	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		345532	B. WING		07/06/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LIBERTY	COMMONS NSG AND F	REHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE SANFORD, NC 27332		
			I	-		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIC	
F 000	INITIAL COMMENT	S	F 000			
		gation survey was conducted Immediate jeopardy was				
	CFR 483.45 at tag F (J)	757 at a scope and severity				
	The tag F757 consti care	ituted substandard quality of				
		began on 3/13/18 and was An extended survey was				
F 580 SS=G	changed to tag F76	2567 by CMS, tag F 757 was 0 and the 2567 was reposted. njury/Decline/Room, etc.) 4)(i)-(iv)(15)	F 580		7/6/18	
	consult with the resi consistent with his or representative(s) wh (A) An accident invo results in injury and physician interventio (B) A significant cha mental, or psychoso deterioration in heal status in either life-ti clinical complication (C) A need to alter to a need to discontinu	mediately inform the resident; dent's physician; and notify, or her authority, the resident nen there is- olving the resident which has the potential for requiring on; unge in the resident's physical, ocial status (that is, a th, mental, or psychosocial hreatening conditions or is); reatment significantly (that is, ue an existing form of verse consequences, or to				

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

07/31/2018

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 08/08/201 RM APPROVE
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		E SURVEY IPLETED
		345532	B. WING		C 07/06/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
		EHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE		
LIDERTT		ERAB CIR OF LEE COUNT		SANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 580	Continued From page	e 1	F 58	0		
	(D) A decision to tran					
	resident from the faci					
	§483.15(c)(1)(ii).	· · · · · · · · · · · · · · · · · · ·				
		ification under paragraph (g)				
		the facility must ensure that				
		on specified in §483.15(c)(2)				
		ded upon request to the				
	physician.	also promptly patify the				
		also promptly notify the dent representative, if any,				
	when there is-	dent representative, il arry,				
		or roommate assignment				
	as specified in §483.	-				
	(B) A change in resid	ent rights under Federal or				
	-	ns as specified in paragraph				
	(e)(10) of this section					
		record and periodically				
	' `	mailing and email) and				
	phone number of the representative(s).	resident				
	§483.10(g)(15)					
		osite distinct part. A facility				
		istinct part (as defined in				
		e in its admission agreement				
		tion, including the various				
		se the composite distinct				
		y the policies that apply to en its different locations				
	under §483.15(c)(9).					
		is not met as evidenced				
	by:					
	Based on record rev	iew and staff, Nurse		The statements made on th	is Plan of	
		Physician interview, the		Correction are not an admiss	sion to and do	
	-	the attending physician		not constitute an agreement		
		nt change in the resident's		alleged deficiencies. To remain		
	condition in relation to	-		compliance with all Federal		
		profen (a nonsteroidal		Regulations the facility has t		
	anti-inflammatory dru	g). The resident required		take the actions set forth in t	nis Plan Of	

Facility ID: 980156

If continuation sheet Page 2 of 21

						IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDING			С
		345532	B. WING			7/06/2018
	ROVIDER OR SUPPLIER	040002		STREET ADDRESS, CITY, STATE, ZIP CODE	0	//06/2018
NAME OF F	ROVIDER OR SUFFLIER			310 COMMERCE DRIVE		
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE
F 580	Continued From page	e 2	F 58	0		
		hemoglobin of 4.2 and		Correction. The Plan of Correct	tion	
		ood. This was evident for 1		constitutes the facilities allegati		
		its reviewed (Resident #1).		compliance such that all allege		
				deficiencies cited have been or		
	Findings included:			corrected by the date or dates i		
	Resident #1 was orig	inally admitted to the facility		F580 Notify of Changes		
		ple diagnoses including		(Injury/Decline/Room, etc.)		
		sophageal reflux disease				
		rly Minimum Data Set (MDS)		Based on record review and sta	aff Nurse	
	assessment dated 3/	•		Practitioner and Physician inter		
	Resident 1's cognitio			facility failed to notify the attend		
				physician regarding a significar	-	
	Resident #1 had a do	octor's order dated 3/13/18		in the resident's condition in rel	-	
	for Ibuprofen 200 mil	ligrams (mgs) 3 tablets by		potential adverse consequence		
	mouth with meals for			Ibuprofen (a non-steroidal		
	discontinued on 4/23	/18 due to black stools.		anti-inflammatory drug). The re	sident	
				required hospitalization due to		
	The nurse's and NP	notes for Resident #1 were		of 4.2 and received 6 units of b		
	reviewed. The notes	dated 4/7/18 at 6:22 PM		was evident for 1 of 3 sampled	residents	
	indicated that the res	ident complained of sore		reviewed (Resident #1).		
	stomach and she wa	s noted to have a small				
		id emesis (vomitus). The		The plan for correcting the spec	cific	
	notes dated 4/8/18 at	t 7:54 AM, the resident was		deficiency and the process that	lead to the	
		indigestion and at 11:59		alleged deficiency:		
		ed that the resident had				
		eating small amount. On		Resident #1 had an allergy to I		
		the resident was yelling out		noted. Physician ordered Ibupr		
	-	know where she was and		resident for Arthritis on 3/13 /18		
	-	On 4/23/18 5:47 PM, the		the physician failed to identify t		
		and diarrhea. The NP was		resident⊡s allergy to Ibuprofen		
		ed the resident with no new		Resident #1 complained of stor		
		M, the notes revealed that		discomfort and brown colored e		
		niting. The NP notes dated		Interviews by the Director of Nu		
		4/25/18 at 2:28 PM) revealed		assigned nursing assistants rev		
		led to check on Resident #1.		they had notified the facility nur		
		nited some burgundy looking		a change in patient condition for		
		ck tarry stools. Her stool		days prior to the nurses notifyir		
	was positive for blood	a. She stopped the		physician. The patient was note	ea by the	

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If continuation sheet Page 3 of 21

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTION		O. 0938-03 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,	6	COM	IPLETED
						С
		345532	B. WING		07	//06/2018
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
				310 COMMERCE DRIVE		
		EHAB CTR OF LEE COUNTY		SANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 580	Continued From page	2				
1 300			F 58		ataala	
		dered complete blood count		nursing assistants to have black		
		d to monitor the resident. AM, the notes indicated that		Interview by the Director of Nurse facility nurses revealed that they		
				contributed the black stool to the		
	-	sessed the resident and he n antibiotic) for urinary tract		resident s receiving iron		
		travenous fluid (IVF) for		supplementation. On 4/23/18 the	nurso	
		/18 at 11:28 AM, the notes		notified the physician of the char		
	indicated that the res			condition and the Nurse Practitio	•	
		8 at 4:11 AM, the notes		ordered a CBC to be drawn on 4	-	
	indicated that the res			Results of the CBC received on 4		
		e received a call from the		revealed a HGB of 4.2. The phys		
	laboratory that the res			notified and the resident was trai		
	-	ne Physician was informed		to the hospital for further evaluat		
		the family if they wanted the		resident was admitted and receiv		
	-	It to the hospital. The family		liters of blood. The resident retur		
		e resident to the hospital.		the facility on 5/7/18 and remains		
	-	t to the hospital at 2:10 AM.		resident of the facility.		
	The physician and N	progress notes for		The procedure for implementing	the	
		iewed. The notes revealed		acceptable plan of correction for	the	
	that Resident #1 was	seen by the Physician on		specific deficiency cited:		
	4/3/18 and by the NP	on 4/16/18 but the notes did				
		ent's GI symptoms of sore		On 7/06/18 Resident #1 was ass	•	
		sis, indigestion and loose		the floor nurse for any change in		
		's notes dated 4/24/18		and allergies related to current o		
		ident had 2 episodes of		identified change in condition ide		
		The stool was positive for		medication vs. allergies were ide	ntified.	
		cult card was expired. The				
		thargic and confused than		On 7/06/18 the Director of Nurse	•	
		There was mild generalized		Support Nurse and staff nurses a		
		domen on palpation. The		all residents for change in condit	-	
		18 revealed that Rocephin		utilizing the 24 hr. report, change		
		nd IVF for nausea and		condition report and observation		
		nt stated that she still didn't		assessment of each resident. 5 r		
	-	peared weak and tired. She		were identified with a change in o		
		The notes further indicated		using the Situation, Background,		
		black tarry stool and was		Assessment, and Recommendat		
		ne plan was "CBC was the extent of bleeding since		Change in Condition Form. Corre Action: The physician has been r		
	Draphan to chack for t	The extent of blooding since	1	action. The physician has been in	to pairing	1

Facility ID: 980156

CENTER		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		E SURVEY IPLETED
		345532	B. WING			С
	ROVIDER OR SUPPLIER	343532		STREET ADDRESS, CITY, STATE, ZIP		7/06/2018
NAME OF PI	ROVIDER OR SUPPLIER				CODE	
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE SANFORD, NC 27332		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETIC
F 580	Continued From page	e 4	F 58	80		
	that she started to ha	k tarry stool on the same day ve symptoms of nausea and er daily Ibuprofen that day as		the identified changes in or staff nurse n 7/6/18.	condition by the	
		on Omeprazole (used to treat		On 7/6/18 all resident alle	raies were	
		while on Ibuprofen. Result		audited by the Support Nu	•	
	still pending".			of Nurses to ensure that t	hey are not	
				receiving medications that		
		je summary dated 5/7/18		allergic to or have docume		
		Idmitting diagnosis was		effects of. Results showed		
		bleed and anemia. The was acute GI bleeding		allergies versus ordered n side effects were identified		
	secondary to duoden			side ellects were identille	J.	
	esophagogastroduod	-		On 7/6/18 The Director of	Nurses and	
		ized the upper tract of the GI		Nurse Consultant educate		
		denum and received 6 units		PRN Nurses, Nursing Ass	•	
	of blood transfusion.			Physician and Nurse Prac	titioner on:	
				Verification of allergies with	th new orders	
		M, Nursing Assistant (NA) #1		prior to administration of		
	was interviewed. She			meds/treatments/tests. Lo		
		#1. She stated that the		identified allergies for eac		
	•	black and loose stools days		their name in the electron		
		arged to the hospital. NA #1		Notification of Physician fo		
		s especially Nurse #2 were nt was having black stool.		allergies or side effects re medications. Change in C identification which includ	ondition	
	On 7/5/18 at 4:34 PM	I, NA #2 was interviewed.		of medication side effects		
		vas assigned to Resident #1.		Condition Reporting and F	•	
		ent was passing cranberry		to the Physician. Follow T		
		of days before she was		Nurses on Reported Char	nge in Condition	
		spital. NA #2 indicated that		by Nursing Assistants. Re		
		re of the cranberry colored		Director of Nurses and or	-	
	-	that it was from the iron pill		Nursing Assistants if nurs		
		ng. The NA also revealed		respond to a reported cha		
		alert and oriented but		This training has been inc	•	
		ed during the time she was		the new hire orientation p		
	passing cranberry col			licensed nurses and nursi The monitoring procedure		
	0n 7/6/18 at 9·10 ΔM	l, NA #3 was interviewed.		the plan of correction is ef		
		e was assigned to Resident		specific deficiency cited re		

Facility ID: 980156

If continuation sheet Page 5 of 21

						. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE : COMPL	
					C)
		345532	B. WING			06/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE SANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 580	Continued From page	e 5	F 58	30		
		that the resident was having	1 00	and/or in compliance with	the regulatory	
		stools several days before		requirements:		
	she was sent to the h	ospital. He revealed that		The Director of Nurses/Su	upport Nurse will	
		as not normal and she was		monitor change in condition		
		#3 stated that the nurses		Friday x 4 weeks and mor	-	
		ack stools especially Nurse		months. All changes in co		
	#2.			reviewed for reporting, no timely implementation and		
	On 7/5/18 at 10:50 Al	M, Nurse #1 (author of		Reports will be presented	5	
		k/7/18) was interviewed. She		QA committee by the Dire		
		mbered Resident #1 had		to ensure corrective action	-	
		tomach and had brown		appropriate. Compliance		
		ted that she didn't call the		and the ongoing auditing		
	physician nor the NP			reviewed at the weekly Q	-	
		of sore stomach and the e had left a note in the		weekly QA Meeting is atte Administrator, Director of	-	
		for the physician and NP.		Minimum Data Set Coord Health Information Manag	inator, Therapy,	
	On 7/6/18 at 11:05 AI	M, Nurse #2 (author of		Dietary Manager. Deficier		
		l/23/18) was interviewed.		identified during the monit	•	
		ad informed the NP on		will be addressed through	-	
		having black stools. The NP		Quality Assurance proces		
		e the Ibuprofen and to check Nurse #2 further indicated		The title of the person res implementing the accepta		
		having loose stools and was		correction:		
		r stated that she didn't know		The Director of Nursing		
	-	having black stools until		07/06/18		
	On 7/5/18 at 12:50 Pl She stated that she w	M, the NP was interviewed.				
		plained of sore stomach and				
		own emesis on 4/7/18. She				
	indicated that she had	d assessed the resident on				
		is informed that the resident pols. She had discontinued				
		lered CBC that Monday.				
		ited that the CBC was not				
		cause the laboratory was				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 08/08/201 RM APPROVE <u>IO. 0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		TE SURVEY MPLETED C
		345532	B. WING		0	7/06/2018
NAME OF P	ROVIDER OR SUPPLIER	I	S	TREET ADDRESS, CITY, STATE, ZIP CO		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		10 COMMERCE DRIVE ANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 580 F 727 SS=E	and Friday. She had 4/25/18 but the CBC On 7/6/18 at 9:35 AM interviewed. He indic the resident on 4/24/7 him that the resident The Physician also st the resident was havin have sent the resider checked the CBC sta indicated that he was resident was having th hospital records. On 7/5/18 at 4:34 PM (DON) was interviewed could not find a note dated 4/7/18 and som shredded. The DON expected the nurse to for symptoms like bro stomach pain. RN 8 Hrs/7 days/Wk, CFR(s): 483.35(b)(1) §483.35(b) Registere §483.35(b)(2) Except paragraph (e) or (f) of	very Monday, Wednesday seen the resident on was still pending. I, the Physician was cated that he came to assess 18 and nobody had informed was having black stools. cated that if he had known ng black stools, he would at to the hospital sooner or t. The physician further made aware that the black stools after reading the I, the Director of Nursing ed. She stated that she in the communication book he notes were already further stated that she o call the physician or the NP own colored emesis and Full Time DON -(3) d nurse when waived under f this section, the facility is of a registered nurse for at ours a day, 7 days a week.	F 580			7/20/18

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		MEDICAID SERVICES			FORM APPROVI OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345532	B. WING		C 07/06/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
		EHAB CTR OF LEE COUNTY		10 COMMERCE DRIVE	
				SANFORD, NC 27332	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO
F 727	Continued From page	e 7	F 727		
	§483.35(b)(3) The di	rector of nursing may serve			
		nly when the facility has an			
		ancy of 60 or fewer residents.			
		T is not met as evidenced			
	by:	view and staff interview, the		Tag 0727 - 483.35(b)(1)-(3) RN 8 Hr	-0/7
		dule a Registered Nurse		days/Wk, Full Time DON (LONG TEI	
		insecutive hours a day for 24		CARE FACILITIES)	
		eviewed (4/2/18, 4/3/18,		,	
		18, 4/16/18, 4/17/18, 4/30/18,		Based on record review and staff	
		3, 5/14/18, 5/23/18, 5/28/18,		interview, the facility failed to schedu	ile a
		18, 6/11/18, 6/12/18, 6/20/18,		Registered Nurse (RN) for at least 8	
	6/29/18, 7/2/18, 7/3/1	18 and 7/4/18).		consecutive hours a day for 24 of the 90 days reviewed (4/2/18, 4/3/18, 4/3	
	The findings included	1:		4/8/18, 4/11/18, 4/16/18, 4/17/18, 4/3	
				5/1/18, 5/3/18, 5/9/18, 5/14/18, 5/23/	
	A review of the facility	y's Daily Schedules and the		5/28/18, 5/29/18, 6/6/18, 6/7/18, 6/12	1/18,
		osting for the past 90 days		6/12/18, 6/20/18, 6/29/18, 7/2/18, 7/3	3/18
		6/18. The Daily Schedules		and 7/4/18).	
	and the Nursing Staf	N) was not scheduled for at		The process leading to the deficience	
		nours a day on the following		The process leading to the deficiency a lack of education for the new Direct	-
		, 4/7/18, 4/8/18, 4/11/18,		Nursing, Scheduler, Support Nurse a	
		0/18, 5/1/18, 5/3/18, 5/9/18,		the Minimum Data Set Coordinator.	
	5/14/18, 5/23/18, 5/2	8/18, 5/29/18, 6/6/18, 6/7/18,			
		0/18, 6/29/18, 7/2/18, 7/3/18		On 7/20/18 the Director of Nursing,	
	and 7/4/18.			Support Nurse, MDS Coordinator an	
		nducted on 7/6/18 at 12:02		Scheduler were educated on 483.35 Nursing Services (b) Registered Nur	
		#4 stated that she was the		(2)Except when waived under	ъс.
		esponsible for completing the		paragraph(c)or(d)of this section, the	
		. She stated that she didn't		facility must use the services of a	
		ould be scheduled at least 8		registered nurse for at least 8	
	hours a day seven da	ays a week.		conservative hours a day, 7 days a v	veek.
	An interview was cor	nducted on 7/6/18 at 12:10		The procedure for implementing the	
	PM with the Director	of Nursing (DON). During		acceptable plan of correction is educ	ation
		N stated that she didn't		on 483.35 Nursing Services provided	d by
	know that the regulat	tion was to have at least 8		the Administrator.	

Facility ID: 980156

	H AND HUMAN SERVICES RE & MEDICAID SERVICES			FOR	D: 08/08/2018 M APPROVEI D. 0938-039 ⁻
NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION	СОМ	E SURVEY PLETED
	345532	B. WING		C 07/06/2018	
F PROVIDER OR SUPPLIEF	R	S	TREET ADDRESS, CITY, STATE, ZIP COD	-	
TY COMMONS NSG AN	ND REHAB CTR OF LEE COUNTY		10 COMMERCE DRIVE		
		s	SANFORD, NC 27332		1
X (EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
27 Continued From consecutive hour week.	page 8 rs of RN coverage 7 days a	F 727	All residents would have the p be affected by the alleged de practice.On 7/20/18 the Direct Nursing, Support Nurse, MDS and Scheduler were educated Nursing Services (b) Register (2)Except when waived unde paragraph(c)or(d)of this secti facility must use the services registered nurse for at least 8 conservative hours a day, 7 c The monitoring procedure to the plan of correction is effect specific deficiency cited rema and/or in compliance with the requirements: On 07/20/18, the Director of N Scheduler along with our full- shift Registered Nurse who w a pay-period and our weeken Nurse Supervisor who works weekend 12 hour shifts have schedule where the Registered Supervisor will cover 3-11 shi night shift Registered Nurse i ensure Registered Nurse cov hours a day for 7 days a wee Director of Nursing and the S meet daily to review the sche	ficient tor of S Coordinator d on 483.35 red Nurse: r on, the of a lays a week. ensure that tive and that ins corrected regulatory Nurses and time night rorks 9 days d Registered every completed a ed Nurse ift when the s off to erage 8 k. The cheduler will	
			and/or in compliance with the requirements: On 07/20/18, the Director of N Scheduler along with our full- shift Registered Nurse who w a pay-period and our weeken Nurse Supervisor who works weekend 12 hour shifts have schedule where the Registere Supervisor will cover 3-11 shi night shift Registered Nurse i ensure Registered Nurse cov hours a day for 7 days a wee Director of Nursing and the S	Vurses and time night vorks 9 days d Registered every completed a ed Nurse iff when the s off to erage 8 k. The cheduler will dule for the on of daily The Director vill notify the	

Event ID: FYZJ11

Facility ID: 980156

If continuation sheet Page 9 of 21

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/08/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345532	B. WING		C 07/06/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0110012010
LIBERTY	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY		310 COMMERCE DRIVE SANFORD, NC 27332	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 727 F 760 SS=J	CFR(s): 483.45(f)(2)	f Significant Med Errors	F 72 F 76	 Nurse will fill in the absence of either Director of Nursing or the Scheduler. The Director of Nursing and Schedule bring to the Quality Assurance Performance Improvement meeting r monthly the staffing sheets for the mot to be reviewed by the Quality Assuran Performance Improvement members which consists of the Administrator, Director of Nursing, Support Nurse, Scheduler, Maintenance, Activities Director, Admissions Director, the Minimum Data Set Coordinator, the Director of Health Information Management, the Nurse Practitioner, Dietary Manager, Housekeeping Supervisor, Pharmacy, and Medical Director quarterly, to ensure complian with 483.35. The person responsible for implement the plan of correction for scheduling weight of the present of Nursing. 	er will held both nce
	medication errors. This REQUIREMENT by: Based on record revi Practitioner (NP) and facility administered II anti-inflammatory dru	ts are free of any significant is not met as evidenced ew and staff, Nurse Physician interview, the buprofen, a nonsteroidal g (NSAID) to a resident and at the resident was allergic		F760 Drug Regimen is Free from Unnecessary Drugs: Based on record review and staff, Nu Practitioner (NP) and Physician inten the facility administered Ibuprofen, a	

Event ID: FYZJ11

Facility ID: 980156

If continuation sheet Page 10 of 21

				F CONSTRUCTION	OMB NO. 0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			A. DOILDING		с
		345532	B. WING		07/06/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
		EHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE	
		ENAB CTR OF LEE COUNTY		SANFORD, NC 27332	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLET
F 760	Continued From page	e 10	F 760		
	1.0	symptoms, the facility failed		nonsteroidal anti-inflammatory drug	
	to recognize the use			(NSAID) to a resident and failed to	
	-	contributing to the GI		recognize that the resident was alle	rgic to
	symptoms, resulting i			the drug. In the presence of initial	
	administration of the	Ibuprofen. The resident		gastrointestinal (GI) symptoms, the	facility
		on due to hemoglobin		failed to recognize the use of the	
		red blood cells that carries		Ibuprofen as potentially causing or	
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	tissues) of 4.2 (normal value		contributing to the GI symptoms, res	•
		ed 6 units of blood. This		in the continued administration of th	e
	was evident for 1 of 3			Ibuprofen. The resident required	
	reviewed (Resident #	:1).		hospitalization due to hemoglobin (p	
	Incorrection to the menual of			molecules in red blood cells that can	
		began on 3/13/18 when o receive the Ibuprofen and		oxygen to the body's tissues) of 4.2 (normal value 11.7-15.5) and receiv	
		18 when the facility provided		units of blood. This was evident for	
	and implemented an			three sampled residents reviewed	
		nce. The facility remains out		(Resident #1).	
		wer scope and severity of D			
		al harm with potential for		The plan for correcting the specific	
	· ·	arm that is not immediate		deficiency and the process that lead	to the
	jeopardy) to complete	e education and ensure		alleged deficiency:	
		out into place are effective.			
				Resident #1 had an allergy to Ibupre	ofen
	Findings included:			noted. Physician ordered Ibuprofen	
				resident for Arthritis on 3/13 /18. Sta	aff and
		inally admitted to the facility		the physician failed to identify the	
		ple diagnoses including		resident⊡s allergy to Ibuprofen. On	
		ophageal reflux disease		Resident #1 complained of stomach	
		rly Minimum Data Set (MDS)		discomfort and brown colored emes	
	assessment dated 3/			Interviews by the Director of Nurses	
		n was intact and she was bowel and bladder. The		assigned nursing assistants reveale they had notified the facility nurses	
	-	ndicated that Resident #1		a change in patient condition for sev	
		sistance with toileting.		days prior to the nurses notifying the	
		contraction of the second s		physician. The patient was noted by	
	Resident #1's care of	an dated 3/30/18 was		nursing assistants to have black sto	
		no care plan to address the		Interview by the Director of Nurses	
	use of the NSAID.			facility nurses revealed that they	
				contributed the black stool to the	

Facility ID: 980156

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	-	ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 08/08 FORM APPRO MB NO. 0938-	OVE
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		DNSTRUCTION	(X	(3) DATE SURVEY COMPLETED	
		345532	B. WING				C 07/06/2018	}
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP COE	DE		
LIBERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY			COMMERCE DRIVE IFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLE COMPLE DAT	TION
F 760	The electronic and havere reviewed. The Administration Record and NP's progress not March 2018 were reversident's allergy to I notes did not indicate resident had to the lap progress notes dated the resident was aller reaction was hives. The physician's ordet that her medications reduce risk of heart aby mouth daily for attl (ASHD) since 5/15/10 iron supplement) 325 for chronic anemia site. Resident #1 had a do for Ibuprofen 200 mil mouth with meals for discontinued on 4/23 Resident #1's laborat revealed that her her The nurse's and NP of reviewed. The notes indicated that the resident was amount of brown liquin notes dated 4/8/18 at	ard copy medical records monthly Medication rds (MARs) and the nurse's otes from January through viewed and listed the buprofen. The MARs and the e what allergic reaction the ouprofen. The doctor's d 3/12/18 also indicated that rgic to Ibuprofen and the rs for Resident #1 revealed included Aspirin (used to attack) 81 milligrams (mgs) nerosclerotic heart disease 6 and Ferrous Sulfate (an 5 mgs by mouth twice a day nce 2/22/17.	F 7		resident □ s receiving iron supplementation. On 4/23/18 notified the physician of the c condition and the Nurse Prace ordered a CBC to be drawn of Results of the CBC received revealed a HGB of 4.2. The p notified and the resident was to the hospital for further eval resident was admitted and re- iters of blood. The resident re- the facility on 5/7/18 and rem resident of the facility. The procedure for implement acceptable plan of correction specific deficiency cited: On 7/06/18 Resident #1 med and physician orders were re- the Director of Nurses for any related to current orders. No vs. allergies were identified. On 7/06/18 the Director of Nu- Nurse Consultant reviewed a for allergy to Ibuprofen and It orders. No further occurrence found.	change in ctitioner on 4/25/18. on 4/26/18 ohysician wa transferred luation. The secived six eturned to tains a ting the for the ical record eviewed by y allergies medication urses and ill residents ouprofen es were rses and t they are no ey are		
	for Ibuprofen 200 mil mouth with meals for discontinued on 4/23 Resident #1's laborat revealed that her her The nurse's and NP reviewed. The notes indicated that the res stomach and she wa amount of brown liqu notes dated 4/8/18 a given Prilosec due to AM, the notes reveal loose stools and was 4/19/18 at 11:41 PM,	ligrams (mgs) 3 tablets by arthritis and was /18 due to black stools. tory report dated 3/14/18 noglobin level was 11.8 notes for Resident #1 were dated 4/7/18 at 6:22 PM ident complained of sore s noted to have a small id emesis(vomitus). The t 7:54 AM, the resident was			the Director of Nurses for any related to current orders. No vs. allergies were identified. On 7/06/18 the Director of Nu Nurse Consultant reviewed a for allergy to Ibuprofen and Ik orders. No further occurrence found. On 7/6/18 all resident allergie audited by the Director of Nu Support Nurse to ensure that receiving medications that the	y allergies medication urses and ill residents puprofen es were rses and t they are no ey are ed side o further lications or	t	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/08/20 FORM APPROV OMB NO. 0938-03
STATEMENT OF DEFICIENCIES (X1) PROV		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345532	B. WING		C 07/06/2018
NAME OF PR	ROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, STATE, ZIP	
	COMMONS NSG AND RI	EHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE	
LIDERTT				SANFORD, NC 27332	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 760	Continued From page	e 12	F 76	0	
		On 4/23/18 5:47 PM, the			
		and diarrhea. The NP was		On 7/6/18, the Director of	Nurses and
		ed the resident with no new		Nurse Consultant educate	
	order and at 7:36 PM	l, the notes revealed that the		PRN Nurses, the Physicia	
	resident was vomiting	 The NP notes dated 		Practitioner on verification	n of allergies with
	4/23/18 (entered on 4	4/25/18 at 2:28 PM) revealed		orders prior to administrat	tion of
		o check on Resident #1. The		meds/treatments/tests. Lo	
		some burgundy looking fluid		identified allergies for eac	
		rry stools. Her stool was		their name in the electron	
	-	ne stopped the Ibuprofen		Notification of the Physici	-
		plete blood count (CBC) on or the resident. On 4/24/18		identified allergies or side	
	at 11:11 AM, the note			to ordered medications. T been incorporated into the	-
		sed the resident and he		orientation process for all	
	-	n antibiotic) for urinary tract		and nursing assistants.	
		travenous fluid (IVF) for			
		/18 at 11:28 AM, the notes		The pharmacy consultant	completed an
	indicated that the res			audit on 7/23/18 of all res	
	confusion. On 4/26/1	18 at 4:11 AM, the notes		compare pharmacy-listed	allergies versus
	indicated that the res	ident was alert with		allergies noted in each re	sident⊡s
		s further indicated that the		electronic health record a	nd an allergy
		from the laboratory at 1:30		versus medication order a	
		had a critical hemoglobin of		percent of residents had a	
		as informed and requested		between the pharmacy sy	
	· ·	ey wanted the resident to be		documented allergies and	•
		al. The family requested to		documented in the reside health record. The Directo	
		he hospital. Resident #1 ital at 2:10 AM on 4/26/18.		verified and corrected the	
	was sent to the nospi	nai al 2.10 ANI 011 4/20/10.		discrepancies with the Me	
	The physician and NI	P progress notes for		the resident s electronic	
		viewed. The notes revealed		and with the pharmacy or	
		seen by the Physician on			-
		on 4/16/18 but the notes did		The monitoring procedure	e to ensure that
		ent's GI symptoms of sore		the plan of correction is e	
		sis, indigestion and loose		specific deficiency cited re	
		's notes dated 4/24/18		and/or in compliance with	
		ident had 2 episodes of		requirements:	
		The stool was positive for			
	blood but "the hem o	ccult card (a card used to		The Director of Nurses/Su	upport Nurse will

Facility ID: 980156

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	S FOR MEDICARE &					O. 0938-03
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345532	B. WING		07	C 7/06/2018
NAME OF PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
			:	310 COMMERCE DRIVE		
BERTY	COMMONS NSG AND R	EHAB CTR OF LEE COUNTY		SANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 760			F 760			
	 F 760 Continued From page 13 check for the presence of blood in the stool) was expired". The resident was more lethargic and confused than usual but arousable. There was mild generalized tenderness to the abdomen on palpation. The NP notes dated 4/25/18 revealed that Rocephin was started for UTI and IVF for nausea and vomiting. The resident stated that she still didn't feel good and she appeared weak and tired. She appeared very pale. The notes further indicated that the resident had black tarry stool and was positive for blood. The plan was "CBC was ordered to check for the extent of bleeding since patient did have black tarry stool on the same day that she started to have symptoms of nausea and vomiting. Stopped her daily lbuprofen that day as well. She has been on Prilosec 20 mgs daily while on lbuprofen. Result still pending". The hospital discharge summary dated 5/7/18 was reviewed. The discharge summary listed the resident's allergy to lbuprofen. The admitting diagnosis was gastrointestinal (GI) bleed and anemia. The discharge diagnosis was acute GI bleeding secondary to duodenal ulcer, status post esophagogastroduodenoscopy (EGD), a procedure that visualized the upper tract of the GI tract down to the duodenum. Resident #1 had received 6 units of blood transfusion. On 7/5/18 at 3:10 PM, a family member of Resident #1 was interviewed. The family member stated that she had discussed her 			 monitor 4 residents x 4 weeks a monthly x2, who have been addread in the readmitted or received new ord identified allergies versus medior orders, as well as a comparison allergies entered into the reside electronic health record vs. phasystem recorded allergies Report presented to the weekly QA count the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be and the ongoing auditing prograreviewed at the weekly QA Meeting is attended Administrator, Director of Nurse Minimum Data Set Coordinator Health Information Manager, an Dietary Manager. Deficiencies i identified during the monitoring will be addressed through the for Quality Assurance process. The title of the person responsi implementing the acceptable plecorrection: The Director of Nursing 07/24 /18 	mitted, ers for cation o of ent urmacy orts will be mmittee by re e monitored am eting. The by the es, , Therapy, nd the that are process acility ble for	
		#2 regarding Resident #1 ind had been throwing up				

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FOR	D: 08/08/2018 MAPPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	IPLE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
	345532	B. WING			C 7/ 06/2018
NAME OF PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CO		
LIBERTY COMMONS NSG AND R	HAB CTR OF LEE COUNTY		310 COMMERCE DRIVE		
			SANFORD, NC 27332		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
 was interviewed. She assigned to Resident resident was having before she was disch stated that the nurses aware that the reside On 7/5/18 at 4:34 PM She stated that she w NA #2 stated that she w NA #2 stated that Reincontinent of bowel a assistance with toileti resident's stool as craresident was passing couple of days before hospital. NA #2 indice aware of the cranbern stated that it was from was taking. The NA #1 was alert and orie confused during the t cranberry colored stood On 7/6/18 at 9:10 AW The NA stated that he #1. NA #3 indicated the was sent to the heresident's stool w more confused. NA #2 indicated the resident's stool as confused that here #1. NA #3 indicated the was sent to the heresident's stool w more confused. NA #2 indicated the resident's stool w more confused. NA #2 indicated that she remer complained of sore since sore sore sore is a stated that she remer complained of sore since sore sore is a sort of sore since sore sore is a sort of sore since sore sore sore is a stated that she remer complained of sore since sore sore is a sort of sore since sore sore sore sore sore is a sort of sore since sore sore sore sore sore sore sore sor	M, Nursing Assistant (NA) #1 e stated that she was #1. She stated that the black and loose stools days arged to the hospital. NA #1 s especially Nurse #2 were nt was having black stool. I, NA #2 was interviewed. vas assigned to Resident #1. sident #1 was always and bladder and she needed ing. She had described the anberry color. She stated the cranberry colored stool e she was discharged to the cated that the nurses were ry colored stool and they in the iron pill the resident also revealed that Resident inted but became more ime she was passing	F 7	60		

Facility ID: 980156

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 08/08/2018 / APPROVED). 0938-0391	
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345532	B. WING			-		C 06/2018	
NAME OF PROVIDER OR S	JPPLIER				STREET ADDRESS, CITY, STA	ATE, ZIP CODE			
LIBERTY COMMONS N	ISG AND RE	HAB CTR OF LEE COUNTY			310 COMMERCE DRIVE SANFORD, NC 27332				
PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
resident's of brown eme communica Nurse #1 of allergic to 1 On 7/6/18 nurse's not She stated 4/23/18 of ordered to the CBC of that the res vomiting. T was allergi she didn't h black stool receiving in On 7/5/18 She stated was placed she was all not informe sore stoma emesis on assessed t informed th stools. Sh ordered CB further indi Monday be come ever She had se CBC was s	nor the NP complaint of esis but she ation book lidn't know buprofen. at 11:05 Al tes dated 4 that she h resident's l discontinu n 4/25/18. sident was the Nurse of c to Ibupro chow that t s until 4/23 fon pill. at 12:50 Pl that she w d on Ibupro lergic to it. ed that Residen that she w d on Ibupro lergic to it. ed that Residen that the residen that the residen the resident the reside	to inform them of the of sore stomach and the e had left a note in the for the physician and NP. that the resident was M, Nurse #2 (author of /23/18) was interviewed. ad informed the NP on having black stools. The NP e the Ibuprofen and to check Nurse #2 further indicated having loose stools and was didn't know that Resident #1 fen. Nurse #2 stated that he resident was having s/18 but the resident was M, the NP was interviewed. vas aware that Resident #1 fen but she had missed that She stated that she was ident #1 had complained of s noted to have brown he indicated that she had t on 4/23/18 when she was dent was passing black ontinued the Ibuprofen and nday (4/23/18). The NP the CBC was not drawn on laboratory was scheduled to Wednesday and Friday. ident on 4/25/18 but the	F	760					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 08/08/2018 MAPPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345532	B. WING				_ 06/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE SANFORD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	allergic to it. He state have caught the allerg He also indicated that resident on 4/24/18 at that the resident was treated the resident was treated the resident was for dehydration. The he had known the resis stools, he should hav resident to the hospita The physician further aware that the residen after reading the hospita on 7/5/18 at 4:34 PM (DON) was interviewed could not find a note in dated 4/7/18 and som shredded. The DON expected the nurse to for symptoms like bro stomach pain. On 7/6/18 at 8:30 AM interviewed. She stat schedule for routine b Wednesday and Frida was ordered "stat", sh sent it to the hospital available in 2-3 hours when Resident #1 wa stools, the CBC should The Nurse Consultan	g that Resident #1 was ed that the pharmacy should gy and alerted the facility. the came to assess the nd nobody had informed him having black stools. He vith antibiotic for UTI and IVF Physician also stated that if sident was having black e done differently, send the al or check the CBC stat. indicated that he was made nt was having black stools bital records. I, the Director of Nursing ed. She stated that she in the communication book he notes were already further stated that she o call the physician or the NP own colored emesis and I, the DON was again ted that the facility had a blood draw every Monday, ay. If the laboratory work he had to draw the blood and and usually the result was a. The DON stated that as noted to have black Id have been ordered stat.	F 76	0			
	allergic to it. He state have caught the allerg He also indicated that resident on 4/24/18 at that the resident was treated the resident was treated the resident was for dehydration. The he had known the resist stools, he should have resident to the hospita The physician further aware that the resident after reading the hospital after reading the hospital on 7/5/18 at 4:34 PM (DON) was interviewed could not find a note it dated 4/7/18 and som shredded. The DON expected the nurse to for symptoms like bro stomach pain. On 7/6/18 at 8:30 AM interviewed. She stat schedule for routine to Wednesday and Frida was ordered "stat", sh sent it to the hospital available in 2-3 hours when Resident #1 wa stools, the CBC should The Nurse Consultant informed of the Imme	ed that the pharmacy should gy and alerted the facility. t he came to assess the nd nobody had informed him having black stools. He vith antibiotic for UTI and IVF Physician also stated that if sident was having black e done differently, send the al or check the CBC stat. indicated that he was made nt was having black stools bital records. I, the Director of Nursing ed. She stated that she in the communication book he notes were already further stated that she o call the physician or the NP won colored emesis and I, the DON was again ted that the facility had a blood draw every Monday, ay. If the laboratory work he had to draw the blood and and usually the result was as noted to have black Id have been ordered stat.					

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			0.00			IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	· · /	E SURVEY IPLETED
345532 NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY			AL DOLLDING			С
		B. WING		0	7/06/2018	
			STREET ADDRESS, CITY, STATE, ZIP CODE			
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		310 COMMERCE DRIVE SANFORD, NC 27332		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 760	Continued From page	e 17	F 760			
		l, the facility provided the egation of Compliance:				
	The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;					
	Physician ordered Ibu Arthritis on 3/13 /18. to identify the residen 4/7/18 Resident #1 co discomfort and brown by the Director of Nur	Illergy to Ibuprofen noted. uprofen for the resident for Staff and the physician failed it's allergy to Ibuprofen. On omplained of stomach o colored emesis. Interviews rses with assigned nursing nat they had notified the				
	facility nurses about a for several days prior physician. The patien assistants to have bla Director of Nurses wi that they contributed	a change in patient condition to the nurses notifying the t was noted by the nursing ack stools. Interview by the th facility nurses revealed the black stool to the				
	4/23/18 the nurse not change in condition a ordered a CBC to be of the CBC received of 4.2. The physician	on supplementation. On ified the physician of the ind the Nurse Practitioner drawn on 4/25/18. Results on 4/26/18 revealed a HGB was notified and the red to the hospital for further				
	evaluation. The resider received six liters of the second six liters of the second six liters of the second	-				
		plementing the acceptable the specific deficiency cited;				
		ent D.M. was assessed by y change in condition and				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345532	B. WING				06/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0.1	
LIBERTY	COMMONS NSG AND RE	HAB CTR OF LEE COUNTY			310 COMMERCE DRIVE SANFORD, NC 27332		
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	allergies related to cu Results: No identified identified or medication identified. On 7/06/18 the Direct and staff nurses asse change in condition b change in condition b change in condition for assessment of each r Results: 5 residents w in condition using the Assessment, and Rec Change in Condition for Corrective Action: The notified of the identified the staff nurse. On 7/6/18 all residen the Support Nurse an ensure that they are r that they are allergic to effects of medications Results: None were ide Education: Nursing Education: Employees to receive Part time and as need Assistants and Medic Nurse Practitioner. Topics discussed: Verification of Allergie administration of med Location of identified under their name in th Notification of Physici allergies or side effect medications.	rrent orders. change in condition on vs. allergies were or of Nurses, Support Nurse ssed all residents for y utilizing the 24 hr. report, eport and observation and esident. vere identified with a change Situation, Background, commendation (SBAR) Form e physician has been ed changes in condition by t allergies were audited by d Director of Nurses to not receiving medications to or have documented side s. dentified. e education: All Full time, ded (PRN) Nurses, Nursing ation Aides, Physician and es with new orders prior to ls/treatments/tests. allergies for each resident the electronic health record. an for any identified	F	760			

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		ID HUMAN SERVICES MEDICAID SERVICES					INTED: 08/08/2018 FORM APPROVED IB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345532	B. WING _				C 07/06/2018		
NAME OF PI	ROVIDER OR SUPPLIER	•		STI	REET ADDRESS, CITY, STATE, ZIP CODE				
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY		310	COMMERCE DRIVE				
				SA	NFORD, NC 27332				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 760	REGULATORY OR LSC IDENTIFYING INFORMATION)		F	760					
	the ongoing auditing weekly QA Meeting. attended by the Admi Minimum Data Set Co	nce will be monitored and program reviewed at the The weekly QA Meeting is nistrator, Director of Nurses, pordinator, Therapy, Health , and the Dietary Manager.							

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 08/08/2018 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		345532	B. WING					C 06/2018
NAME OF P	ROVIDER OR SUPPLIER	I	I	S	TREET ADDRESS, CITY, STATE	E, ZIP CODE	•••	
LIBERTY	COMMONS NSG AND RE	EHAB CTR OF LEE COUNTY			10 COMMERCE DRIVE ANFORD, NC 27332			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	3		AN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTI) CROSS-REFERENCE	VE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY)		COMPLETION DATE
F 760	Continued From page	20	F	760				
		will be reported to the						
	The title of the persor implementing the Qua	n responsible for ality Improvement Plan.						
	The Administrator. Compliance Date: 7/6	5/18						
	Compliance Date: 7/6/18 The credible allegation was verified on 7/6/18 at 3:50 PM as evidenced by staff interview and review of the in-service records. Nurses were interviewed and they verified that they had received training on verification and notification of MD of allergies and identification and notification of MD of resident's change in condition. Nursing Assistants were interviewed and they verified that they had received training on notification of nurses, DON and Administrator of resident's change in condition. The sign in sheets for the in-service were reviewed.							

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