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

PRINTED: 09/24/2018 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|---|-----------------|-------------------------------|----------------------------|
| | | 345468 B. WING | | | C 08/15/2018 | | |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 121 RACINE DRIVE | | | |
| LIBERTY COMMONS REHABILITATION CENTER | | | | WILMINGTON, NC 28403 | | | |
| (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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | | | (X5) COMPLETION DATE |
| F 921 SS=D | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO | | e e of | 9/4/18 |
| ARODATODY | 9:25 AM. He stated t the 200 hall needed t toilets re-caulked. He bathrooms on the 200 | he toilets and bathrooms on o be deep cleaned and the | | TITLE | | | X6) DATE |

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

09/05/2018 **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.

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| | | 345468 | B. WING_ | | | C | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 121 RACINE DRIVE WILMINGTON, NC 28403 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTION CROSS-REFERENCE | PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY) | (X5) COMPLETION DATE | |
| F 921 | An interview was con Nursing (DON) on 08. observed the resident 204, and 209. She expathrooms on the 200 free, with clean white toilets, and they were An interview was con Administrator on 08/1 it was his expectation on the 200 hall would | ducted with the Director of /13/18 at 10:10 AM. She to bathrooms in rooms 202, expected the resident of hall to be clean and odor grout around the base of all | FS | 021 | | | |