STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345309	A. BUILDING _____ B. WING _____	C 06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY	101 CAROLINE AVENUE WELDON, NC 27890

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 6/12/23 through 6/15/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #4EHW11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/12/2023 through 6/15/2023. Event ID# 4EWH11. The following intake was investigated: NC00196666. Six of the six complaint allegations did not result in deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code an admission Minimum Data Set (MDS) in the area of anticoagulants for 1 of 16 (Resident #17) residents reviewed for MDS accuracy. Findings included: Resident #17 was admitted to the facility on 3/10/23 with diagnoses that included atrial fibrillation (an irregular heartbeat). Resident #17's admission MDS dated 3/10/23 indicated she received 7 of 7 days of an anticoagulant (a blood thinner that prevents blood clots). Review of Resident #17's physician's orders	F 641	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. 1. Corrective action for resident(s) affected by the alleged deficient practice.	6/30/23

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

Electronically Signed | 06/29/2023

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

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F 641	Continued From page 1 included an order for Clopidogrel (an anti-platelet medication that prevents blood clots) by mouth one time daily. During an interview on 6/14/23 at 1:40 PM, the MDS nurse revealed Resident #17 was on Clopidogrel. She was not aware an anti-platelet medication should not be coded as an anti-coagulant. During an interview on 6/15/23 at 11:30 AM, the Director of Nursing (DON) revealed Clopidogrel should not be coded as an anticoagulant. During an interview on 6/15/23 at 12:50 PM, the Administrator revealed that Clopidogrel should not be coded as an anticoagulant. The MDS nurse had been made aware of the issue.	F 641	MDS Nurse completed a modification for Resident #17 on 6/14/2023. MDS Nurse was given 1:1 re-education on accurate coding of anticoagulants by the Director of nursing on 6/14/2023. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Audit of most current MDS reviewed for all residents currently receiving Plavix (antiplatelet) completed on 6/15/23 by DON. One other modification completed and no further concerns identified. . 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice. MDS Nurse was given 1:1 re-education on accurate coding of anticoagulants by the Director of nursing on 6/14/2023. 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 audit medical records of residents receiving Plavix to ensure accurate coding 1 time per week for 2 weeks and then monthly for 3 months. The MDS Nurse will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard.	

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F 641	Continued From page 2	F 641	The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director, Medical Director, and the Director of Social Services.	
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 by: Based on observation and staff interviews, the	F 761	The statements made on this plan of	6/30/23

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F 761	Continued From page 3 facility failed to maintain a medication storage refrigerator within the recommended temperature range for 1 of 1 medication refrigerator reviewed (100 Hall medication storage refrigerator). Findings included: An observation of the medication storage refrigerator located in the 100 hall medication storage room was made on 6/14/23 at 11:59 AM with Nurse #1. The refrigerator thermometer was observed at 30 degrees Fahrenheit (°F). Nurse #1 viewed the refrigerator thermometer and stated it appeared to read between 30 and 32 degrees. The June 2023 temperature monitoring log for the medication storage refrigerator had been noted daily with temperatures between 38°F and 40°F. The instructions at the bottom of the monitoring log indicated "refrigerator temps must be between 36 and 46 degrees. If temps are not between these ranges all medications must be moved to a different refrigerator." The refrigerator contained: 8 Insulin aspart 100 unit pens. Insulin package instructions note to store unopened insulin in a refrigerator at 36°F to 46°F and do not freeze. 7 Insulin glargine 100 unit pens. Insulin package instructions note to store unopened insulin in a refrigerator at 36°F to 46°F and do not freeze. 6 Acetaminophen 650 milligram suppositories. The package instructions note to store at 68°F -77°F or in a cool place. 4 Tuberculin purified protein 1 milliliter vials. The package instructions note to store at 35°F -46°F	F 761	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. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 6/14/2023, the Maintenance Director placed new thermometer in medication refrigerator, DON removed all medications and placed in alternate refrigerator with noted temperature in range of 36-46 degrees Fahrenheit. DON called pharmacy for guidance, which was received and followed. Results were: medication refrigerator monitored and within 36-46 degrees Fahrenheit. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 6/14/2023, the Maintenance Director placed new thermometer in medication refrigerator, DON removed all medications and placed in alternate refrigerator with noted temperature in range of 36-46 degrees Fahrenheit. DON called pharmacy for guidance, which was received and followed. Results were: medication refrigerator monitored and	

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F 761	Continued From page 4 and do not freeze. 8 Pneumococcal 20-valent Conjugate vaccines. The package instructions note to store refrigerated at 36°F -46°F, do not freeze and discard if the vaccine has been frozen. An interview with the Administrator was conducted on 6/14/23 at 12:22 PM was conducted. The Administrator stated the refrigerator temperatures should be in the recommended range.	F 761	within 36-46 degrees Fahrenheit. The Director of Nurses verified that the refrigerator log reflected that the temperature range in medication refrigerator is to be maintained between 36-46 degrees Fahrenheit. No other concerns identified. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 6/19/2023, the Director of Nurses began education of all FT, PT, PRN and Agency Nurses, Medication Aides and the Maintenance Director. The following medication storage medication education was provided: verifying that medication refrigerator temperatures are verified daily and maintained within the required temperature range and to notify the Maintenance Director if temperatures are not maintained in the required range or any associated equipment such as refrigerator thermometers are not functioning appropriately. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training by 6/29/2023 will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that	

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F 761	Continued From page 5	F 761	specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nurses or designee will monitor medication refrigerators to assure that refrigerators temperatures are maintained within the manufacturer range for acceptable medication storage and report to the Maintenance Director if not in compliance with required temperature range. Monitoring will be completed weekly x 2 and then monthly x 3 or until resolved. Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	