STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

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E 000	Initial Comments An unannounced recertification survey and complaint investigation was conducted onsite 03/14/22 - 03/17/22 and remotely through 03/18/22. The surveyor returned to the facility on 04/05/22 to obtain additional information, therefore the exit date was changed to 04/05/22.The facility was found to be in compliance with CFR §483.73, Emergency Preparedness. Event ID #4GD411.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted onsite from 03/14/22 - 03/17/22 and remotely through 03/18/22. The surveyor returned to the facility on 04/05/22 to obtain additional information, therefore the exit date was changed to 04/05/22. Event ID # 4GD411. Intake # NC00186241, NC00180782, NC00186490. 1 of the 5 complaint allegations was substantiated resulting in a deficiency. Immediate Jeopoardy was identified at: CFR 483.45 at tag F760 scope and severity (K) CFR 483.45 at tag F756 scope and severity (J) Tag F760 constituted Substandard Quality of Care. Immediate Jeopardy for F760 began on 02/02/22 and was removed on 03/26/22. Immediate Jeopardy for F756 began on 02/03/22 and was removed on 03/27/22. An extended survey was conducted.	F 000		
F 641	Accuracy of Assessments	F 641		4/14/22

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

Electronically Signed 04/14/2022

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F 641 SS=D	Continued From page 1 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 interviews, the facility failed to accurately code a Minimum Data Set (MDS) quarterly assessment for behaviors for refusal of care and failed to accurately code an MDS assessment for speech and falls for 2 of 18 residents (Resident #3 and Resident #87) reviewed for MDS. Findings included: 1.Resident #3 was admitted to the facility on 04/06/21. Diagnoses included, in part, depression and vascular dementia without behaviors. The Minimum Data Set (MDS) quarterly assessment dated 02/26/22 revealed Resident #3 was severely cognitively impaired. The behavior section for rejection of care indicated no behavior was exhibited. Review of the Medication Administration Record (MAR) for February 2022 revealed on 02/22/22 Resident #3 refused the following medications as evidenced by documenting the #2 (which indicated drug refused) with nursing initials: Famotidine 20 milligrams (mg) 1 tablet daily, Ferrous Sulfate 325 mg 1 capsule daily, Flomax 0.4 mg one capsule daily, Furosemide 40 mg one tablet daily, Insulin Detemir 16 units at bedtime, Potassium Chloride 20 milliequivalents 2 packets daily, Metoprolol Tartrate 25mg one tablet daily,	F 641	F-641 Accuracy of Assessments Corrective actions for Resident #3 Specific deficiency for Resident #3 was resolved on 04/11/22 by the facility Minimum Data Set Coordinator who modified and corrected the coding for question E0800 – rejection of care on assessment with Assessment Reference Date of 02/26/22. This corrected assessment was re-submitted and accepted into state database on 04/11/22 in MDS Batch #2012. Corrective actions for Resident #87 Specific deficiency for Resident #87 was resolved on 04/11/22 by the facility Minimum Data Set Coordinator who modified and corrected the coding for questions B0600: Speech Clarity; B0700: Makes Self Understood and J1800/1900: Falls on assessment with Assessment Reference Date of 02/09/22. This corrected assessment was re-submitted and accepted into state database on 04/11/22 in MDS Batch #2012. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of all current residents who have had a Minimum Data Set assessment completed within the past 30	

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F 641	Continued From page 2 MiraLAX powder 17 grams daily, multivitamin one tablet daily, and Flonase Suspension 60 micrograms spray in both nares twice daily. An interview with Medication Aide #2 on 03/16/22 at 1:35 PM revealed the resident refused his medications at times and if he refused the Medication Aide would document the number "2" in the MAR as she did on 02/22/22. An interview was conducted with the MDS Nurse on 03/17/22 at 2:30 PM. The MDS nurse stated she was expected to complete portions of the MDS which included recording behaviors for refusal of care. She stated she would review the nurse's notes, physician progress notes, pharmacy review notes, physician orders and the MAR to determine if a resident was refusing care. Additionally, she reported she would ask the nursing staff if the resident was refusing care. The MDS nurse reviewed the February MAR and stated she must have missed seeing the refusal documentation when she completed her assessment. The MDS nurse stated the behavior for refusal of care exhibited should have been coded as "yes" in the quarterly assessment. An interview was conducted with Social Worker (SW) #1 on 03/18/22 at 10:49 AM via phone. SW #1 reported she was responsible for a portion of the MDS to include the behavior section. SW #1 stated she would speak to the resident and observe for behaviors and speak with the family or the nurse to see if the resident has had any behaviors. SW #1 stated the MDS nurse would usually let her know as well in the daily meeting if a resident was demonstrating any refusal of care or other behaviors. SW #1 was not aware the resident was refusing medications.	F 641	days 03/11/22-04/11/22 was completed in order to identify if the following questions were coded accurately: • B0600 – speech clarity • B0700 – makes self-understood • E0800 – rejection of care • J1800/1900 - falls Any resident who is identified as having inaccurate coding of any one or more of the above questions will have a correction of that assessment completed immediately by the facility Minimum Data Set Coordinator. This audit was completed by the facility Minimum Data Set Nurses and facility Social Services Director and was completed on 04/13/22. Audit results are: • 22 of 22 residents reviewed were noted to have accurate coding of B0600 speech clarity. • 0 of 22 residents reviewed were identified as having inaccurate coding of B0600 speech clarity. • 21 of 22 residents reviewed were identified as having accurate coding of B0700 makes self-understood. • 1 of 22 residents reviewed were identified as having inaccurate coding of B0700 makes self-understood. • 19 of 22 residents reviewed were identified as having accurate coding of E0800 rejection of care. • 3 of 22 residents reviewed were identified as having inaccurate coding of	

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F 641	Continued From page 3 An interview with the Administrator on 03/17/22 at 4:00 PM revealed she expected the MDS nurse and the SW to be completing assessments accurately and it should have reflected the refusal of medication. 2.Resident #87 was admitted to the facility from her home on 02/02/22. Her diagnoses included in part; Epilepsy, and history of traumatic brain injury at birth. The Minimum Data Set (MDS) admission assessment dated 02/09/22 revealed Resident #87 was coded as having clear speech, could make herself understood and could understand others. No BIMS (brief interview for mental status) was assessed. The MDS was coded as Resident #87 was rarely or never understood. She had acute mental status change, with inattentive behaviors and disorganized thoughts. She required one-to-two-person assistance with activities of daily living. The MDS discharge assessment dated 02/09/22 due to Resident #87 having an unplanned discharge revealed Resident #87 was coded on the assessment as no falls had occurred since admission. Review of Resident #87's progress notes revealed in part, on 02/04/22 at 05:06 AM nurse aide called nurse to room, Resident (#87) was sitting (on floor) in bathroom straight up beside of the toilet. No injuries were noted during the assessment of resident, and resident stated no pain. Resident was assisted back up and now in bed. An interview was conducted on 03/17/22 at 8:48	F 641	E0800 rejection of care. • 21 of 22 residents reviewed were identified as having accurate coding of J1800/1900 falls. • 1 of 22 residents reviewed were identified as having inaccurate coding of J1800/1900 falls. All residents who were identified as having inaccurate coding for any of the above areas had a modification to the affected assessment completed in order for the coding to be corrected and affected assessments were re-submitted to state database. This was completed by the facility Minimum Data Set Nurse on 04/12/2022. Systemic Changes On 04/12/22, the Regional Minimum Data Set Consultant completed an in-service training for the facility Social Services Director and Minimum Data Set Nurses that included the importance of thoroughly reviewing each resident's medical record in order ensure that the assessment is coded accurately. Special emphasis was placed on the following areas of the Minimum Data Set assessment: B0600 – Speech Clarity and B0700 – Makes Self Understood: In order to be able to code these questions accurately and to reflect the resident's current ability to communicate, the assessing nurse should make all attempts to interact with the resident. Interacting with the resident will give the best indications of any difficulties with speech and ability to make	

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F 641	Continued From page 4 AM with MDS Nurse #2. She stated Resident #87's admission assessment was conducted on 02/09/22 which was the day Resident #87 was discharged to the hospital. She stated Resident #87's speech was not completely clear, and she was not easily understood. She stated she should have coded Section B to reflect that instead of coding Resident #87 as having clear speech, and being easily understood, and understands others which she stated was inaccurate at the time of the assessment on 02/09/22. She stated she reviewed the risk management section in the electronic medical record to see the resident's historical data which would show a history of falls in the facility. She stated she did not look in Resident #87's progress notes which showed that a fall did occur on 02/03/22 during the look back period. She stated she should have coded that Resident #87 had a fall after admission and stated the MDS was coded in error. An interview was conducted on 03/16/22 at 02:44 PM with the Director of Nursing (DON). She indicated the MDS assessments should be coded accurately.	F 641	themselves understood. E0800 – Rejection of Care must also be coded accurately. In order to code this question correctly, the assessor must thoroughly review the resident's medical record to see if there is evidence of resident behaviors in the documentation. The assessor should review the progress notes, medication administration record as well as the daily point of care documentation completed by the nursing aide in order to determine if the resident had any episodes of rejecting care during the 7 day assessment reference date lookback timeframe. Based on the review of the resident's record, the assessor must then code the presence of and frequency of any behavior documented during the lookback timeframe. J1800/1900 – Falls should accurately reflect whether the resident has had any falls during the specified timeframe. The assessing nurse must conduct a thorough review of the resident's record in Point Click Care in order to ascertain whether or not they have had a fall. Review of the risk management portal in Point Click Care as well as the progress notes in the resident's record should guide the assessing nurse as to whether a fall has taken place during the assessment lookback timeframe. Based on the information reviewed, the assessor should then code Section J1800 and 1900 as yes if the resident was documented as having a fall, and as to whether any type of injury was sustained as a result of fall(s). This information has been integrated into the standard orientation training for new	

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F 641	Continued From page 5	F 641	Social Services Directors and Minimum Data Set Coordinators. 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 Administrator or designee will begin auditing minimum data set assessments that have been completed for current residents during the past 30 days to determine if B0600 – speech clarity, B0700 makes self-understood, E0800 – rejection of care and J1800/1900 – falls were accurately coded in order to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to 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 Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and/or Director of Nursing. Date of Compliance: 04/14/2022	

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F 677	Continued From page 6	F 677		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to assist a dependent resident with eating for 1 of 21 residents reviewed for activities of daily living (ADLs) (Resident #22). The findings included: Resident #22 was admitted to the facility on 9/28/21 with diagnoses to include adult failure to thrive. The quarterly Minimum Data Set (MDS) assessment dated 1/5/22 indicated Resident #22 was severely cognitively impaired. She was unable to speak and was rarely or never understood. It further revealed Resident #22 was totally dependent on staff for assistance with eating. The Care Plan for Resident #22 dated 1/5/22 revealed a plan of care for self-care performance deficit for activities of daily living. The goal for Resident #22 was to receive staff assistance with all aspects of daily care to ensure that all her needs were met. It further revealed Resident #22 required total assistance of 1 staff member for eating. Review of the electronic medical record (EMR)	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F677 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident # 22 was not assisted with her meal intake by staff on 3/16/2022 for breakfast meal. On 3/16/2022 the CNA task was updated to reflect the required meal assistance by the Nurse Consultant. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who require assistance with meals have the potential to be affected. On 04/14/2022, the Director of Nurses (DON), Unit Support Nurses, and the Minimum Data Set Nurse (MDS Nurse)	4/14/22

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F 677	Continued From page 7 for Resident #22 revealed an active order (initiated 9/28/21) for a regular diet, pureed texture, thin consistency. An observation of the 500 Hall meal cart on 3/16/22 at 08:50 AM revealed Resident #22's breakfast tray was covered and had not been removed from the meal cart. An interview was conducted with Nurse Aide (NA) #1 on 3/16/22 at 11:00 AM. She stated she was working on the 400 Hall that day. She further stated she had not fed Resident #22 her breakfast that morning. She indicated the NA on the 500 Hall was supposed to have fed her because they were responsible for 3 rooms on the 400 Hall. These 3 rooms included Resident #22's room. An interview was conducted with Certified Medication Aide (CMA) #1 on 3/16/22 at 11:25 AM. She stated she was usually the CMA on the 500 Hall. She further stated she had not fed Resident #22 breakfast that morning and her tray had not been removed from the meal cart. She stated she did not have a NA working with her on the 500 Hall that day, so she was only assigned 1 room on the 400 Hall and this was not Resident #22's room. She stated when she worked with a NA on the 500 Hall they were responsible for 3 rooms on the 400 Hall including Resident #22's room. She indicated that since Resident #22 was not on her 400 hall assignment she didn't think she was responsible for feeding her that morning. An interview was conducted with NA #2 on 3/16/22 at 11:07 AM. She stated she was working on the 400 Hall that day. She indicated Resident #22's favorite meal was breakfast because she	F 677	initiated an audit of all current residents to identify residents who require assistance with meals. The audits were completed on 04/14/2022. Each resident identified as needing assistance with meal intake, their task was updated to notify staff that they require assistance with meals. All residents who require assistance with meals had their care plan and the Kardex updated to reflect the need for meal assistance by the MDS Nurse. Care plan and Kardex updates were completed on 04/14/2022. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 3/16/2022, the DON initiated the following education to all Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Medication Aides, Medication Tech's, and Certified Nursing Assistants (CNAs), full time, part time, agency, and PRN staff: • Ensuring residents receive a meal tray As of 03/25/2022, any of the above identified employee who has not received this education will not be allowed to work until the training has been completed. The in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that	

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F 677	Continued From page 8 loved grits. She stated she had not fed Resident #22 breakfast that morning. She further stated Resident #22's meal tray came on the 500 Hall meal cart and when she hadn't seen the breakfast tray in her room, she thought she had already been fed. She stated she would have fed Resident #22 that morning if she had known there wasn't an NA on the 500 Hall. An interview was conducted with CMA #4 on 3/16/22 at 11:12 AM. She stated Resident #22 loved breakfast especially grits. She further stated she had not fed Resident #22 her breakfast that morning. An interview was conducted with Nurse #6 on 3/16/22 at 11:18 AM. She stated the staff was supposed to try to feed Resident #22 her meals. She further stated she had not fed Resident #22 breakfast that morning. An interview was conducted with Director of Nursing (DON) on 3/16/22 at 2:00 PM. She stated Resident #22 was supposed to be assisted by staff with eating at every meal. She indicated the NAs on the 400 Hall should have fed Resident #22 because there was not a NA on the 500 Hall. She further stated there was currently not a system in place to identify if a resident had been fed. An interview was conducted with the Administrator on 3/18/22 at 9:05 AM. She stated she expected dependent residents to be assisted with eating every meal everyday.	F 677	specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or designee will monitor compliance utilizing the F677 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved by the QA committee. The DON will monitor to ensure that dependent residents receive assistance with meal intake and receive a tray. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 04/14/2022	
F 756 SS=J	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		4/14/22

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F 756	Continued From page 9 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 756		

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F 756	Continued From page 10 Based on record review, staff interviews, the Consultant Pharmacist, and Physician interviews the facility failed to act upon the recommendations contained in the Consultant Pharmacist's initial Medication Regimen Review (MRR) to follow up on an order entry for Phenobarbital an anticonvulsant used in the treatment of Epilepsy (a brain disorder that causes seizures) resulting in failure to administer 12 doses of the medication for 1 of 1 resident whose medications were reviewed (Resident #87). Immediate Jeopardy began on 02/03/22 when the facility failed to act upon the Consultant Pharmacist's initial MRR to follow up on the order entry for the Phenobarbital resulting in 12 missed doses. Resident #87 experienced a seizure at 04:30 AM on 02/09/22 as a result of failure to administer the needed anticonvulsant medication, Phenobarbital, and failure to administer the correct dose of the anticonvulsant medication, Dilantin. Immediate Jeopardy was removed on 03/27/22 when the facility provided and implemented an acceptable plan of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" to ensure monitoring systems put in place are effective. Findings included. Resident #87 was admitted to the facility from her home on 02/02/22. Her diagnoses included in part; Epilepsy, and history of traumatic brain injury at birth. Resident #87's active medication list upon admission to the facility on 02/02/22 revealed	F 756	This removal plan is submitted as required under State and/or Federal law. The submission of this removal plan does not constitute an admission on the part of the facility or community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this removal plan also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the facility's or community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The facility / community submits this removal plan with the intention that it be inadmissible by any third party in any civil or criminal action against the facility/community or any employee, agent, officer, director, attorney, or shareholder of the facility/community or affiliated entities. The Removal Plan F756: The entity's removal plan must include the following: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. Resident # 87 was admitted on 2/2/2022	

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	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

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F 756	Continued From page 11 Phenobarbital 32.4 mgs (milligrams) take 2 tablets by mouth twice a day. A progress note dated 02/03/22 documented by Consultant Pharmacist #1 who completed the initial Medication Regimen Review (MRR) revealed a note to nursing to follow up on the order entry for Phenobarbital 32.4 mgs. A review of Resident #87's medication orders following the Consultant's Pharmacists (#1) MRR revealed from 02/03/22 - 02/08/22 there was no follow up on the order entry for Phenobarbital 32.4 mgs. Review of the Medication Administration Record (MAR) dated February 2022 revealed from admission on 02/02/22 through 02/08/22 Phenobarbital 32.4 mgs 2 tablets twice a day was not administered to Resident #87 resulting in 12 missed doses. This order was not entered on the MAR until 02/08/22. A progress note documented by Nurse # 3 dated 02/09/22 at 05:49 AM revealed at 04:30 AM resident (#87) had a seizure lasting 2 minutes, ordered per physician to give Dilantin 100 mgs now and Phenobarbital 40 mgs now, and we could borrow a one-time dose of the medication (Phenobarbital) until it was in from pharmacy of 10 mls (milliliters) equaling 40 mgs, and recheck Dilantin level in one week. Residents (#87) vital signs are within normal limits, and oxygen saturation is 97% on room air, no seizure activity at this time. RP (Responsible Party) aware of seizure and new orders. A hospital admission note, and summary of stay dated 02/09/22 - 02/16/22 for Resident #87	F 756	and had an order for Phenobarbital. The phenobarbital was started on 2/8/2022, which resulted in 12 missed doses. On 2/9/2022 the resident had a seizure lasting 2 minutes and the physician ordered Dilantin 100 mg and Phenobarbital 30 mg now which were administered. The resident's vital signs were within normal limits and oxygen saturation was 97 % on room air. The consultant pharmacist completed the medication regimen review on 2/3/2022. It was recommended that the facility follow up on the Phenobarbital order. This was not completed because the Director of Nursing did not get the report via email. It was determined that the Director of Nursing did not receive the email due to a blocked email account. This was corrected on 3/17/2022. An additional root cause was that the Director of Nursing did not validate that the medication regimen review was received or addressed. On 3/25/2022, the director of nursing reviewed the medication regimen review for all new admissions from 3/16/2022 to 3/25/2022. All residents audited had a medication regimen review completed. Recommendations were reviewed by the Director of Nursing to ensure that recommendations were addressed and clarifications were obtained from the physician. No errors were identified. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from	

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F 756	Continued From page 12 revealed on 02/09/22 at 9:57 PM Resident #87 was evaluated following a seizure at nursing home and had been post ictal since that time. (Resident #87) was awake and alert to surroundings upon arrival, but unable to provide accurate review of systems due to cognitive impairment secondary to history of seizure disorder. Upon examination Resident 87's general appearance was lethargic, well nourished, with no acute distress. She would awake with verbal stimuli but then immediately fall back asleep. She would look at you with painful stimuli. Resident #87 was admitted for management of seizures, Dilantin and Phenobarbital levels, and pneumonia. A hospital note dated 02/11/22 revealed (Resident #87) remained somnolent and was unable to consume anything orally at the time. On 02/14/22 (Resident #87) remained NPO (nothing by mouth), was unable to consume anything orally, family decided against any type of artificial nutrition. A note dated 02/14/22 revealed two brief breakthrough seizures in the setting of fever. A neurology note dated 02/15/22 revealed EEG (electroencephalogram) showed intermittent bilateral sharp waves and slowing suggestive of a known history of epilepsy, also has pneumonia. The neurology note revealed (Resident #87) had become more responsive on a daily basis, and if there was no improvement in mental status despite all levels being in (residents) usual therapeutic range, given EEG x 2 not showing seizures, would recommend transferring for prolonged EEG monitoring to rule out subclinical seizures. Resident was discharged to another hospital for EEG monitoring on 02/16/22. Resident #87 passed away at her home March 2022.	F 756	occurring or recurring, and when the action will be complete. On 3/25/2022, the Vice President of Operations in serviced the Director of Nursing that within three business days after a new admission that the medication regimen review should be received and reviewed. Any clarification or corrective actions recommended by the pharmacist should be addressed with the physician as needed. If the medication regimen review is not received within three business days the Director of Nursing should contact the pharmacy and request that the review be completed. The administrator was also trained that in the absence of the Director of Nursing, they should ensure that the medication regimen review is received and they should work with the nurses to initiate follow up and corrective action. When the pharmacist conducts the medication regime review (MRR) for all newly admitted patients (within 3 business days), the consultant pharmacist will call the Director of Nursing, or the Administrator if Director of Nursing is not available, or the facility Charge Nurse if the Administrator is not available. The consultant pharmacist will call until he/she reaches stated disciplines to ensure the clarification is acted upon timely. This education was completed by the Vice President of Operations, in collaboration with the Pharmacist Manager, 3/26/22 to ensure communication by the consultant pharmacist is immediate for high risk medication reviews that have	

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F 756	Continued From page 13 A phone interview was conducted on 03/15/22 at 3:53 PM with Nurse #3. She stated she was Resident #87's assigned nurse on the night of the seizure. She stated she was not aware of Resident #87 having any seizures at the facility prior to that night. Nurse #3 stated after the seizure and after the medications were given (Phenobarbital and Dilantin) she slept well, and her vital signs were stable. She stated she had another resident on liquid Phenobarbital, and she received an order to give liquid Phenobarbital to Resident #87 when she had the seizure which she had to borrow from another resident, and she received an order to start Phenobarbital the following morning. She stated she was not sure why the Phenobarbital was not available for Resident #87 but stated she did call the pharmacy that night after calling the physician but didn't receive a return phone call from the pharmacy. A phone interview was conducted on 03/16/22 at 04:18 PM with the Consultant Pharmacist (#1). She stated she conducted the initial admission MRR for Resident #87 on 02/03/22. She stated she sent a nursing note to follow up on the Phenobarbital order. She stated after the initial MRR was completed, she entered a note in Resident #87's progress notes on 02/03/22 to follow up on the Phenobarbital order and stated she also sent an email with the notes and recommendations to the facility on the day of the review. She stated the recommendation read to follow up with the Phenobarbital order entry. A follow up phone interview was conducted on 04/05/22 at 12:15 PM with Consultant Pharmacist #1. She stated the initial MRR review was conducted remotely on 02/03/22. She stated she	F 756	recommendations for follow up required, through calling facility leadership (Director of Nursing, Administrator, or Clinical licensed leadership team/charge nurse to communicate recommendation(s) directly, effective 3/26/22. On 3/25/2022, the Director of Nursing in serviced the nurse leadership team that within three business days after a new admission that the medication regimen review should be received and reviewed. Any clarification or corrective actions recommended by the pharmacist should be addressed with the physician as needed. If the Director of Nursing is absent, the administrator will provide the medication regimen review to the nurse manager on duty for review. On 3/25/2022, the Quality Assurance admission checklist that is to be completed the next business day after admission was updated by the administrator. The update included a line to include validating that the medication regimen review has been received. On 3/25/2022, the Director of Nursing educated the nurse leaders on the changes to the admission checklist. All education regarding verification of physician orders was initiated 3/17 by the clinical consultant and completed for all active licensed staff, including medication aides, medication techs, licensed nursing staff on or before 3/25/22, by either the clinical consultant, MDS RN, or Director of Nursing. All other education, including method for ensuring MRRs are received and enacted upon was completed by the Vice	

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F 756	Continued From page 14 saw the Phenobarbital order on the orders that were scanned into the electronic medical record and put a note in the resident's progress note to follow up on the Phenobarbital order entry. She stated she also sent the pharmacy recommendation via email to the DON (Director of Nursing) on the same day which included to follow up on the medication order which was the process used when conducting initial MRR's. She stated she did not make a recommendation regarding the Dilantin order. An interview was conducted on 03/16/22 at 02:44 PM with the Director of Nursing (DON). She indicated that she was not aware of the Consultant Pharmacist's (#1) note contained in the progress notes on 02/03/22 that noted to follow up on the Phenobarbital order. She stated she looked back through her emails after the Pharmacist's initial MRR and did not see an email with the recommendations. She indicated the Consultants Pharmacist's initial MRR should have been acted on following the medication review. An interview was conducted on 03/17/22 at 1:00 PM with the Physician. He stated not receiving Phenobarbital lowered Resident #87's threshold for seizure activity after 4-5 days of not having the medication which led to her having a seizure. The Administrator was notified of the Immediate Jeopardy via phone on 03/25/22 at 4:45 PM. Immediate Jeopardy Removal Plan: F756: Removal plan completion date: 03/27/22 1.Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.	F 756	President of Operations on 3/26/22 with the Director of Nursing and the Licensed Administrator. The Licensed Administrator and the MDS RN were added to the MRR electronic distribution list 3/25/22, which also includes the Director of Nursing. The Pharmacist Manager was notified on 3/25/22 to expand the distribution list and validated on 3/25/22 as completed by the Vice President of Operations. As stated previously, all high-risk medication reviews by the consultant pharmacist will be communicated through phone call to validate receipt and follow through. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or designee will monitor compliance utilizing the F756 and F760 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved by the QA committee. The DON will monitor to ensure that admission orders are entered according to the physician ordered admission order set and ensure that the Initial pharmacy MRR (Medical Record Review) is completed within 72 hours of admission. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly	

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F 756	Continued From page 15 Resident # 87 was admitted on 2/2/22 and had an order for Phenobarbital. The phenobarbital was started on 2/8/22, which resulted in 12 missed doses. On 2/9/22 the resident had a seizure lasting 2 minutes and the physician ordered Dilantin 100 mg and Phenobarbital 30 mg now which were administered. The resident's vital signs were within normal limits and oxygen saturation was 97 % on room air. The consultant pharmacist completed the medication regimen review on 2/3/22. It was recommended that the facility follow up on the Phenobarbital order. This was not completed because the Director of Nursing did not get the report via email. It was determined that the Director of Nursing did not receive the email due to a blocked email account. This was corrected on 3/17/22. An additional root cause was that the Director of Nursing did not validate that the medication regimen review was received or addressed. On 3/25/22, the director of nursing reviewed the medication regimen review for all new admissions from 3/16/22 to 3/25/22. All residents audited had a medication regimen review completed. Recommendations were reviewed by the Director of Nursing to ensure that recommendations were addressed, and clarifications were obtained from the physician. No errors were identified. 2.Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. On 3/25/22, the Vice President of Operations in serviced the Director of Nursing that within three business days after a new admission that the	F 756	QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Completion date: 3/27/2022.	

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F 756	Continued From page 16	F 756		

medication regimen review should be received and reviewed. Any clarification or corrective actions recommended by the pharmacist should be addressed with the physician as needed. If the medication regimen review is not received within three business days, the Director of Nursing should contact the pharmacy and request that the review be completed. The administrator was also trained that in the absence of the Director of Nursing, they should ensure that the medication regimen review is received, and they should work with the nurses to initiate follow up and corrective action. When the pharmacist conducts the medication regime review (MRR) for all newly admitted patients (within 3 business days), the consultant pharmacist will call the Director of Nursing, or the Administrator if Director of Nursing is not available, or the facility Charge Nurse if the Administrator is not available. The consultant pharmacist will call until he/she reaches stated disciplines to ensure the clarification is acted upon timely. This education was completed by the Vice President of Operations, in collaboration with the Pharmacist Manager, 3/26/22 to ensure communication by the consultant pharmacist is immediate for high-risk medication reviews that have recommendations for follow up required, through calling facility leadership (Director of Nursing, Administrator, or Clinical licensed leadership team/charge nurse to communicate recommendation(s) directly, effective 3/26/22.

On 3/25/22, the Director of Nursing in serviced the nurse leadership team that within three business days after a new admission that the medication regimen review should be received and reviewed. Any clarification or corrective actions recommended by the pharmacist should

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F 756	Continued From page 17	F 756		

be addressed with the physician as needed. If the Director of Nursing is absent, the administrator will provide the medication regimen review to the nurse manager on duty for review.

On 3/25/22, the Quality Assurance admission checklist that is to be completed the next business day after admission was updated by the administrator. The update included a line to include validating that the medication regimen review has been received. On 3/25/22, the Director of Nursing educated the nurse leaders on the changes to the admission checklist.

Completion date: 3/27/22 - all education regarding verification of physician orders was initiated 3/17/22 by the clinical consultant and completed for all active licensed staff, including medication aides, medication techs, licensed nursing staff on or before 3/25/22, by either the clinical consultant, MDS RN, or Director of Nursing.

All other education, including method for ensuring MRRs are received and enacted upon was completed by the Vice President of Operations on 3/26/22 with the Director of Nursing and the Licensed Administrator. The Licensed Administrator and the MDS RN were added to the MRR electronic distribution list 3/25/22, which also includes the Director of Nursing. The Pharmacist Manager was notified on 3/25/22 to expand the distribution list and validated on 3/25/22 as completed by the Vice President of Operations. As stated previously, all high-risk medication reviews by the consultant pharmacist will be communicated through phone call to validate receipt and follow through.

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F 756	Continued From page 18 The Licensed Nursing Home Administrator is responsible for ensuring the plan of correct for F756 have been implemented and completed. Facility alleges Immediate Jeopardy was removed 03/27/22. The Immediate Jeopardy was removed on 03/27/22. A sample of staff that included nurses, and pharmacy staff were interviewed regarding in-servicing related to the deficient practice. All staff interviewed stated they received in-service training including in-person education and written materials, regarding the facility policy and procedures related to the MRR process. New procedures had been implemented regarding the pharmacists MRR process. Staff were allowed the opportunity to interact with dialogue to ensure understanding of the in-services that were presented. A review of all documents developed to correct the deficient practice was completed. Facility policies and procedures that were revised to address the deficient practice were reviewed. The audit form that was developed to monitor that the systems put in place were effective was also reviewed.	F 756		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, the facility Pharmacist, the Pharmacy Manager, and	F 760	This removal plan is submitted as required under State and/or Federal law.	4/14/22

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F 760	Continued From page 19 Physician interviews, the facility 1.a) failed to transcribe a medication order upon admission resulting in failure to administer 12 doses of a medication (Phenobarbital) an anticonvulsant used in the treatment of Epilepsy (a brain disorder that causes seizures). b) failed to clarify a medication order upon admission resulting in failure to administer 4 doses of the anticonvulsant medication Dilantin (prescribed to treat and prevent seizures) which resulted in the resident having a seizure and being transported to the hospital for 1 of 1 resident reviewed (Resident # 87). Immediate Jeopardy began on 02/02/22 when the facility failed to transcribe the Phenobarbital order into the electronic medical record (EMR) upon admission and failed to obtain a hard script for the Phenobarbital so that the medication order could be filled by the pharmacy resulting in 12 missed doses. The facility failed to clarify an incomplete medication order for Dilantin upon admission resulting in 4 missed doses. Resident #87 experienced a seizure on 02/09/22 at 04:30 AM as a result of failure to administer the needed anticonvulsant medication, Phenobarbital, and failure to administer the correct dose of the anticonvulsant medication, Dilantin. Immediate Jeopardy was removed on 03/26/22 when the facility provided and implemented an acceptable plan of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" to ensure monitoring systems put in place are effective. Findings included. 1a.) Resident #87 was admitted to the facility from her home on 02/02/22 following the death of	F 760	The submission of this removal plan does not constitute an admission on the part of the facility or community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this removal plan also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the facility's or community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The facility / community submits this removal plan with the intention that it be inadmissible by any third party in any civil or criminal action against the facility/community or any employee, agent, officer, director, attorney, or shareholder of the facility/community or affiliated entities. The Removal Plan F760: The entity's removal plan must include the following: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and Resident # 87 was admitted on 2/2/2022 and had orders for Phenobarbital and Dilantin. The phenobarbital was started on 2/9/2022 at 04:30 AM, which resulted in 12 missed doses The Dilantin order was corrected on	

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F 760	Continued From page 20	F 760		

her lifelong caregiver. Her diagnoses included in part; Epilepsy, and history of traumatic brain injury at birth.

Resident #87's active medication list upon admission to the facility on 02/02/22 revealed Phenobarbital 32.4 mgs (milligrams) take 2 tablets by mouth twice a day.

Review of the Medication Administration Record (MAR) dated February 2022 revealed from 02/02/22 through 02/08/22 Phenobarbital 32.4 mgs 2 tablets twice a day was not administered to Resident #87 resulting in 12 missed doses. This order was not entered on the MAR until 02/08/22.

An interview was conducted on 03/16/22 at 01:45 PM with Nurse #5 the admission nurse on duty when Resident #87 was admitted to the facility. She stated she entered the medication orders from a medication picture but stated she didn't recall seeing page 2 which listed the Phenobarbital on it. She stated she wasn't aware Resident #87 had not received Phenobarbital until now. She stated if she had seen the Phenobarbital order, she would have sent a message to the physician to get a hard script to send to pharmacy because pharmacy would not fill the medication without a hard script since it was a controlled medication. She stated she usually checked and initialed by the medication once she entered the orders but stated the copy provided from Resident #87's medical record didn't have any initials on it. She stated a second nurse double checked to make sure all medication orders were entered accurately and would have initialed the order as well, but she could not recall who that second nurse was that checked behind her that day. She stated it was an 2/7/2022, which resulted in 4 missed doses. On 2/9/2022 the resident had a seizure lasting 2 minutes and the physician ordered Dilantin 100 mg and Phenobarbital 30 mg now which were administered. The resident's vital signs were within normal limits and oxygen saturation was 97 % on room air.
A root cause analysis was conducted by the nurse consultant on 3/15/2022.
The Phenobarbital was not entered into the electronic health record on admission and a hard script was not received. The admitting nurse stated in an interview that she did not receive the second page of the photocopied orders that the family had provided. The FL-2 was not used for the admission process. The Dilantin order was entered into the electronic health record by the admission nurse. The photocopied medication list provided by the family stated that the Dilantin 100 mg cap should be given "2caps Sunday thru Friday and 1 cap by mouth 2x daily on Saturday". The information provided in quotes is the exact language from the medication list. The nurse entered into the electronic health record that 2 capsules should be given one time a day Sunday thru Friday and 2 capsules twice a day on Saturday.
On 2/7/2022 the physician was contacted by the nurse because the family had questioned the dosing. The physician then ordered Dilantin 100 mg 2 capsules twice a day on Monday, Tuesday, Wednesday, Thursday, Friday and Sunday. Dilantin 100 mg twice a day on Saturday. The root cause of this error is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 21 error. A care plan dated 02/03/22 revealed Resident #87 had seizure disorder with a risk for injuries. The goal of care was to remain free from injury related to seizure activity through the next 90 days. Interventions included in part to give seizure medications as ordered by the physician, and to monitor and document side effects and effectiveness. The Minimum Data Set (MDS) admission assessment dated 02/09/22 revealed Resident #87 had acute mental status change, with inattentive behaviors and disorganized thoughts. She required one-to-two-person assistance with activities of daily living. An interview was conducted on 03/15/22 at 4:30 PM with the Admissions Coordinator. She stated Resident #87 was admitted from home not from a hospital. She stated since she was admitted from home, she did not have a hard script to get the Phenobarbital filled on the day of admission. She stated she just started her role as the admission nurse in December 2021 and she should have obtained a hard script from the physician on the day of admission, and she didn't which was an error on her part. She stated when Resident #87's family member talked with her about her medications the day prior to the seizure, she sent a message to the physician to get the Phenobarbital hard script. She stated the morning Resident #87 had the seizure the family and the physician were notified, and the physician wrote a one-time medication order because there was no phenobarbital for her in the facility, and a borrowed dose was administered. She stated she was a nurse and came in at 8:00 AM that morning	F 760	that the order did not indicate the frequency for Sunday thru Friday and this was not clarified by the nurse. The consultant pharmacist completed the medication regimen review on 2/3/2022. It was recommended that the facility follow up on the Phenobarbital order. This was not completed because the Director of Nursing did not get the report via email. It was determined that the Director of Nursing did not receive the email due to a blocked email account. This was corrected on 3/17/2022. An additional root cause was that the Director of Nursing did not validate that the medication regimen review was received or addressed. On 3/25/2022, all new admissions from 3/16/2022 to 3/25/2022 were audited to ensure medications were entered into the electronic health record according to the new admission orders. This review, including verifying that the orders were complete (includes medication name, dose, number of tablets, and frequency, and that there were no incomplete (pending confirmation) medication orders. If the resident had a controlled substance order, the Director of Nursing ensured that the nurses had the necessary medications in the facility meaning that hard scripts had been obtained. This audit was completed by the Director of Nursing on 3/25/2022. No errors were identified. On 3/25/2022, the Director of Nursing reviewed the medication regimen review for all new admissions from 3/16 to 3/25/2022. All residents audited had a medication regimen review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

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F 760	Continued From page 22 following the seizure and Resident #87 was post ictal (period following a seizure), she was asleep, and had no distress. She stated the DON (Director of Nursing) and Administrator asked the family if they wanted the resident sent to the hospital or to wait until after lab results were obtained and they wanted to wait for lab reports, then later that day family asked to have resident sent to the hospital for further evaluation. A phone interview was conducted on 03/16/22 at 11:46 AM with Pharmacist #1. She stated Phenobarbital was dispensed from the pharmacy for Resident #87 when a hard script was submitted on 02/09/22 for 64.8 mg one tablet by mouth twice a day. She stated the pharmacy could not fill controlled medications without a hard script, but no hard copies were sent on 02/02/22. She stated Phenobarbital was sent for Resident #87 on 02/09/22. A phone interview was conducted on 04/05/22 at 12:00 PM with the Pharmacy Manager. He stated the pharmacy did not receive an order for Phenobarbital on 02/02/22 for Resident #87. He stated the medications for the resident were filled according to what was entered into the residents EMR. He stated the pharmacy received an order for Phenobarbital for Resident #87 on 02/09/22. An interview was conducted on 03/16/22 at 02:44 PM with the Director of Nursing (DON). She stated she expected the nurses to notify the physician for a hard script for controlled medications at the time the order was received at the facility so that the medications could be filled and sent from pharmacy. She stated the admission nurse and the second nurse that checked the medication orders for accuracy	F 760	Recommendations were reviewed by the Director of Nursing to ensure that recommendations were addressed and clarifications were obtained from the physician. No errors were identified. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. On 3/17/2022, education for all licensed practical nurses, medication aides and registered nurses was initiated by the facility clinical consultant. The education included all full time, part time and as needed staff. The facility does not utilize agency. Education included: the use of the FL-2 for admission medications if received from the home, how to review admission orders to ensure that they are complete and clearly indicate the dose and frequency, that the physician should be called for clarification for incomplete or confusing orders, and that they should contact the physician for any hard scripts that are needed. All newly admitted orders will be verified with the attending physician by the Admission Coordinator, and then the charge nurse will enter the orders in the electronic order system (Point Click Care) after first ensuring the orders were reviewed with physician and verified as accurate. As of 3/25/2022 nine staff members have not attended the in-service because they are either as needed employees or on medical leaves. The Director of Nursing will ensure that any of the nine staff who have not complete the in-service training	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

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

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F 760	Continued From page 23	F 760		

should have identified the Phenobarbital order and obtained a hard script.

An interview was conducted on 03/17/22 at 1:00 PM with the Physician. He stated not receiving Phenobarbital lowered Resident #87's threshold for seizure activity after 4-5 days of not having the medication which led to her having a seizure.

b.) Resident #87's active medication list upon admission to the facility on 02/02/22 revealed Phenytoin Sodium (Dilantin) 100 mg capsules give 2 capsules Sunday - Friday and 1 capsule by mouth twice a day on Saturday.

Review of the Medication Administration Record (MAR) dated February 2022 for Resident #87 revealed Phenytoin Sodium (Dilantin) 100 mg extended capsule. The order was entered to give 2 capsules (200 mgs) by mouth one time a day every Monday, Tuesday, Wednesday, Thursday, Friday, Sunday and give 1 capsule twice a day on Saturday for seizures. Dilantin 2 capsules (200 mgs) was documented as administered to Resident #87 once a day on 02/03/22, 02/04/22, 02/06/22, and 02/07/22. The medication order was corrected on 02/08/22.

A progress note dated 02/09/22 at 9:41 AM (late entry) documented by the Admissions Coordinator revealed a notification to the physician stating the family stated Resident #87 should be receiving (Dilantin) two capsules twice a day and the order is two capsules once a day.

An interview was conducted on 03/15/22 at 4:30 PM with the Admissions Coordinator. She stated Resident #87 was admitted from home not from a hospital. She stated she talked to Resident #87's

by 3/25/2022, will not be allowed to work until the training is completed.
On 3/25/2022, the Vice President of Operations in serviced the Director of Nursing that within three business days after a new admission that the medication regimen review should be received and reviewed by a licensed pharmacist. Any clarification or corrective actions recommended by the pharmacist should be addressed with the physician immediately. If the medication regimen review is not received within three business days the Director of Nursing should contact the pharmacy and request that the review be completed. The administrator was also trained that in the absence of the Director of Nursing, he/she should ensure that the medication regimen review is received, and they should work with the nurses to initiate follow up and corrective action same day.
The Director of Nursing or clinical designee, will ensure all newly admitted residents have an MRR within 3 business days, if the MRR is not received via the electronic delivery, the Director of Nursing, the Administrator, and/or clinical designee will reach out to the consultant pharmacist to ensure review has been completed and recommendations are received. The Director of Nursing and the Administrator were educated on 3/25/22 regarding procedure for ensuring all MRR's are validated as received and enacted on, this education was completed by the Vice President of Operations.
On 3/25/2022, the Director of Nursing in serviced the nurse leadership team that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 24 family member who had talked to one of the nurses to review Resident #87's medications. Upon review it was determined the Dilantin order had been entered wrong, the Dilantin was supposed to be two capsules twice a day (400 mgs) on Sunday-Friday, and one capsule twice a day (200 mgs) on Saturday. She stated the order was corrected immediately once they became aware it was not accurate and Resident #87 received the correct dose on 02/08/22. She indicated Resident #87's admission nurse entered the original order into the electronic medical record (EMR). Review of the Medication Administration Record (MAR) dated February 2022 for Resident #87 revealed a new order entry with a start date of 02/08/22 for Phenytoin Sodium (Dilantin) 100 mg extended capsule, give 2 capsules by mouth two times a day every Sunday - Friday for epilepsy. This was documented as administered to Resident #87 on 02/08/22 and 02/09/22. An interview was conducted on 03/16/22 at 01:45 PM with Nurse #5 the admission nurse on duty when Resident #87 was admitted to the facility. She stated the Dilantin order was entered as it appeared on the admission medication sheet but stated she should have clarified with the physician on how often to schedule the Sunday - Friday dose instead of scheduling the medication to be given once a day since the order was unclear. She stated that the order was entered in error. She stated she usually checked and initialed by the medication once she entered the orders but stated the copy provided from Resident #87's medical record didn't have any initials on it. She stated a second nurse double checked to make sure all medication orders were	F 760	within three business days after a new admission that the medication regimen review should be received and reviewed. Any clarification or corrective actions recommended by the pharmacist should be addressed with the physician immediately. If the Director of Nursing is absent, the administrator will provide the medication regimen review to the nurse manager on duty for review. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or designee will monitor compliance utilizing the F756 and F760 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved by the QA committee. The DON will monitor to ensure that admission orders are entered according to the physician ordered admission order set and ensure that the Initial pharmacy MRR (Medical Record Review) is completed within 72 hours of admission. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Completion date: 3/26/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

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

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F 760	Continued From page 25	F 760		

entered accurately and would initial the order as well, but she could not recall who that second nurse was that checked behind her that day.

An interview was conducted on 03/16/22 at 02:44 PM with the DON. She stated since the Dilantin order did not indicate the frequency for the Sunday - Friday dose and was an incomplete order, the order should have been clarified by the nurse on the day of admission. She stated she expected the nurses to notify the physician to get clarification when medication orders were incomplete or unclear.

A progress note documented by Nurse # 3 dated 02/09/22 at 05:49 AM revealed at 04:30 AM resident (#87) had a seizure lasting 2 minutes, ordered per physician to give Dilantin 100 mgs now and Phenobarbital 40 mgs now, and we could borrow a one-time dose of the medication until it was in from pharmacy of 10 mls (milliliters) equaling 40 mgs, and recheck Dilantin level in one week. Residents (#87) vital signs are within normal limits, and oxygen saturation is 97% on room air, no seizure activity at this time. RP (Responsible Party) aware of seizure and new orders.

A review of the Dilantin level drawn on 02/09/22 at the facility revealed a result of 6.8 mcg/ml (micrograms per milliliter- normal range 10-20 mcg/ml). There was no physician order to draw Phenobarbital levels on 02/09/22. Phenobarbital levels were drawn at the hospital on 02/09/22 and resulted in 11.7 mcg/ml (normal range 15-40 mcg/ml).

A hospital admission note, and summary of stay dated 02/09/22 - 02/16/22 for Resident #87

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 26	F 760		

revealed on 02/09/22 at 9:57 PM Resident #87 was evaluated following seizure at nursing home and had been post ictal since that time. (Resident #87) was awake and alert to surroundings upon arrival, but unable to provide accurate review of systems due to cognitive impairment and history of seizure disorder. Upon examination Resident 87's general appearance was lethargic, well nourished, with no acute distress. She would awake with verbal stimuli but then immediately fall back asleep. She would look at you with painful stimuli. Resident #87 was admitted for management of seizures, Dilantin and Phenobarbital levels, and pneumonia. A hospital note dated 02/11/22 revealed (Resident #87) remained somnolent and was unable to consume anything orally at the time. On 02/14/22 (Resident #87) remained NPO (nothing by mouth), was unable to consume anything orally, and family decided against any type of artificial nutrition. A note dated 02/14/22 revealed two brief breakthrough seizures in the setting of fever. A neurology note dated 02/15/22 revealed EEG (electroencephalogram) showed intermittent bilateral sharp waves and slowing suggestive of a known history of epilepsy, also has pneumonia. The neurology note revealed (Resident #87) had become more responsive on a daily basis, and if there was no improvement in mental status despite all levels being in (residents) usual therapeutic range, given EEG x 2 not showing seizures, would recommend transferring for prolonged EEG monitoring to rule out subclinical seizures. Resident was discharged to another hospital for EEG monitoring on 02/16/22. Resident #87 passed away at her home March 2022.

A phone interview was conducted on 03/15/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

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

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F 760	Continued From page 27	F 760		

3:53 PM with Nurse #3. She stated she was Resident #87's assigned nurse on the night of the seizure. She stated she was not aware of Resident #87 having any seizures at the facility prior to that night. She stated the resident was fine all night until that point and stated a nurse aide was in front of the resident's door when the seizure started but she did not recall which nurse aide it was. She stated you could ask if she was in pain, and she could say yes. Nurse #3 stated after the seizure and after the medications were given (Phenobarbital and Dilantin) she slept well, and her vital signs were stable. She stated she had another resident on liquid Phenobarbital, and she received an order to give liquid Phenobarbital to Resident #87 when she had the seizure which she had to borrow from another resident, and she received an order to start Phenobarbital the following morning. She stated she continued to check her vital signs and she would wake her up to assess her during the night and she was stable. Resident #87 was still sleeping at 7:00 AM when she left after her shift ended. She stated she was not sure why the Phenobarbital was not available for Resident #87 but stated she did call the pharmacy that night after calling the physician but didn't receive a return phone call from the pharmacy. She indicated the admissions coordinator or the nurse on the hall when the resident was admitted would have entered the admission orders.

An interview was conducted on 03/17/22 at 1:00 PM with the Physician. He stated not receiving Phenobarbital and receiving only half of the Dilantin dose the resident received at home lowered Resident #87's threshold for seizure activity after 4-5 days of not having the medication which led to her having a seizure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 28	F 760		

The Administrator was notified of the Immediate Jeopardy via phone on 03/25/22 at 4:45 PM.

Immediate Jeopardy Removal Plan:
F760: Removal plan completion date: 03/26/22

1.Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance;

Resident # 87 was admitted on 2/2/22 and had orders for Phenobarbital and Dilantin. The phenobarbital was started on 2/9/22 at 04:30 AM, which resulted in 12 missed doses.

The Dilantin order was corrected on 2/7/22, which resulted in 4 missed doses. On 2/9/22 the resident had a seizure lasting 2 minutes and the physician ordered Dilantin 100 mg and Phenobarbital 30 mg now which were administered. The resident's vital signs were within normal limits and oxygen saturation was 97 % on room air.

A root cause analysis was conducted by the nurse consultant on 3/15/22.

The Phenobarbital was not entered into the electronic health record on admission and a hard script was not received. The admitting nurse stated in an interview that she did not receive the second page of the photocopied orders that the family had provided. The FL-2 was not used for the admission process. The Dilantin order was entered into the electronic health record by the admission nurse. The photocopied medication list provided by the family stated that the Dilantin 100 mg capsule should be given "2caps Sunday thru

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

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F 760	Continued From page 29	F 760		

Friday and 1 cap by mouth 2x daily on Saturday". The information provided in quotes is the exact language from the medication list. The nurse entered into the electronic health record that 2 capsules should be given one time a day Sunday thru Friday and 2 capsule twice a day on Saturday.

On 2/7/22 the physician was contacted by the nurse because the family had questioned the dosing. The physician then ordered Dilantin 100 mg 2 capsules twice a day on Monday, Tuesday, Wednesday, Thursday, Friday, and Sunday. Dilantin 100 mg twice a day on Saturday. The root cause of this error is that the order did not indicate the frequency for Sunday thru Friday, and this was not clarified by the nurse.

The consultant pharmacist completed the medication regimen review on 2/3/22. It was recommended that the facility follow up on the Phenobarbital order. This was not completed because the Director of Nursing did not get the report via email. It was determined that the Director of Nursing did not receive the email due to a blocked email account. This was corrected on 3/17/22. An additional root cause was that the Director of Nursing did not validate that the medication regimen review was received or addressed.

On 3/25/22, all new admissions from 3/16/22 to 3/25/22 were audited to ensure medications were entered into the electronic health record according to the new admission orders. This review, including verifying that the orders were complete (included medication name, dose, number of tablets, and frequency, and that there were no incomplete (pending confirmation)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 760	Continued From page 30	F 760		

medication orders. If the resident had a controlled substance order, the Director of Nursing ensured that the nurses had the necessary medications in the facility meaning that hard scripts had been obtained. This audit was completed by the Director of Nursing on 3/25/22. No errors were identified.

On 3/25/22, the Director of Nursing reviewed the medication regimen review for all new admissions from 3/16 to 3/25/22. All residents audited had a medication regimen review. Recommendations were reviewed by the Director of Nursing to ensure that recommendations were addressed, and clarifications were obtained from the physician. No errors were identified.

2.Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 3/17/22, education for all licensed practical nurses, medication aides and registered nurses was initiated by the facility clinical consultant. The education included all full time, part time and as needed staff. The facility does not utilize agency. Education included: the use of the FL-2 for admission medications if received from the home, how to review admission orders to ensure that they are complete and clearly indicate the dose and frequency, that the physician should be called for clarification for incomplete or confusing orders, and that they should contact the physician for any hard scripts that are needed. All newly admitted orders will be verified with the attending physician by the Admission Coordinator, and then the charge nurse will enter the orders in the electronic order system (Point Click Care) after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

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

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F 760	Continued From page 31	F 760		

first ensuring the orders were reviewed with physician and verified as accurate.

As of 3/25/22 nine staff members have not attended the in-service because they are either as needed employees or on medical leaves. The Director of Nursing will ensure that any of the nine staff who have not complete the in-service training by 3/25/22, will not be allowed to work until the training is completed.

On 3/25/22, the Vice President of Operations in serviced the Director of Nursing that within three business days after a new admission that the medication regimen review should be received and reviewed by a licensed pharmacist. Any clarification or corrective actions recommended by the pharmacist should be addressed with the physician immediately. If the medication regimen review is not received within three business days, the Director of Nursing should contact the pharmacy and request that the review be completed. The administrator was also trained that in the absence of the Director of Nursing, he/she should ensure that the medication regimen review is received, and they should work with the nurses to initiate follow up and corrective action same day. The Director of Nursing or clinical designee will ensure all newly admitted residents have an MRR within 3 business days, if the MRR is not received via the electronic delivery, the Director of Nursing, the Administrator, and/or clinical designee will reach out to the consultant pharmacist to ensure review has been completed and recommendations are received. The Director of Nursing and the Administrator were educated on 3/25/22 regarding the procedure for ensuring all MRR's are validated as received and enacted on, this

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	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 32	F 760		

education was completed by the Vice President of Operations.

On 3/25/22, the Director of Nursing in serviced the nurse leadership team that within three business days after a new admission that the medication regimen review should be received and reviewed. Any clarification or corrective actions recommended by the pharmacist should be addressed with the physician immediately. If the Director of Nursing is absent, the administrator will provide the medication regimen review to the nurse manager on duty for review.

Completion date: 3/26/22

The Licensed Nursing Home Administrator is responsible for ensuring the plan of correct for F760 have been implemented and completed.

Facility alleges Immediate Jeopardy was removed 03/26/22.

The Immediate Jeopardy was removed on 03/26/22.

The Removal Plan of Immediate Jeopardy was validated on 04/05/22.

A sample of staff that included nurses, medication aides, and pharmacy staff were interviewed regarding in-servicing related to the deficient practice. All staff interviewed stated they received in-service training including in-person education and written materials, regarding the facility policy and procedures related to medication administration, that included transcribing medications, and ensuring complete medication orders were received. Staff were allowed the

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	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 33 opportunity to interact with dialogue to ensure understanding of the in-services that were presented. A review of all documents developed to correct the deficient practice was completed. Facility policies and procedures that were revised to address the deficient practice were reviewed. The audit forms that were developed to monitor that the systems put in place were effective were also reviewed.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		4/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

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F 761	Continued From page 34 by: Based on observations and staff interviews the facility failed to dispose of 7 individual packages of expired medications and failed to properly store 4 tablets in its original package to indicate what the expiration date was in 2 of 3 medication carts (100 Hall Medication Cart and 200 Hall Medication Cart) observed for medication storage. Findings included: 1. An observation of the 100 Hall medication cart with Certified Medication Aide (CMA) #2 on 03/16/22 at 8:30 AM revealed there were 6 individual packets of Loperamide Hydrochloride 2 milligrams (mg) on stored in the medication cart with an expiration of 12/2021. This medication was a stock medication to be used for any resident who was receiving it. An interview with CMA #2 on 03/16/22 at 8:30 AM revealed she believed the medication carts were checked and cleaned on the night shift. CMA #2 stated she checked her stock medications and insulin pens before administering them. CMA #2 stated she did not have to administer the Loperamide Hydrocholoride (allergy medicine) to any resident so far on this shift on 03/16/22 so she missed seeing that it had expired. 2. An observation of the 200 Hall medication cart with CMA #3 on 03/16/22 at 9:10 AM revealed 1 individual packet of Loperamide Hydrochloride 2 mg on the medication cart with an expiration date of 12/2021 and 4 tablets of Omeprazole 20 mg which were not in the original box. The tablets were unopened in an aluminum package with no expiration date. The original Omeprazole box was	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 1. Corrective action for resident(s) affected by the alleged deficient practice: The Certified Medication Aide removed the expired loperamide hydrochloride 2mg and the 4 tablets of Omeprazole 20mg tabs from the medication cart and discarded it. This was completed on 03/16/2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents who receive Over the counter (OTC) medication have the potential to be affected by the alleged deficient practice. On 3/27/2022, the Nurse management team completed an audit of all current medication carts for the following: audited to ensure no OTC medication was expired or stored without its original packaging/box if expiration date was not listed on the medication. This was completed by the Nurse Management Team. 3. Measures/Systemic changes to	

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	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

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

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F 761	Continued From page 35 not on the medication cart to verify the expiration date. An interview with CMA #3 on 03/16/22 at 9:15 AM revealed the medication carts were checked one time per week, and she believed the night nurses checked them. CMA #3 stated when she was on a medication cart she would check for expired medications, make sure all insulins were dated when they were opened and any other medication that was opened has an opened date. CMA #2 stated the Omeprazole tablets must have come out of their original box and the box was thrown away. She stated she did not realize the tablets did not have an expiration date on them. CMA #2 stated she overlooked that there was an expired Loperamide Hydrochloride 2 mg. CMA #3 stated both of these medications were stock medications that were shared with all the residents, and she did not administer them so far on this shift. An interview was conducted with the Director of Nursing (DON) on 03/17/22 at 4:10 PM. The DON reported she expected the medication carts to be cleaned and checked to include checking expiration dates of all medications, checking that medications are dated when opened, and making sure there were no loose pills or spilled liquids on the cart. The DON stated each nursing staff should be checking their medications before administering the medication and the night nurses were to do a weekly check and clean on the night shift every Wednesday night.	F 761	prevent reoccurrence of alleged deficient practice: Education: On 3/18/2022, the Director of Nursing initiated the following education to all Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Medication Aides, and Medication Tech's, full time, part time, agency, and PRN staff: • Med Cart and Ensuring medications are not expired • Storing OTC medications in its original box for identification of expiration date if the expiration date is not listed on the medication. Effective 4/12/2022, any of the above identified employees who have not received this education will not be allowed to work until the training has been completed. The in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or designee will monitor compliance utilizing the F761 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved by the QA committee. The DON will monitor to ensure that the medication cart is free of expired drugs and OTC medications are stored in their original packaging as indicated. Reports will be presented to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

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

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F 761	Continued From page 36	F 761	the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 4/14/2022	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the	F 812	The statements made on this plan of	4/14/22

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	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

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

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F 812	Continued From page 37 facility failed to ensure the sanitization solution strength used in 1 of 1 three compartment sinks and in 3 of 3 red buckets used to sanitize the kitchen countertops was within the manufacturer's recommendation. This failure had the potential to affect all residents who were served food. Findings included: On 03/16/22 at 1:55 PM the water in the three-compartment sink used to sanitize cooking dishware and utensils was tested using test strips purchased from the manufacturer. The test strips did not change color as indicated on the box of the test strips. The tests were conducted by the Dietary Manager. During an interview with the Dietary Manager on 03/16/22 at 1:55 PM she stated she did not know why the water in the three compartment sink was not properly sanitized because the "146 Multi Quat" sanitizer solution was automatically added to the sink water when the water was turned on to fill the sink. She reported the (5) test strips (each submerged in the water for 90 seconds according to the manufacturer's instructions) that remained orange should have turned green indicating the water contained 200 parts per million (ppm) or greater of sanitizing solution suggested by the manufacturer. Inspection of the tubing running from the sanitizing solution (light red in color) to the sink visibly showed the solution was not moving through the tube when the water was turned on. The Dietary Manager stated she did not know why the automatic system was not working properly and would contact the supplier. She stated she tested the water for sanitization every day and the water had tested 200 ppm the	F 812	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services, a corrective action was obtained on 3/16/2022 . During initial walk through of the kitchen, it was noted dietary services had failed to test and confirm the sanitation strength of the 3 compartment sink and a sanitation bucket prior to use. The Dietary Service Director drained the sanitation compartment of the 3 compartment sink and refilled the sink manually adding sanitation solution; a test strip was used to indicate the correct ppm per manufacture recommendations prior to use. The PM cook dumped and refilled the sanitation bucket manually adding sanitation solution; ppm was confirmed to be within the manufacture recommended ppm via testing strip prior to use. Dietary staff were alerted the automatic function of the sanitation system was down and to use the manual function to obtain sanitation solution. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice.	

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	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 38 day before but she did not keep documentation of test strip results. She stated she had not checked the water that day prior to use. She confirmed the water had been used to wash dishware that day and a ladle was observed laying in the water. She stated every time the spicket was turned on sanitizer was supposed to automatically be added no matter who filled the sink. On 03/16/22 at 2:15 PM the water in three red buckets used to sanitize the kitchen countertops was tested. The test strips submerged in each bucket for 90 seconds did not turn color as indicated on the box of test strips. During an interview with Cook #1 on 03/16/22 at 2:15 PM she stated the water used in the red buckets came from the same spicket used to fill the three-compartment sink and would not contain sanitizing solution if the sink did not. She went to the three-compartment sink and manually added sanitizing solution. The water was re-tested and the test strip immediately turned green indicating the sanitizing solution was 200 ppm or greater. She concluded the test strips were working properly.	F 812	All residents have the potential to be affected by the alleged deficient practice. On 3/16/2022, the Dietary Service Director and PM cook drained and refilled the 3 compartment sink and all sanitation buckets; testing with test strips to ensure ppm was within the manufactures recommendation for use in the kitchen. On 3/16/2022 the chemical supplier was contacted and the automatic function of the sanitation system was fixed. 3. Systemic changes In-service education was provided to all full time, part time, and as needed dietary staff on 4/11/2022. Topics included: • Sanitation policies and regulations. • Using testing strips, how to read testing strips, and understanding manufactures ppm recommendations prior to use of sanitation component of the 3 compartment sink and sanitation buckets. If the automatic function of the sanitation system is noted to be broken; dietary staff are to alert the dietary manager immediately and then use the manual function of the sanitation system. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained.	

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	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 39	F 812	4. Quality Assurance monitoring procedure. The Dietary Service Director will monitor procedures for proper sanitation practices weekly x 2 weeks then monthly x 3 months using the Dietary QA Audit. The Dietary QA Audit will include monitoring and testing sanitation strength of the 3 compartment sink and sanitation buckets to confirm staff are following proper sanitation practices. Reports will be presented to the weekly Quality Assurance committee by the Dietary Service Director to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Service Director.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		4/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 40 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches	F 842		

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F 842	Continued From page 41 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility inaccurately documented the Medication Administration Record (MAR) when a Certified Medication Aide (CMA) #5 documented her initials on the MAR that an intravenous (IV) medication was administered for 1 of 1 residents reviewed for IV administration (Resident #11). Findings included: 1. Resident #11 was admitted to the facility on 01/13/20. Diagnoses included, in part, surgical amputation of left great toe and osteomyelitis (bone infection). Physician orders revealed orders were written on 02/18/22 for Cubicin (antibiotic) 500 milligrams (mg) via intravenously PICC (peripherally inserted central catheter) line every 24 hours for osteomyelitis for 6 weeks, flush PICC before and after each medication with 5 cubic centimeters (cc) of normal saline and after IV infusion flush	F 842	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F842 1. Corrective action for resident(s) affected by the alleged deficient practice: On 04/11/2022, the Director of Nursing audited the MAR (Medication Administration Record) for Resident #11 Corrections to the MAR were made on 04/12/2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 42 with 2 cc of 100 units/milliliter (u/ml) of heparin (blood thinning medication) one time a day for maintenance of PICC line, and an order to assess PICC line each shift for signs of infection. The Medication Administration Record (MAR) for March revealed on 03/14/22 the Certified Medication Aide (CMA) #5 documented her initials for the administration of the Cubicin IV antibiotic, documented her initials for flushing the PICC line before and after the antibiotic infusion, and documented her initials for assessing the PICC line every shift for signs of infection on the first shift and the second shift. An interview was conducted with CMA #5 via phone on 03/17/22. CMA #5 reported she was not trained to give any medications intravenously. She stated she was not trained to flush IV lines or assess the IV access site. CMA #5 stated she documented that she completed those tasks on the MAR on 03/14/22 because the Minimum Data Set (MDS) Nurse #2 told her to. CMA #5 stated by documenting her initials it looked as though she administered the medication, flushed the medication, and assessed the IV site. CMA #5 stated she should not have documented her initials on these orders because she did not carry out these orders, and added MDS Nurse #2 administered the medication, flushed the PICC line and assessed the IV site. An interview was conducted with Nurse #1 via phone on 03/18/22 at 9:30 AM. MDS Nurse #2 reported she was working as the charge nurse on 03/14/22. MDS Nurse #2 stated she hung the antibiotic to be administered to Resident #11, flushed the line when the antibiotic was done infusing and assessed the site before and after	F 842	All current residents on the 100/200/300/400 hall have the potential to be affected. On 04/11/2022 the Director of Nursing audited all current residents current MAR on the 100/200/300/400 halls for the past 7 days to audit for Intravenous medications documented by the Medication Aide. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 3/18/2022, the DON initiated the following education to all Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Medication Aides, full time, part time, agency, and PRN staff: • Documentation guidelines to include accurate documentation of the MAR. Effective 03/25/2022, any of the above identified employees who have not received this education will not be allowed to work until the training has been completed. The in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or designee will monitor compliance utilizing the F842 Quality Assurance Tool weekly for 2 weeks then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 43 the infusion. Nurse #1 stated she told CMA #5 that she would go ahead and document that she had given the medication, flushed the line and assessed the site and CMA #5 told her she had already signed it off. MDS Nurse #2 stated she did not tell CMA #5 to sign off those orders as being done and added she should have told CMA #5 not to document on the MAR for another nursing staff. An interview was conducted with the Director of Nursing (DON) on 03/18/22 at 10:34 AM. The DON reported that it was not within the scope of practice for CMAs to administer medications via an IV, flush an IV or assess an IV and the CMA should not have documented that she completed those tasks. The DON stated it was inaccurate documentation and the nurse who completed the tasks should be only one documenting in the MAR.	F 842	monthly x 3 months or until resolved by the QA committee. The DON will monitor to ensure that MAR documentation is accurate and Medication Aides have not signed of Intravenous Medications. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 04/14/2022	