter monthly and had been changing it prior to his stay at the facility. In an interview on 1/8/17 at 2:10 PM, the MDS consultant stated Resident #164 ' s urinary catheter should have been care planned as stated his CAA. She also stated the lack of his urinary catheter care plan should have been	F 656	had been accurately coded as having the urinary catheter. His admission Minimum Data Set assessment that was completed with an Assessment Reference Date of 6/22/17, and his Care Area Assessment for Resident #164 for Urinary / Indwelling catheter had the use of the catheter coded and the indication that this would be care planned but no care plan had been developed to address the indwelling catheter. The most recent care plan revision had been completed on 09/21/17 and did not include the presence of an indwelling urinary catheter. A full audit for all residents with an indwelling catheter was completed by the Minimum Data Set Consultant and the new Minimum Data Set Nurse on 01/23/18. All the residents in the facility with an indwelling catheter that had triggered a Care Area Assessment were found to have a comprehensive care plan addressing the indwelling urinary catheter. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 01/23/18 the Director of Nursing and the Minimum Data Set Nurse Consultant re-educated the Minimum Data Set Nurse on accurately ensuring that any triggered Care Area Assessment that had areas of concern indicated to be addressed in care plan must have a care plan developed or implemented to address the areas. A comprehensive care plan will be developed / implemented from the relevant Care Area Assessment triggers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 656	Continued From page 6 noticed during his last quarterly assessment on 9/29/17. In an interview on 1/8/18 at 3:59 PM, the Administrator stated it was her expectation that Resident #164 have a comprehensive care plan including the presence of his indwelling urinary catheter. On 1/8/18 at 5:45 PM, the MDS consultant provided a care plan for the presence of Resident #164 ' s urinary catheter initiated 1/8/18. 2. Resident #35 was admitted on 6/12/17 and readmitted on 12/13/17 with cumulative diagnoses of cerebral vascular accident and anxiety. The most recent significant MDS dated 11/15/17 indicated she was cognitively intact with no behaviors. She required supervision to extensive assistance with her activities of daily living. The Care Assessment Area (CAA) dated 11/15/17 indicated she was prescribed an antidepressant. The CAA indicated the medication was to be care planned. A review of Resident #35 ' s November 2107 orders to present read she was to take Trazadone (antidepressant) at night for insomnia. A review of Resident #35 ' s last revised care plan dated 12/4/17 did not include a care plan for the use of an antidepressant for insomnia. In an interview on 1/8/18 at 10:10 AM, Resident #35 stated since her recent surgery, she was less anxious and resting at night. She confirmed she received a medication at bedtime to help her sleep. In an interview on 1/8/17 at 2:10 PM, the MDS	F 656	that are appropriate and applicable to the resident per the Resident Assessment Instrument guidelines. The care plan will then be updated / revised with applicable new interventions and new goals or goal changes. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nursing and the Minimum Data Set Nurse will complete the Quality Assurance audit tool for monitoring comprehensive care plan triggers, weekly x 4 then monthly x 3. Reports will be presented to the Administrator weekly that in turn will be shared with the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is 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 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:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 656	Continued From page 7 consultant stated Resident #35 ' s antidepressant medication prescribed for insomnia should have been care planned as stated her CAA dated 11/15/17. On 1/8/18 at 3:20 PM, the MDS consultant provided a care plan for the use of a prescribed antidepressant for Resident #35 ' s insomnia initiated 1/8/18. 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 656	The Director of Nursing and the Minimum Data Set Nurse. 02/05/18	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 657	Continued From page 8 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and 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 findings included: Resident #16 was admitted to the facility on 11/28/12 and most recently readmitted on 4/21/17 with diagnoses that included insomnia. The annual Minimum Data Set (MDS) assessment dated 10/20/17 indicated Resident #16 ' s cognition was intact. He was noted to have a diagnosis of insomnia and had received antidepressant medication on 7 of 7 days during the MDS review period. A review of Resident #16 ' s physician ' s orders indicated Trazodone (antidepressant medication) was discontinued on 12/1/17. A review of Resident #16 ' s Medication Administration Record from 12/2/17 through 1/7/18 indicated he received no antidepressant medication since the discontinuation of Trazodone on 12/1/17. The comprehensive plan of care for Resident #16 was reviewed on 1/8/18. The plan of care included, in part, the focus area of antidepressant	F 657	F657 Care Plan Timing and Revision Based on record review and staff interview, the facility failed to review and 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 the alleged deficiency: The annual Minimum Data Set assessment with Assessment Reference Date of 10/20/17 for resident #16, revealed that the resident had an active diagnosis of insomnia and was receiving an antidepressant medication daily to assist with the insomnia during the entire look back period of the Minimum Data Set assessment. The physician□s orders indicated that the antidepressant medication was discontinued on 12/01/17. The surveyors reviewed the resident□s care plan on 01/08/18 and found the antidepressant medication still showing on the active care plan. The antidepressant medication should have been resolved from the care plan since it had been discontinued. The Minimum Data Set Consultant resolved the medication from the active care plan on 01/08/18. The procedure for implementing the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 657	Continued From page 9 medication use initiated on 10/29/15. An interview was conducted with the MDS Nurse Consultant on 1/8/18 at 2:40 PM. She indicated she had been assisting the facility with completion of MDS assessments and care plans for a couple of months as they had just hired a new MDS Nurse. The care plan related to antidepressant medication for Resident #16 was reviewed with the MDS Nurse Consultant. The physician ' s order dated 12/1/17 that discontinued Trazodone for Resident #16 as well as the MAR from 12/2/17 through 1/7/18 that indicated he had received no antidepressant medication during that time frame was reviewed with the MDS Nurse Consultant. She revealed Resident #16 ' s care plan should have been revised to indicate the discontinuation of the focus area related to antidepressant medication. An interview was conducted with the Administrator and Director of Nursing (DON) on 1/8/18 at 3:51 PM. The Administrator and DON both indicated they expected care plans to accurately reflect the status of the resident and to be reviewed and revised to reflect changes in their status.	F 657	acceptable plan of correction for the specific deficiency cited: All residents with the diagnoses of Insomnia were reviewed by the Director of Nursing, Minimum Data Set Nurse and Minimum Data Set Consultant on 01/23/18. All the Minimum Data Set assessments were reviewed to see if the diagnosis of Insomnia was still an active diagnosis for the resident. Any residents with an active diagnosis of Insomnia, had their care plan revised and updated to reflect the current orders. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 01/23/18 the Director of Nursing and the Minimum Data Set Clinical Consultant re-educated the new Minimum Data Set Nurse on the care plan revision and updates as a daily practice and on as needed basis. All new orders to be reviewed by the Minimum Data Set Nurse during daily Quality Assurance and updates made to the care plans as indicated on the orders. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nursing and the Minimum Data Set Nurse will complete 3 residents using the Quality Assurance audit tool for care plan revision and update weekly x 4 then monthly x 3. Reports will be presented to the Administrator weekly that in turn will be shared with the weekly Quality Assurance committee by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 657	Continued From page 10	F 657	Director of Nursing to ensure corrective action for trends or ongoing concerns is 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 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 Data Set Nurse. 02/05/18	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688		1/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 688	Continued From page 11 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews, the facility failed to prevent decreased range of motion which resulted in decreased use of the resident ' s left hand for 1 of 2 residents (Resident #20). Findings included: 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. A physicians ' order dated 9/7/17 revealed an order for occupational therapy consultation and check left hand and an x-ray of the left hand 2 views. X-ray results dated 9/8/17 revealed left hand had no acute fracture or dislocation, the mineralization was decreased, and there was moderate joint degenerative changes with no suspicious erosions. No there was no focal soft tissue findings. A review of the therapy notes revealed there were no notes for 2017. Resident's care plan dated 11/22/17 revealed	F 688	F688 Increase/Prevent Decrease in ROM/Mobility Based on record review, resident interview, and staff interviews, the facility failed to prevent decreased range of motion which resulted in decreased use of the resident ' s left hand for 1of 2 residents (Resident #20). The plan for correcting the specific deficiency and the process that lead to the alleged deficiency: On 01/10/18 Resident #20 was screened and picked-up for treatment by the Occupational Therapist for management in Range of Motion. Upon screening, a splint was ordered for resident to prevent further decline in Range of Motion. Therapy automatically screens all new admissions. Residents admitted since 01/01/2018 who have had outside consults since admission will be reviewed for rehabilitation orders. Any resident identified as having orders for rehabilitation will be given to the Rehab Director for follow-up and treatment as necessary. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: All residents with outside consults will be monitored by the Director of Nursing or Support Nurse upon return to the facility to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 688	Continued From page 12 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 stated several weeks ago she requested and was seen by the physician who ordered an x-ray and therapy. The resident had an x-ray but no therapy. The resident stated that she believed she needs therapy and some exercises to retain use of her left hand. The resident stated she had lost some range of motion to her left hand since she was admitted. 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 obtained a notice from nursing. RD stated that Resident #20 had not received ordered occupational therapy services for her left hand. RD agreed without therapy services for range of motion the range can be decreased. On 1/8/18 at 11:30 am an interview was conducted with the Director of Nursing (DON). The DON stated that it was unacceptable not to follow the physician's order for occupational therapy evaluation to prevent decreased range of motion.	F 688	ensure any follow-up orders are relayed to the appropriate department for follow-up and treatment as necessary. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nursing or Support Nurse will report daily in the Quality Assurance meeting on residents who had consults and new orders resulting in need for Rehabilitation Services or other services needed. 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 or the Support Nurse. 02/05/18	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d)	F 745		2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 745	Continued From page 13 §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interview, the facility failed to ensure Resident #62 had transportation arrangements for an oncology appointment that was indicated on her hospital discharge instructions resulting in the resident missing the appointment for one of one residents reviewed for medically related social services. The findings included: Resident #62 was admitted to the facility on 7/19/17 with diagnoses that included bone cancer. A review of Resident #62 ' s medical record included the hospital discharge summary dated 7/19/17. The discharge instructions included a follow up appointment with Resident #62 ' s oncology (cancer specialist) physician on 7/26/17. The admission Minimum Data Set (MDS) assessment dated 7/26/17 indicated Resident #62 ' s cognition was intact. She had no behaviors and no rejection of care. Resident #62 had an active diagnosis of cancer. A Grievance Report Form dated 8/4/17 indicated a grievance was filed on behalf of Resident #62 by her Responsible Party (RP). The form stated Resident #62 missed an orthopedic appointment and an oncology appointment on 7/26/17. A review of the investigation revealed Resident #62 had missed the appointment with her oncology physician on 7/26/17 that was indicated on her	F 745	F745 Provision of Medically Related Social Service Based on record review, family interview, and staff interview, the facility failed to ensure Resident #62 had transportation arrangements for an oncology appointment that was indicated on her hospital discharge instructions resulting in the resident missing the appointment for one of one residents reviewed for medically related social services. The plan for correcting the specific deficiency and the process that lead to the alleged deficiency: Appointments for Resident#62 for oncology and orthopedics were rescheduled. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Resident appointments from 01/01/18 were reviewed by the Director of Nursing and Transportation aide for the possibility of any missed appointments or transportation issues. There were no identified issues. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 745	Continued From page 14 discharge instructions from the hospital. The investigation also revealed Resident #62 had missed an orthopedic appointment that was not indicated on her discharge instructions and was unknown to the facility staff. Both appointments were rescheduled by facility staff. A phone interview was conducted with Resident #62 ' s RP on 1/8/18 at 9:30 AM. She confirmed the information in the 8/4/17 Grievance Report Form. An interview was conducted with the Administrator on 1/8/18 at 10:33 AM. The Grievance Report Form dated 8/4/17 related to Resident #62 was reviewed with the Administrator. The Administrator confirmed the 7/26/17 oncology appointment noted on Resident #62 ' s discharge instructions was missed by the nursing staff and arrangements had not been made for transportation resulting in the resident missing the appointment. She explained that she believed the orthopedic appointment had been scheduled by Resident #62 ' s family and the facility had been unaware of the appointment. The Administrator indicated both appointments were rescheduled for Resident #62. This interview with the Administrator continued. She indicated her expectation was for the facility to ensure transportation arrangements were made for all appointments the facility had knowledge of.	F 745	requirements: The Transportation Aide will bring the daily appointment schedule to the daily Quality Assurance meeting for review and validation by the Director of Nursing and Administrator of scheduled appointments and transportation arrangements. The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing and Support Nurse. 02/05/18	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758		2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 15 affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 16 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and Pharmacy Consultant interview, the facility failed to administer antipsychotic medication as ordered (Resident #7) and failed to ensure physician ' s orders for as needed (PRN) psychotropic medications were time limited in duration for 4 of 6 residents (Residents #7, #14, #35, and #60) reviewed for unnecessary medications. The findings included: 1a. Resident #7 was initially admitted to the facility on 6/2/16 and most recently admitted on 11/20/17 with diagnoses that included dementia, psychotic disorder, and schizophrenia. The significant change Minimum Data Set (MDS) assessment dated 10/6/17 indicated Resident #7 ' s cognition was severely impaired. Resident #7 was assessed with no behaviors and no rejection of care. She received antipsychotic medication on 7 of 7 days and antianxiety medication on 1 of 7 days. A physician ' s order dated 12/19/17 indicated Zyprexa (antipsychotic medication) 5 milligrams (mg) by mouth in the morning (9:00 AM) for Resident #7. A physician ' s order dated 12/19/17 indicated Zyprexa solution reconstituted 5 mg to be injected	F 758	F758 Free from Unnecessary Psychotropic Meds/PRN Based on record review, staff interview, and Pharmacy Consultant interview, the facility failed to administer antipsychotic medication as ordered (Resident #7) and failed to ensure physician ' s orders for as needed psychotropic medications were time limited induration for 4 of 6 residents (Residents #7, #14,#35, and #60) reviewed for unnecessary medications The plan for correcting the specific deficiency and the process that lead to the alleged deficiency: Written as needed psychotropic medication orders failed to contain the 14 day maximum duration limit as per regulation. All as needed Psychotropic Medication orders were audited by the Director of Nursing and Pharmacy Consultant on 1/25/18 to ensure that these orders meet the regulation of the 14 day duration limit and review for unnecessary medications. No other residents were identified as being outside the 14 day regulations for psychotropic medications. An audit of the corrected orders was completed by the Director of Nurses to ensure that the new orders are correctly reflected on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 17 intramuscularly (IM) as needed (PRN) for Resident #7. The instructions stated, "Give if patient refuses to take the pill". A review of Resident #7 ' s Medication Administration Record (MAR) for December 2017 was reviewed. On 12/29/17 Resident #7 received Zyprexa 5 mg in the morning as ordered. On 12/29/17 at 4:58 PM Resident #7 was administered Zyprexa 5 mg IM PRN by Nurse #1. An interview was conducted with Resident #7 ' s physician on 1/8/18 at 11:45 AM. The physician ' s order for Resident #7 dated 12/19/17 for routine Zyprexa was reviewed with the physician. The physician ' s order for Resident #7 dated 12/19/17 for Zyprexa IM PRN that indicated it was to be given if Resident #7 refused to take "the pill" was reviewed with the physician. The December 2017 MAR for Resident #7 that indicated she received both the routine Zyprexa and the PRN Zyprexa on 12/29/17 was reviewed with the physician. The physician stated his Nurse Practitioner (NP) had written the Zyprexa PRN IM order on 12/19/17 for Resident #7. He indicated it was his belief she intended the PRN IM Zyprexa to be administered only if Resident #7 had refused the routine Zyprexa by mouth. He reported expected his orders and his NP's orders to be followed. An interview was conducted with the NP on 1/8/18 at 11:55 AM. The physician ' s order for Resident #7 dated 12/19/17 for routine Zyprexa was reviewed with the NP. The physician ' s order for Resident #7 dated 12/19/17 for Zyprexa IM PRN that indicated it was to be given if Resident #7 refused to take "the pill" was reviewed with the NP. The December 2017 MAR for Resident #7 that indicated she received both	F 758	Medication Administration Record and that the prior order has been discontinued. As needed Psychotropic Medication orders will be reviewed as part of the Daily Quality Assurance Meeting to assure ongoing compliance with the 14 day maximum duration limit. The Director of Nursing will review every 14 days the as needed psychotropic medications and bring to the attention of the physician those that need to be addressed. All as needed Anti-Psychotic Medication orders will be audited to ensure that these orders meet the regulation of the 14 day duration limit. An audit of the corrected orders will be completed by the Director of Nurses to ensure that the new orders are correctly reflected on the Medication Administration Record and that the prior order has been discontinued. As needed o psychotropic orders will be reviewed as part of the Daily Quality Assurance Meeting to assure ongoing compliance. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 01/23/18 the Director of Nursing began re-education of all nurses and the nurse practitioner regarding regulations related to the limit in duration of prn anti-psychotic medications orders to 14 days. All nurses and the Nurse Practitioner will be re-educated by 1/ 31/18. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 18 the routine Zyprexa and the PRN IM Zyprexa on 12/29/17 was reviewed with the NP. The NP confirmed she had written the order for the PRN IM Zyprexa on 12/19/17 for Resident #7. She stated the PRN IM Zyprexa was intended to be administered only if Resident #7 had refused the Zyprexa by mouth. An interview was conducted with Nurse #1 on 1/8/18 at 3:02 PM. The physician ' s order for Resident #7 dated 12/19/17 for routine Zyprexa was reviewed with Nurse #1. The physician ' s order dated 12/19/17 for Zyprexa IM PRN that indicated it was to be given if Resident #7 refused to take "the pill" was reviewed with Nurse #1. The December 2017 MAR for Resident #7 that indicated she received both the routine Zyprexa and the PRN IM Zyprexa on 12/29/17 was reviewed with Nurse #1. Nurse #1 confirmed she had administered PRN IM Zyprexa to Resident #7 on 12/29/17 as the resident had refused some of her evening medications. She reported the medications that were refused by Resident #7 had not included routine Zyprexa. She stated she thought the PRN IM Zyprexa order was to be administered if Resident #7 had refused any pill. Nurse #1 revealed she was unaware the PRN IM Zyprexa order was only to be administered if Resident #7 had refused the routine Zyprexa by mouth. An interview was conducted with the Administrator and Director of Nursing (DON) on 1/8/18 at 3:51 PM. They both indicated they expected physician's orders to be followed. 1b. Resident #7 was initially admitted to the	F 758	and/or in compliance with the regulatory requirements: The Director of Nursing or Support Nurse will complete the Quality Assurance audit tools for as needed Anti-psychotic Medication Orders, weekly x 4 then monthly x 3. Reports will be presented to the Administrator weekly that in turn will be shared with the Quality Assurance Committee by the Director of Nursing, to ensure that corrective action for trends or 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 19	F 758		

facility on 6/2/16 and most recently admitted on 11/20/17 with diagnoses that included dementia, psychotic disorder, and schizophrenia.

The significant change Minimum Data Set (MDS) assessment dated 10/6/17 indicated Resident #7 ' s cognition was severely impaired. Resident #7 was assessed with no behaviors and no rejection of care. She received antipsychotic medication on 7 of 7 days and antianxiety medication on 1 of 7 days.

A physician ' s order dated 12/19/17 indicated Zyprexa solution reconstituted (antipsychotic medication) 5 milligrams (mg) to be injected intramuscularly (IM) as needed (PRN) for Resident #7. The instructions stated, "Give if patient refuses to take the pill". There was no stop date for this PRN Zyprexa order.

A "Note to Attending Physician/Prescriber" dated 12/28/17 and written by the Pharmacy Consultant indicated PRN antipsychotic medication was limited to 14 days. Resident #7 was noted with an order for Zyprexa 5 mg PRN IM with no discontinuation date. The form had not yet been addressed by the physician as of 1/8/18.

An interview was conducted with the physician on 1/8/18 at 9:30 AM. He stated he expected the regulations related to PRN psychotropic medications to be followed.

A phone interview was conducted with the Pharmacy Consultant on 1/8/18 at 1:30 PM. She stated she was aware of the new regulations regarding PRN psychotropic medications. She indicated she had been making recommendations for all PRN orders for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 20	F 758		

antipsychotic medications to have a maximum duration of 14 days as per the regulations. She stated she had also been making recommendations regarding all other PRN orders for psychotropic medications to be time limited in duration as per the regulations. The Pharmacy Consultant indicated for any PRN psychotropic medication (excluding antipsychotic medications) the prescriber was required to document a rationale and indicate a time limited duration if the order was to extend past 14 days.

An interview was conducted with the Administrator and Director of Nursing (DON) on 1/8/18 at 3:51 PM. They both indicated they expected all PRN orders for antipsychotic medications to have a maximum duration of 14 days as per the regulations.

1c. Resident #7 was initially admitted to the facility on 6/2/16 and most recently admitted on 11/20/17 with diagnoses that included dementia, psychotic disorder, and schizophrenia.

The significant change Minimum Data Set (MDS) assessment dated 10/6/17 indicated Resident #7 ' s cognition was severely impaired. Resident #7 was assessed with no behaviors and no rejection of care. She received antipsychotic medication on 7 of 7 days and antianxiety medication on 1 of 7 days.

A physician ' s order dated 11/30/17 indicated Lorazepam Powder (antianxiety medication) as needed (PRN) every 8 hours for Resident #7. There was no stop date for this PRN Lorazepam Powder order.

A "Note to Attending Physician/Prescriber" dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 21	F 758		

12/28/17 and written by the Pharmacy Consultant indicated PRN psychotropic medication was limited to 14 days and if the prescriber wanted to extend the order past 14 days a rationale and time limited duration was to be documented in the medical record. Resident #7 was noted with an order for Ativan Powder every 8 hours PRN with no discontinuation date. The form had not yet been addressed by the physician as of 1/8/18.

An interview was conducted with the physician on 1/8/18 at 9:30 AM. He stated he expected the regulations related to PRN psychotropic medications to be followed.

A phone interview was conducted with the Pharmacy Consultant on 1/8/18 at 1:30 PM. She stated she was aware of the new regulations regarding PRN psychotropic medications. She indicated she had been making recommendations for all PRN orders for antipsychotic medications to have a maximum duration of 14 days as per the regulations. She stated she had also been making recommendations regarding all other PRN orders for psychotropic medications to be time limited in duration as per the regulations. The Pharmacy Consultant indicated for any PRN psychotropic medication (excluding antipsychotic medications) the prescriber was required to document a rationale and indicate a time limited duration if the order was to extend past 14 days.

An interview was conducted with the Administrator and Director of Nursing (DON) on 1/8/18 at 3:51 PM. They both indicated they expected all PRN orders for psychotropic medications to have a time limited duration as per the regulations. They additionally both indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 22	F 758		

they expected the prescriber to document a rationale and indicate a time limited duration if the PRN psychotropic order was to extend past 14 days. They stated if the physician had documented rationale and a time limited duration they expected the electronic order to be updated accordingly.

2a. Resident #14 was admitted to the facility on 7/13/17 with diagnoses that included dementia with behavioral disturbance and mood disorder.

The quarterly Minimum Data Set (MDS) assessment dated 10/20/17 indicated Resident #14 ' s cognition was severely impaired. She had delusions, no behaviors, and rejected care on 1 to 3 days during the MDS review period. Resident #14 received antipsychotic medication, antidepressant medication, and antianxiety medication on 7 of 7 days.

A physician ' s order dated 8/11/17 indicated Lorazepam (antianxiety medication) 0.5 milligram (mg) as needed (PRN) twice daily for Resident #14. There was no stop date for this PRN Lorazepam order.

A "Note to Attending Physician/Prescriber" dated 11/28/17 and written by the Pharmacy Consultant indicated PRN psychotropic medication was limited to 14 days and if the prescriber wanted to extend the order past 14 days a rationale and time limited duration was to be documented in the medical record. Resident #14 was noted with an order for Lorazepam 0.5 mg PRN twice daily. The form was addressed by the physician on 12/1/17 and indicated the Lorazepam 0.5 mg PRN twice daily was to continue for 3 months due to long standing vascular dementia, depression,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 23	F 758		

and anxiety complicated by psychosis and paranoia. The physician indicated Resident #14 had frequent anxiety exacerbations/behavioral outbursts that were relieved by the PRN Lorazepam.

A review of the current physician ' s orders for Resident #14 on 1/3/18 revealed the physician ' s order for PRN Lorazepam 0.5 mg twice daily had not been updated with a stop date. The order indicated the end date was "indefinite".

An interview was conducted with the Director of Nursing (DON) on 1/3/18 at 3:05 PM. She stated if a medication had an end date it was to be indicated on the electronic order. The "Note to Attending Physician/Prescriber" form dated 11/28/17 related to Resident #14 ' s PRN Lorazepam 0.5 mg twice daily was reviewed with the DON. The physician ' s instructions on the form dated 12/1/17 that indicated the PRN Lorazepam 0.5 mg twice daily was to be continued for 3 months for Resident #14 was reviewed with the DON. The electronic physician ' s order for Resident #14 dated 8/11/17 that had no stop date as of 1/3/18 was reviewed with DON. The DON indicated the Support Nurse was in charge of reviewing the physician's responses on the "Note to Attending Physician/Prescriber" form and updating the electronic orders accordingly.

An interview was conducted with the Support Nurse on 1/3/18 at 3:20 PM. She stated that prior to December 2017 she and/or the floor nurses were reviewing the "Note to Attending Physician/Prescriber" forms and updating the electronic orders accordingly. She indicated around the beginning of December she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 24	F 758		

asked to take over primary responsibility of updating the electronic orders as per the physician ' s response on the "Note to Attending Physician/Prescriber" form. She revealed she asked for this responsibility because she had noticed a "stack" of these forms that had not been completed.

This interview with the Support Nurse continued. The "Note to Attending Physician/Prescriber" form dated 11/28/17 related to Resident #14 ' s PRN Lorazepam 0.5 mg twice daily was reviewed with the Support Nurse. The physician ' s instructions on the form dated 12/1/17 that indicated the PRN Lorazepam 0.5 mg twice daily was to be continued for 3 months for Resident #14 was reviewed with the Support Nurse. The electronic physician ' s order for Resident #14 dated 8/ 11/17 for PRN Lorazepam 0.5 mg twice daily that had no stop date as of 1/3/18 was reviewed with the Support Nurse. The Support Nurse revealed Resident #14 ' s PRN Lorazepam 0.5 mg twice daily should have been updated with an end date of 90 days from the date the physician had signed the "Note to Attending Physician/Prescriber" form on 12/1/17.

An interview was conducted with the physician on 1/8/18 at 9:30 AM. He stated he expected the regulations related to PRN psychotropic medications to be followed.

A phone interview was conducted with the Pharmacy Consultant on 1/8/18 at 1:30 PM. She stated she was aware of the new regulations regarding PRN psychotropic medications. She indicated she had been making recommendations for all PRN orders for antipsychotic medications to have a maximum

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 25	F 758		

duration of 14 days as per the regulations. She stated she had also been making recommendations regarding all other PRN orders for psychotropic medications to be time limited in duration as per the regulations. The Pharmacy Consultant indicated for any PRN psychotropic medication (excluding antipsychotic medications) the prescriber was required to document a rationale and indicate a time limited duration if the order was to extend past 14 days.

An interview was conducted with the Administrator and Director of Nursing (DON) on 1/8/18 at 3:51 PM. They both indicated they expected all PRN orders for psychotropic medications to have a time limited duration as per the regulations. They additionally both indicated they expected the prescriber to document a rationale and indicate a time limited duration if the PRN psychotropic order was to extend past 14 days. They stated if the physician had documented a rationale and a time limited duration for a PRN psychotropic medication they expected the electronic order to be updated accordingly.

2b. Resident #14 was admitted to the facility on 7/13/17 with diagnoses that included dementia with behavioral disturbance and mood disorder.

The quarterly Minimum Data Set (MDS) assessment dated 10/20/17 indicated Resident #14 ' s cognition was severely impaired. She had delusions, no behaviors, and rejected care on 1 to 3 days during the MDS review period. Resident #14 received antipsychotic medication, antidepressant medication, and antianxiety medication on 7 of 7 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 26	F 758		

A physician ' s order dated 12/14/17 indicated Ativan (antianxiety medication) crème topically 0.5 milligrams (mg) as needed (PRN) if Resident #14 unwillingly/uncooperative with oral medication. There was no stop date for this PRN Ativan creme order.

An interview was conducted with the physician on 1/8/18 at 9:30 AM. He stated he expected the regulations related to PRN psychotropic medications to be followed.

A phone interview was conducted with the Pharmacy Consultant on 1/8/18 at 1:30 PM. She stated she was aware of the new regulations regarding PRN psychotropic medications. She indicated she had been making recommendations for all PRN orders for antipsychotic medications to have a maximum duration of 14 days as per the regulations. She stated she had also been making recommendations regarding all other PRN orders for psychotropic medications to be time limited in duration as per the regulations. The Pharmacy Consultant indicated for any PRN psychotropic medication (excluding antipsychotic medications) the prescriber was required to document a rationale and indicate a time limited duration if the order was to extend past 14 days.

An interview was conducted with the Administrator and Director of Nursing (DON) on 1/8/18 at 3:51 PM. They both indicated they expected all PRN orders for psychotropic medications to have a time limited duration as per the regulations. They additionally both indicated they expected the prescriber to document a rationale and indicate a time limited duration if the PRN psychotropic order was to extend past 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 27	F 758		

days.

3. Resident #60 was admitted to the facility on 7/17/17 and most recently readmitted on 9/12/17 with diagnoses that included dementia with behavioral disturbance and anxiety.

A physician ' s order dated 9/12/17 indicated Ativan (antianxiety medication) 1 milligram (mg) as needed (PRN) every 6 hours for Resident #60. There was no stop date for this PRN Ativan order.

The admission Minimum Data Set (MDS) assessment dated 9/19/17 indicated Resident #60 ' s cognition was intact. She had no behaviors and no rejection of care. Resident #60 received antipsychotic medication, antidepressant medication, and antianxiety medication on 7 of 7 days.

A "Note to Attending Physician/Prescriber" dated 11/28/17 and written by the Pharmacy Consultant indicated PRN psychotropic medication was limited to 14 days and if the prescriber wanted to extend the order past 14 days a rationale and time limited duration was to be documented in the medical record. Resident #60 was noted with an order for Ativan 1 mg PRN every 6 hours. The form was addressed by the physician on 12/1/17 and indicated the Ativan 1 mg PRN every 6 hours was to continue for 3 months due to chronic dement, depression, anxiety, and insomnia. The physician indicated Resident #60 had frequent anxiety/agitation/behavioral outbursts for which the PRN Ativan was effective.

The quarterly MDS assessment dated 12/18/17 indicated Resident #60 ' s cognition was intact. She had other behaviors on 1-3 days during the 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 28	F 758		

day MDS review period and no rejection of care. Resident #60 received antipsychotic medication, antidepressant medication, and antianxiety medication on 7 of 7 days.

A review of the current physician ' s orders for Resident #60 on 1/3/18 revealed the physician ' s order for PRN Ativan 1 mg every 6 hours had not been updated with a stop date. The order indicated the end date was "indefinite".

An interview was conducted with the Director of Nursing (DON) on 1/3/18 at 3:05 PM. She stated if a medication had an end date it was to be indicated on the electronic order. The DON indicated the Support Nurse was in charge of reviewing the physician's responses on the "Note to Attending Physician/Prescriber" form and updating the electronic orders accordingly.

An interview was conducted with the Support Nurse on 1/3/18 at 3:20 PM. She stated that prior to December 2017 she and/or the floor nurses were reviewing the "Note to Attending Physician/Prescriber" forms and updating the electronic orders accordingly. She indicated around the beginning of December she had asked to take over primary responsibility of updating the electronic orders as per the physician ' s response on the "Note to Attending Physician/Prescriber" form. She revealed she asked for this responsibility because she had noticed a "stack" of these forms that had not been completed.

An interview was conducted with the physician on 1/8/18 at 9:30 AM. He stated he expected the regulations related to PRN psychotropic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 29	F 758		

medications to be followed.

A phone interview was conducted with the Pharmacy Consultant on 1/8/18 at 1:30 PM. She stated she was aware of the new regulations regarding PRN psychotropic medications. She indicated she had been making recommendations for all PRN orders for antipsychotic medications to have a maximum duration of 14 days as per the regulations. She stated she had also been making recommendations regarding all other PRN orders for psychotropic medications to be time limited in duration as per the regulations. The Pharmacy Consultant indicated for any PRN psychotropic medication (excluding antipsychotic medications) the prescriber was required to document a rationale and indicate a time limited duration if the order was to extend past 14 days.

An interview was conducted with the Administrator and Director of Nursing (DON) on 1/8/18 at 3:51 PM. They both indicated they expected all PRN orders for psychotropic medications to have a time limited duration as per the regulations. They additionally both indicated they expected the prescriber to document a rationale and indicate a time limited duration if the PRN psychotropic order was to extend past 14 days. They stated if the physician had documented a rationale and a time limited duration for a PRN psychotropic medication they expected the electronic order to be updated accordingly.

4. Resident #35 was admitted on 6/12/17 and readmitted on 12/13/17 with cumulative diagnoses of cerebral vascular accident, recent left above the knee amputation (AKA) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 30	F 758		

anxiety. The most recent significant MDS dated 11/15/17 indicated she was cognitively intact with no behaviors. She required supervision to extensive assistance with her activities of daily living.

A review of Resident #35 ' s December 2107 readmission orders dated 12/13/17 to present read she was to take Lorazepam (antianxiety) 1 milligram (mg) as needed twice daily for anxiety.

A review of Resident #35 ' s December 2017 medication administration record (MAR) indicated she received Lorazepam 1 mg one 8 occasions from 12/1317 to 12/31/17 and her January 2018 MAR indicated she received Lorazepam 1 mg on 4 occasions from 1/1/18 to 1/8/18.

A review of a nurse practitioner progress note dated 12/15/17 read Resident #35 reported she did not feel anxious as before. The plan for Resident #35 ' read continuation of the Lorazepam as needed for anxiety.

A review of a pharmacy recommendation dated 12/28/17 read Resident was prescribed Ativan (antianxiety) 0.5 mg twice daily as needed for anxiety rather than the ordered Lorazepam 1mg twice daily as needed for anxiety on 12/13/17. The recommendation read that Resident #35 ' s as needed psychotropic medications which include her antianxiety medications were to be limited to 14 days unless a rationale and indicated duration were documented in Resident #35 ' s medical record.

A review of Resident #35 ' s last revised care plan dated 1/2/18 included a care plan for her anxiety. Interventions included: consultant pharmacist to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 31	F 758		

review all psychotropic medications for possible changes, dose reductions and staff to monitor for potential adverse side effects and any observed behaviors to warrant the administration of the Lorazepam.

In an interview on 1/8/18 at 9:30 AM, the Medical Director stated he was aware of the 14-day time limit on as needed medications for anxiety and he would have expected the continued use of the Lorazepam for anxiety to have been addressed by Resident #35 ' s attending physician.

In an interview on 1/8/18 at 10:10 AM, Resident #35 stated since her recent left AKA, she was less anxious. Nursing Assistant (NA) #1 stated since Resident #35 ' s recent surgery, she had noted less anxiety and confusion in Resident #35.

In an interview on 1/8/18 at 1:15m PM, the nurse practitioner stated Resident #35 ' s continued need for the prescribed Lorazepam past 14 days should have been addressed either with documentation to support the continued use with a new stop date or should have been discontinued after 14 days.

In a telephone interview on 1/8/18 at 1:30 PM the consultant pharmacist she expected any as needed antianxiety medication to be time limited in duration and for any pharmacy recommendations agreed upon by the physician to be followed. She clarified that the pharmacy recommendation dated 12/28/17 which read Resident #35 ' s prescribed Ativan should have read her prescribed Lorazepam but both medications are anxiety medications Resident #5 ' s has taken either presently or in the past.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 758	Continued From page 32 A telephone call was placed to the attending physician on 1/8/18 at 2:40 PM with instructions to contact the surveyor and at the time of exit, there was no return telephone call. In an interview on 1/8/18 at 3:05 PM, Nurse #1 stated Resident #35 continues to have episodes on anxiety but not as often since having her recent left AKA surgery. In an interview on 1/8/18 3:07 PM, NA #2 stated Resident #35 had not displayed any crying or evidence of anxiety on second shift in a month. In an interview on 1/8/18 at 3:59 PM, the Administrator stated it was her expectation that Resident #35 ' s Lorazepam for anxiety would have a time limit of 14 days or documentation to support continued use with another order with a specified time limit duration.	F 758		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside	F 825		2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 825	Continued From page 33 resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews, the facility failed to provide occupational therapy services as ordered for one of two residents reviewed for range of motion (Resident #20). Findings included: The resident was admitted on 12/11/15. The annual comprehensive Minimum Data Set 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. A physicians ' order dated 9/7/17 revealed an order for occupational therapy consultation and check left hand and an x-ray of the left hand 2 views. X-ray results dated 9/8/17 revealed left hand had no acute fracture or dislocation, the mineralization was decreased, and there were moderate joint degenerative changes with no suspicious erosions. There was no focal soft tissue findings.	F 825	F825 Provide/Obtain Specialized Rehab Services Based on record review, resident interview, and staff interviews, the facility failed to provide occupational therapy services as ordered for one of two residents reviewed for range of motion (Resident #20). The plan for correcting the specific deficiency and the process that lead to the alleged deficiency: On 1/10/18 Resident #20 was screened and picked-up for treatment by the Occupational Therapist for management in Range of Motion. Upon screening a splint to prevent further decline in Range of Motion was ordered for Resident #20. Therapy automatically screens all new admissions. Residents admitted since 01/01/2018 who have had outside consults since admission will be reviewed between 01/24/2018 and 01/31/2018 for orders for rehabilitation. Any resident identified as having orders for rehabilitation will be given to the Rehab Director for follow-up and treatment as necessary. There were no residents identified as having missed orders for Rehab Services. The procedure for implementing the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 825	Continued From page 34 A review of the therapy notes revealed there were no notes for 2017. Resident's care plan dated 11/22/17 revealed 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 obtained a notice from nursing. On 1/8/18 at 11:30 am an interview was conducted with the Director of Nursing (DON). The DON stated that it was unacceptable not to follow the physician's order for occupational therapy evaluation to prevent decreased range of motion.	F 825	acceptable plan of correction for the specific deficiency cited: All residents with outside consults will be monitored by the Director of Nursing or Support Nurse upon return to the facility to ensure any orders for rehabilitation or other are relayed to physical therapy for follow-up and treatment as necessary. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nursing or Support Nurse will report daily in the Quality Assurance meeting on residents who had consults and new orders resulting in need for Rehabilitation Services or other needed services. 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 or the Support Nurse will be responsible for implementing this plan of correction. 02/05/18	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State	F 865		2/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 865	Continued From page 35 Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in 1/20/17 recertification survey. Minimum Data Set accuracy (242), develop a comprehensive care plan (279), revision of a care plan (280), and prevent decreased range of motion (318) was originally cited in the 1/20/17 recertification survey and again recited in the 1/8/18 recertification/complaint survey. The continued failure of the facility during the two federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referenced to: F 641 (also known as [aka] 242) - Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS)	F 865	F865 QAPI Program/Plan, Disclosure/Good Faith Attempt Based on record review, observation, resident and staff interviews, the facility's Quality Assessment and Assurance Committee, failed to maintain implemented procedures and monitor these interventions that the committee put into place in 1/20/17 recertification survey. Minimum Data Set accuracy (641), develop a comprehensive care plan (656), revision of a care plan (657), and prevent decreased range of motion (688) was originally cited in the 1/20/17recertification survey and again recited in the1/8/18 recertification/complaint survey. The continued failure of the facility during the two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance program Based on record review, observation, resident and staff interviews, the facility's Quality Assessment and Assurance (QAA)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 865	Continued From page 36 assessment accurately in the area of medications for 1 of 6 residents sampled (Resident #13) reviewed for unnecessary medications. The facility was cited for F 242 on the recertification survey of 1/20/17 for failure to accurately code the MDS. F 656 (aka 279) - Based on observation, staff and resident interviews and record review, the facility failed to develop a comprehensive care plan for an indwelling urinary catheter (Resident # 164) and for the use of an antidepressant medication used to treat insomnia (Resident #35) for 2 of 18 residents reviewed for care planning. The facility was cited for F 279 on the recertification survey of 1/20/17 for failure to develop a comprehensive care plan. F 657 (aka 280) - Based on record review and 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 failure to revise a care plan. F 688 (aka 318) - Based on record review, resident interview, and staff interviews, the facility failed to prevent decreased range of motion which resulted in decreased range of motion of the resident ' s left hand for 1 of 2 sampled residents (Resident #20). The resident was cited for F 318 on the recertification survey of 1/20/17 for failure to	F 865	Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in 1/20/17 recertification survey. Minimum Data Set accuracy (641), develop a comprehensive care plan (656), revision of a care plan (657), and prevent decreased range of motion (688) was originally cited in the 1/20/17 recertification survey and again recited in the 1/8/18 recertification/complaint survey. The continued failure of the facility during the two federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referenced to: F 641 (also known as [aka] 242) - Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of medications for 1 of 6 residents sampled (Resident #13) reviewed for unnecessary medications. The facility was cited for F 242 on the recertification survey of 1/20/17 for failure to accurately code the MDS. F 656 (aka 279) - Based on observation, staff and resident interviews and record review, the facility failed to develop a comprehensive care plan for an indwelling urinary catheter (Resident # 164) and for the use of an antidepressant medication used to treat insomnia (Resident #35) for 2 of 18 residents reviewed for care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 865	Continued From page 37 prevent decreased range of motion. 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.	F 865	planning. The facility was cited for F 279 on the recertification survey of 1/20/17 for failure to develop a comprehensive care plan. F 657 (aka 280) - Based on record review and 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 failure to revise a care plan. F 688 (aka 318) - Based on record review, resident interview, and staff interviews, the facility failed to prevent decreased range of motion which resulted in decreased range of motion of the resident ' s left hand for 1 of 2 sampled residents (Resident #20). The resident was cited for F 318 on the recertification survey of 1/20/17 for failure to prevent decreased range of motion. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 865	Continued From page 38	F 865	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 plan for correcting the specific deficiency and the process that lead to the alleged deficiency: Corrective action has been implemented for all residents having been identified as 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 correction to identify residents having the potential to have been affected by the alleged deficient practice. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Daily reporting during the daily Quality Assurance meeting continues indefinitely for the individual cited deficiencies. The title of the person responsible for implementing the acceptable plan of correction: The Administrator and Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 880	Continued From page 39	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		2/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 880	Continued From page 40 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to properly dispose of contaminated sharps during 2 out of 3 blood draws reviewed during blood glucose testing for 1 of 2 nurses (Nurse #5). Findings included: The facility policy for infection control did not	F 880	F880 Infection Control Based on observation and staff interviews, the facility failed to properly dispose of contaminated sharps during 2 out of 3 blood draws reviewed during blood glucose testing for 1 of 2 nurses. (Nurse#5) The plan for correcting the specific deficiency and the process that lead to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 880	Continued From page 41 address disposal of sharps. An observation was done on 1/3/18 at 4:00 pm of medication pass with Nurse #5. Nurse #5 performed blood glucose monitoring technique for three residents. Nurse #5 used a lancet to obtain a blood sample for the blood glucometer for the first resident. The contaminated lancet was thrown away into the medication cart garbage. The lancet had a retractable sharp that could be depressed to expose the sharp after use. Nurse #5 used a lancet to obtain a blood sample for the blood glucometer for the second resident. The contaminated lancet was thrown away into the medication cart garbage. The medication cart was observed to have a sharps container available. Nurse #5 was asked by the surveyor the facility process for disposing of contaminated sharps. Nurse #5 was then observed to place the third contaminated sharp in the sharps container. An interview was conducted on 1/3/18 at 4:20 pm with Nurse #5. Nurse #5 stated after being asked about the facility sharps process "I guess I should place the lancet in the sharps container, it is considered contaminated." Nurse #5 stated that going forward she will properly dispose of the lancet into the sharps container. Nurse #5 stated she had been disposing the lancet in the regular garbage. An interview was conducted on 1/3/18 at 5:00 pm with the Director of Nursing (DON). DON stated that all sharps were required to be placed in the appropriate/provided sharps container. Placing contaminated sharps in the garbage was not acceptable nor facility policy.	F 880	alleged deficiency: On 01/08/18 Nurse #5 was re-educated on facility policy for the proper disposal of all sharp safety devices by the Director of Nursing and the Nurse Consultant. A return demonstration by Nurse #5 of correct safety sharps use and disposal practice was observed by the Director of Nursing and the Nurse Consultant. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 01/09/18 the Director of Nurses began re-education of all full time, part time and per diem nurses on the correct disposal of all sharp safety devices following the facility exposure control plan. All full time, part time and per diem nurses were re-educated as of 01/20/18. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses or Support Nurse will complete the Quality Assurance audit tool for Lancet Sharp Disposal Practice, weekly x 4 then monthly x 3. The audit will include direct visual observation of lancet sharp disposal practice by full time, part time and per diem nurses on all shifts, including weekends. Reports will be presented to the Administrator weekly that in turn will be shared with the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(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 880	Continued From page 42	F 880	the Director of Nurses, Minimum Data Set Coordinator, Support Nurse, Therapy 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 Support Nurse 02/05/18	