		AND HUMAN SERVICES				APPROVEI 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		345496	B. WING _		08/	14/2014
NAME OF	PROVIDER OR SUPPLIER	·	·	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	COMMONS N&R AL	AMANCE		791 BOONE STATION DRIVE		
				BURLINGTON, NC 27215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 327 SS=D		ENT FLUID TO MAINTAIN	F 32	7		9/11/14
		ovide each resident with te to maintain proper hydration				
	by: Based on observa interviews with resi to provide a resider maintain hydration room and within rea (Resident #18) revi Findings included: Resident #18 was n 2/23/13. Her diagno depression, reflux, sided hemiplegia. Record review of th following: 11/11/13: Resid diet with mechanica Interventions includ every meal. 11/19/13: Resid Interventions includ water, etc, in reach 7/17/14: Resid constipation. Interv resident to drink ple Keep my water pito needed. " 8/11/14: Reside	NT is not met as evidenced tions, record review, and dent and staff the facility failed nt with sufficient fluid to by not keeping fluids in the ach for 1 of 1 resident ewed for hydration. most recently admitted on oses included diabetes, dysphagia, stroke and left he Care Plan revealed the dent #18 was on a therapeutic ally altered consistency. ded: Monitor intake and record dent #18 was at risk of falls. ded: "Keep needed items, t." ent #18 was at risk for entions included: Encourage enty of fluids each day and " ther in my reach and refill as ent #18 had a urinary tract tions included: Encourage		The statements made on thi correction are not an admission not constitute an agreement wit alleged deficiencies. To remain in compliance with a and state regulations the facility or will take the actions set forth plan of correction. The plan of of constitutes the facility s allegat compliance such that all alleged deficiencies cited have been or corrected by the dates indicated Corrective Action for Resident # Resident #18 the facility alleged provide the resident with sufficien intake to maintain proper hydra health. This was corrected on A 2014 by placing an insulated co bedside to store chilled thicken to ensure resident #18 has acc fluids as she so desires. In add cooler will be checked every sh ensure that there is an adequat thickened liquids available for h Due to her current heath condit will provide assistance by open making available the thickened containers on bedside table. Ba manufacturers recommendation	it o and do th the ll federal v has taken in this correction tion of d will be d. Affected dly failed to ent fluid tion and ugust 13, boler at ed liquids ess to ition, the ift to e supply of er use. ions, staff ing and liquid ased upon	

09/03/2014

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.

Electronically Signed

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			OMB NO.	0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · /	E SURVEY PLETED
		345496	B. WING		08/	14/2014
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, Z	IP CODE	
LIBERTY	COMMONS N&R AL	AMANCE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 327	Continued From pa	age 1	F 32	7		
	adequate fluid intal	-		thickened liquids that are	provided to the	
				resident will remain stabl	e at room	
		ritional assessment dated ne resident's daily fluid needs		temperature. The dietary provides thickened liquid		
		1900 milliliters (mls).		which consists of 840ml		
	U U			600ml for lunch and dinn	er respectively.	
		mum Data Set (MDS) dated		This amount (2040ml), e		
		esident #18 was moderately d, had clear speech, made		recommended fluid intak is ordered by the register		
		, and understood others. She		Corrective Action for Res		
	required limited as	sistance with eating and was		Affected		
		altered, therapeutic diet. She		All residents with orders		
	did not reject care.			liquids have the potential this alleged deficient practice.		
	The Dietary Review	w dated 8/7/14 indicated		were reviewed by Directo		
		on nectar thick liquids, her oral		Dietary Manager on 8/26		
		less than 1500 mls each day, I herself after set-up.		each resident who has o thickened liquids have th		
		i hersen alter set-up.		insulated cooler at bedsi		
		tion on 8/11/14 at 12:34 pm,		they have access to fluid	s as they desire.	
		s and mucous membranes		Each resident with order		
		as no water or other liquids in her room. There was a sign		liquid now have a task in the ADL grid for the certi	•	
		of her bed that stated, "No		assistance notifying then		
	water pitcher at be	dside " and indicated Resident		are at the bedside each		
	#18 required necta	r thick fluids.		Systemic Changes		
	During on interview	v on 8/11/14 at 12:34 pm, when		An in-service will be cone and 9/5/14 by the Directo		
		red the fluids she wants in		Those who will attend an		
		esident #18 indicated multiple		and CNAs, FT, PT, and I	PRN. Hospice	
		thirsty. She further indicated		providers were included		
		ater if she rings her call bell, ept in her room for her to drink		provide fluids to resident Any in-house staff memb		
		she is able to do so.		receive in-service training		
				allowed to work until train	ning has been	
		tion of the lunch meal on		completed. The in-servic		
		n, Resident #18 was observed al, asleep, with her lunch tray in		included: Providing each orders for thicken liquids		
		overbed table. There were 2		fluid intake to maintain p		

Facility ID: 960494

If continuation sheet Page 2 of 15

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	· · /	E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COM	PLETED	
		345496	B. WING		08/ [.]	14/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LIBERT	COMMONS N&R AL	AMANCE		791 BOONE STATION DRIVE BURLINGTON, NC 27215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 327	 327 Continued From page 2 containers of buttermilk and a container of thickened water, unopened, on the tray. During an observation on 8/11/14 at 1:10 pm, Nurse Aide (NA) #1 removed Resident #18 ' s meal tray. The resident remained asleep. 0% of the lunch meal, including fluids, was consumed. After the aide removed the lunch tray, including fluids, there were no fluids in the resident ' s room. During an interview with NA #1 on 8/11/14 at 1:12 pm, she indicated Resident #18 was able to eat and drink independently and she would document the amount consumed on the wall kiosk. She further indicated fluids were not kept at the resident ' s bedside. Record review of NA #1 ' s documentation of 		F 327	and health. This information has been integrates the standard orientation training a required in-service refresher court all nursing employees and will be reviewed by the Quality Assurance Process to verify that the change been sustained. Quality Assurance The Director of Nursing or Staff Development Coordinator will more issue using the "Survey QA Tool Maintaining Proper Hydration. T monitoring will include verifying the Resident #18 and all residents withickened liquids have liquids at will be reviewed. See attached more tool. This will be done daily Mon	and in the rses for be has onitor this for he hat ith bedside nonitoring		
	Resident #18 ' s lur Resident #18 consi During an observat Resident #18 did n During an observat Resident #18 did n During an observat the breakfast meal bed and 100% of th been consumed. T buttermilk containe stated she consum and she preferred t reach during the da	hch meal on 8/11/14 indicated umed "51-75%" of her meal. ion on 8/11/14 at 3:00 pm, ot have fluids in her room. ion on 8/12/14 at 4:15 pm, ot have fluids in her room. ion on 8/13/14 at 8:25 am of , Resident #18 was sitting up in he meal, including fluids had There were 2 empty 236 ml rs on her tray. Resident #18 ed her meal independently to have her fluids within her		Friday for four weeks and then w times three months or until resolv QOL/QA committee. Reports wil to the weekly Quality of Life- QA committee and corrective action as appropriate. Results of the au then be shared in the Quarterly C Meeting with the Medical Directo verification of her attendance alo all members of the QA Team and Department Heads.	ved by I be given initiated udits will QA r with ng with		

		AND HUMAN SERVICES				FORM	10/10/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345496	B. WING	i		08/	14/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LIBERTY	COMMONS N&R AL	AMANCE			91 BOONE STATION DRIVE BURLINGTON, NC 27215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 327	beg for it." She ind water or other fluids reach. There were if During an interview Nurse Supervisor # does not have thick because she likes if the nourishment roo indicated fluids are residents who are of they are able to ind indicated thickened refrigerator in the no- ' station. During an interview Director of Nursing able to eat and drin only, and are on thi- liquids at their beds indicated she was r Resident #18 shoul within her reach. During an observat Resident #18 was s was a cooler that co- her overbed table. thickened liquid in h independently drink consumed 4 ounce During an interview asked about water Resident #18 stated I can drink it myself	hardly get no water unless I icated staff does not keep is in her room or within her no fluids in her room. To 8/13/14 at 11:40 am, 1 stated, " [Resident #18] tened liquids kept in her room t cold. We just go get it out of om if she asks." She further not kept in rooms for on thickened liquids, even if ependently drink. She I liquids are kept in the ourishment room at the nurses to n 8/13/14 at 12:40 pm, the indicated residents who are k independently, or with set-up ckened liquids should have side and within their reach. She not aware of a reason Id not, and did not, have fluids ion on 8/13/14 at 2:47 pm, sitting up in her bed. There ontained thickened liquids on There was an opened her hand and she was sing without difficulty. She s of the thickened liquid. to n 8/13/14 at 2:49 pm, when on her overbed table, d, "They put water in here now. f and now I am not as thirsty."	1	327	DEFICIENCY)		
	I can drink it myself						

Facility ID: 960494

If continuation sheet Page 4 of 15

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/10/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION (E SURVEY PLETED
		345496	B. WING			08/*	14/2014
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS N&R AL	AMANCE			1 BOONE STATION DRIVE URLINGTON, NC 27215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 327	Continued From pa her reach.	ge 4	F 3	27			
	the Rehab Director, gets a quarterly nut indicated that on 10 evaluated her due t evaluation indicated	on 8/14/14 at 9:50 am with he indicated Resident #18 ritional review. He further 0/30/13 Speech Therapy o her history of stroke and the d she was at her baseline and difficulty with drinking the					
	#2 stated, "We op buttermilk for her. I days a week since a yesterday. Before t cooler bag in her ro	on 8/14/14 at 11:15 am, NA en [Resident #18 ' s] have worked with her about 3 April. I did not work with her today, she did not have the om. The kitchen would have n the nourishment room, she or water. "					
F 332 SS=E	Physician #1 stated needs the fluids bes with it." 483.25(m)(1) FREE	on 8/14/14 at 11:30 am, , " [Resident #18] definitely side her. She is usually very E OF MEDICATION ERROR MORE	F 3	32			9/11/14
		sure that it is free of tes of five percent or greater.					
	by: Based on observat review the facility fa error rate of 5% or 1	NT is not met as evidenced ion, staff interview and record iled to ensure the medication ess. There were 8 errors of 41 dent #101, #63, #102, and			The statements made on this plan of correction are not an admission to a not constitute an agreement with the alleged deficiencies.	nd do	

Facility ID: 960494

If continuation sheet Page 5 of 15

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	OMB NO.	E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		345496	B. WING _		08/1	4/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
LIBERTY	COMMONS N&R AL	AMANCE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 332	Continued From pa	ge 5	F 33	32		
		medication error rate of		To remain in compliance v and state regulations the to or will take the actions set	facility has taken	
	Findings Included:	 .		plan of correction. The pla constitutes the facility⊡s a	an of correction allegation of	
	Hypertension, Hype	iagnosis included Anemia, erlipidemia, Dementia, ssion, and Chronic Kidney		compliance such that all a deficiencies cited have be corrected by the dates ind Corrective Action for Resi	en or will be licated. dent Affected	
# L	#1 revealed she ad units (by mouth) to	50 AM an observation of Nurse ministered Vitamin D3 50,000 Resident #101. The Physician tion Administration Record		The facility allegedly failed is free of medication error percent or less. The nurse the alleged error rate of al present was removed fror	rates of five e responsible for bove five	
	(MAR) for Resident D3 50,000 units we	#101 indicated the Vitamin re ordered once every 28 days 's was due on 8/22/2014.		for a period of twelve days to 8/25/14, received a Too Improvement written notic and has been required to	s, from 8/14/14 Is for e of deficiency	
	Hypertension, Perip Hyperlipidemia, De	agnosis included Anemia, oheral Vascular Disease, mentia, Depressive Disorder,		mandatory in-servicing on pass on 8/26/14 and 8/28 by Staff Development Coo	medication /14 conducted ordinator.	
		onomic Neuropathy Disorder. t 8:58 AM an observation		Medication pass was obse by Staff Development Coo nurse received a 0% error	ordinator and	
	Depakote (seizure	announced the medication medication) was a new order d she would need to check if		Corrective Action for Resi Affected All residents who receive	2	
	the new medication with the medication	came in. Nurse #1 proceeded pass for Resident #63 which		the potential to be affected deficient practice. On 8/2	d by this alleged 8/14 the facility	
	Sulfate, Lexapro, L B12, Vitamin D3, W	, Aspirin, Claritin, Ferrous isinopril, Multivitamin, Vitamin /elbutrin, Colace, Norvasc, e, Neurontin, and artificial		has begun using electroni administration records, eli of paper MAR⊡s. All nurs PRN will be required to be	minating the use es FT, PT and	
	tears. Depakote waa administered during	as not observed being g the medication pass. hysician Orders and MAR		the Director of Nursing or Medication Administration Record (please see attack	SDC on the Observation	
	revealed Depakote was ordered on 8/8	/2014 and the order was be 250 mg by mouth twice a		the week of 9/1/14 until w and have an error rate of below or they will be remo	eek on 9/8/14 five percent or	

Facility ID: 960494

If continuation sheet Page 6 of 15

IAIEMENI	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE	SURVEY
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
		345496	B. WING			08/1	4/2014
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS N&R AL	AMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 332	Continued From pa	age 6	F 3	32			
	day dated 8/12/201	-			schedule until they can pass the		
	,				Medication Administration Observat		
		2:30 PM an observation was			Record with a score of less than five	е	
		#63 ' s MAR and indicated the by mouth was administered.			percent. Systemic Changes		
		ure initials were in the box for			An in-service will be conducted on §	9/4/14	
	the 9:00 AM medic				and 9/5/14 by the Director of Nursin		
	On 8/12/2014 at 12	20 DM during on interview			Those who will attend are all RNs, L		
		2:30 PM during an interview ed to identify if she followed up			FT, PT, and PRN. Hospice provider not included because they do not pr		
		esident #63. Nurse #1 pulled a			medication administration in the fac		
		e medication cart for Resident			Any in-house staff member who did		
		roex (generic for Depakote)			receive in-service training will not be		
		8/8/2014. When asked if pakote Nurse #1 's response			allowed to work until training has be completed. The in-service topics	en	
		osest thing to it " Nurse #1			included: Proper Medication		
		administering two Divalproex			Administration per facility and comp		
		to Resident #63 at the 9:00			policy and State and Federal Guide This information has been integrate		
		ss. Nurse #1 reported her the MAR indicated that she			the standard orientation training and		
		on so she must have given it.			required in-service refresher course		
	-				all licensed personal and will be rev		
		t 9:20 AM an observation of she verbalized and			by the Quality Assurance Process to that the change has been sustained		
		nin B12 500 to Resident #63.			Quality Assurance	1.	
		nysician Order and MAR			The Director of Nursing or Staff		
		of Vitamin B12 250 mcg by			Development Coordinator will monit		
	mouth one time a c	day.			issue using the "Survey QA Tool for Medication Administration". The		
	2c. on 8/13/2014 a	t 9:20 AM an observation of			monitoring will include verifying prop	ber	
	Nurse #1 revealed	she administered Vitamin D3			technique and ability to follow prope	er	
		outh). The Physician orders			policy for Medication Administration		
		lent #63 indicated the Vitamin ere ordered once every 30 days			attached monitoring tool. This will b done daily for 2 nurses per day, 50%		
		s was due on $8/22/2014$.			nursing staff each week for 2 weeks		
					cover 100% of all nurses. This will b	be	
	3) Resident #102 d				done weekly for 4 months or until re		
	Hypertension, Peril	pheral Vascular Disease,	1	ļ	by QOL/QA committee. Reports will	li be	

Facility ID: 960494

If continuation sheet Page 7 of 15

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	IPLETED
		345496	B. WING		08/	14/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERT	COMMONS N&R AL	AMANCE		791 BOONE STATION DRIVE BURLINGTON, NC 27215		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 332	 3a. on 8/13/2014 a revealed Nurse #1 (cardiac medication Resident #102 with s pulse rate or bloc Physician order for give 12.5 mg by me heart rate < 60 or s Resident # 102 ' s pressure and heart observed assessin blood pressure or r from fellow staff me 3b. on 8/13/2014 a Nurse #1 revealed 50,000 units (by me Physician order for Vitamin D3-50 50,0 one cap by mouth the 16th start day of MAR for August 20 physician order but the month except of nurse to administer 16th day. 4) Resident #136 of Fracture and Demo 4a. on 8/13/2014 a revealed Nurse #1 medications were t attempted to releas s stool softener (Do 	and Chronic Kidney Disease. t 10:08 AM an observation administered Metoprolol n) 12.5 mg by mouth to nout assessing Resident #102 ' od pressure. Resident #102 's Metoprolol read as Metoprolol outh two times a day, hold for systolic blood pressure <100. MAR included to check blood t rate daily. Nurse #1 was not g resident #102 's pulse and retrieving the numerical values embers. t 10:08 AM an observation of she administered Vitamin D3 outh) to Resident #102. The Resident #102 indicated the 200 units were ordered as give one time a day and ending on of 5/20/2014. Resident #102 's 14 indicated the same t had marked out all days of one day 8/16/2014 for the r a dose once a month on the	F 33	2 committee and corrective action as appropriate. Results of the au then be shared in the Quarterly O Meeting with the Medical Directo verification of her attendance alo all members of the QA Team and Department Heads	udits will QA r with ng with	

If continuation sheet Page 8 of 15

		AND HUMAN SERVICES				FORM	10/10/2014 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED
		345496	B. WING			08/ [.]	14/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS N&R AL	AMANCE			91 BOONE STATION DRIVE BURLINGTON, NC 27215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 332 F 431 SS=D	circled her signature medication was not be okay if the reside 4b. on 8/13/2014 at revealed Nurse #1 of (diabetic medication medication pass bu signature initial that administered to Res Nurse #1 was unab stock card she with Glipizide from. The Glipizide from. The Glipizide 5 mg by m twice a day and the at 5:00 PM. On 8/13/2014 at 12 Nurse #1 when ask #136 ' s Glipizide w #1 had no response 483.60(b), (d), (e) D LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in s accurate reconciliat reconciled. Drugs and biologica labeled in accordan professional princip appropriate access	e initial indicating the administered stating it would ent went without one dose. 12:00 PM an observation did not administer Glipizide n) to Resident # 136 during the t indicated on the MAR with the medication Glipizide was sident #136 at 12:15 PM. le to locate the medication drew Resident #136 ' s Physician Order indicated the nouth was to be administered second dose was scheduled :30 PM during an interview ed about signing off Resident ithout administering it Nurse e. DRUG RECORDS, UGS & BIOLOGICALS hploy or obtain the services of cist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug r and that an account of all maintained and periodically	F 3	131			9/11/14

Facility ID: 960494

If continuation sheet Page 9 of 15

		AND HUMAN SERVICES			FORM	: 10/10/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		345496	B. WING		08	/14/2014
NAME OF	PROVIDER OR SUPPLIER		ſ	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
LIBERTY	COMMONS N&R AL	AMANCE			91 BOONE STATION DRIVE SURLINGTON, NC 27215	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From pa applicable.	ge 9	F 4	31		
	facility must store a locked compartmer	State and Federal laws, the Il drugs and biologicals in hts under proper temperature t only authorized personnel to keys.				
	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distri	ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can				
	by: Based on observation interview the facility resident medication (Residents #101 and medication pass. The facility policy for Administration inclue During administration cart is k out of sight of the modications are kee 1. Resident #101 di Hypertension, Hyper	NT is not met as evidenced tion, record review and staff of failed to properly store as for 2 of 4 residents ad #63) observed during or Preparation of Medication uded: (read in part) tration of medication, the tept closed and locked when nedication nurse. No pt on top of the cart. tagnoses included Anemia, erlipidemia, Dementia, ssion, and Chronic Kidney			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 taker or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Resident Affected Resident # 101 and #63 the facility allegedly failed to properly store resident medications during the medication pass.	1

Facility ID: 960494

If continuation sheet Page 10 of 15

		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	E SURVEY PLETED
		345496	B. WING		08/1	14/2014
NAME OF	PROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERT	COMMONS N&R AL	AMANCE		791 BOONE STATION DRIVE BURLINGTON, NC 27215		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 431	Continued From pa	age 10	F 431			
	Record review of F Administration Rec through 8/31/2014 medications includ Packet 4 Gm (gran (milligrams); Norva 500 mcg (microgra On 8/13/2014 at 8: leaving the Medica a stock bottle of As medications Chole Norvasc, Vitamin E AM medication pas Nurse #1 was awa On 8/13/2014 at 8: the medication car medication pass. 2. Resident #63 dia Hypertension, Peri Hyperlipidemia, De and Peripheral Auto Record review of F 8/1/2014 through 8 and 9:00 AM medic mg; Aspirin 81 mg; 15 mg. On 8/13/2014 at 9: leaving the Medica medication pass to Claritin. Resident #	Resident #101 ' s Medication ford (MAR) for 8/1/2014 revealed her 9:00 AM ed Cholestyramine Light ns); Metoprolol 12.5 mg usc 2.5 mg; and Vitamin B12 ms). 46 AM Nurse #1 was observed tion Cart unattended to retrieve spirin. Resident # 101 ' s pulled styramine, Metoprolol, 812, and Vitamin D for the 9:00 as on top of the cart while		8/13/14 by the Director of Nursi leave medication on top of the r unattended and if a pill is dropp floor to dispose of it immediatel trash can or sharps container. Corrective Action for Resident F Affected All residents who receive medic the potential to be affected by th deficient practice. All nurses F ⁻ PRN will be required to be revise the Director of Nursing or desig Medication Administration Obse Record (please see attached) b the week of 9/1/14 until week of which entails the proper way to drugs and biologicals in locked compartments and permit only personal to have access to the the proper way to dispose of a r that was dropped on the floor. Systemic Changes An in-service will be conducted and 9/5/14 by the Director of Nu Those who will attend are all Rt FT, PT, and PRN. Hospice prov not included because they do n medication administration in the Any in-house staff member who receive in-service training will n allowed to work until training ha completed. The in-service topic included: Proper Medication Administration per facility and c policy and State and Federal G This information has been integ the standard orientation training	ned cart ed on the y in the Potentially ation have his alleged F, PT and eved by nee on the ervation reginning n 9/8/14 store all authorized keys and medication on 9/4/14 ursing. Ns, LPNs, viders were ot provide e facility. o did not ot be s been cs ompany uidelines. irated into	

Facility ID: 960494

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED	
		345496	B. WING _		08/	14/2014	
NAME OF	PROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY, STATE, ZIP CO		14/2014	
LIBERT	COMMONS N&R AL	AMANCE		791 BOONE STATION DRIVE BURLINGTON, NC 27215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 431 F 514 SS=D	On 8/13/2014 at 9:0 observed returning On 8/13/2014 at 9: observed leaving a Lisinopril (heart me dropped on the floo for Resident #63 or while she entered F complete the medic On 8/13/2014 at 9: returning to the me dropped medication On 8/13/2014 at 2: Director of Nursing expectation was for cart to keep her eye times. The facility te medications in the I you. 483.75(I)(1) RES RECORDS-COMPL LE The facility must ma resident in accorda standards and prace accurately docume systematically orga	 D7: AM Nurse #1 was to the medication cart. 28 AM Nurse #1 was single pill identified as dication) that had been or during the medication pass in top of the medication cart Resident #63 ' s room to cation pass. 30 AM Nurse #1 was observed dication cart and disposing the in to the trash container. 32 PM an interview with the (DON) revealed her the nurse on the medication es on pulled medications at all eaches to put the pulled locked cart or take them with LETE/ACCURATE/ACCESSIB anitain clinical records on each nice with accepted professional tices that are complete; and 		by the Quality Assurance Pro- that the change has been su Quality Assurance The Director of Nursing or de- monitor this issue using the Tool for Medication Administ monitoring will include verify technique and ability to follow policy for Medication Adminis attached monitoring tool. The done daily for 2 nurses per of nursing staff each week for 2 cover 100% of all nurses. The done weekly for 4 months or by QOL/QA committee. Re given to the weekly Quality of committee and corrective act as appropriate. Results of the then be shared in the Quartee Meeting with the Medical Dir verification of her attendance all members of the QA Team Department Heads.	esignee will "Survey QA ration". The ing proper w proper stration. See is will be lay, 50% of 2 weeks to is will be until resolved ports will be of Life- QA tion initiated ne audits will erly QA ector with e along with		

If continuation sheet Page 12 of 15

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-039 (X3) DATE SURVEY	
ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 345496		A. BUILDING		· · /	COMPLETED	
				08/14/2014		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	DDE	
LIBERTY	COMMONS N&R AL	AMANCE		791 BOONE STATION DRIVE BURLINGTON, NC 27215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 514	Continued From page 12 and progress notes.		F 51	4		
	 by: Based on observative review the facility farmedications for 2 or and #102) directly and #102) directly and #102) directly and #102) directly for Administration inclution. The individual with the individual with the resident 's MAF is given. 1) Record review of Administration Record review of Administration Record for (grams) by more 12.5 mg (milligrams). Norvasc 2.5 mg by Vitamin B12 500 m times a day; Amantatimes a day; Ecotripative two times a day; and two times a day. On 8/13/2014 at 8:5 completing a medication and the fact that a fact the fact the fact that the fact the fact that the fact the fact that t	NT is not met as evidenced ion, staff interview, and record illed to record administered f 4 residents (Resident #101 after the medication was given. or Preparation of Medication ided: (read in part) who administered the cords the administration on R directly after the medication ord (MAR) for 8/1/2014 included the 9:00 AM olestyramine Light Packet 4 uth one time a day; Metoprolol s) by mouth one time a day; mouth one time a day; cg (micrograms) by mouth one dine 100 mg by mouth two n (aspirin) 325 mg by mouth d Tylenol 650 mg by mouth 50 AM Nurse #1 was observed cation pass on Resident #101. cluded Cholestyramine Light		The statements made on the correction are not an admission not constitute an agreement with a langed deficiencies. To remain in compliance with a and state regulations the facilities or will take the actions set forther plan of correction. The plan of constitutes the facility is allegat compliance such that all alleged deficiencies cited have been on corrected by the dates indicate Corrective Action for Resident # 101 and #102 the fat allegedly failed to record admir medications directly after the medications directly after the medication after they are a to the resident. Corrective Action for Resident Affected All residents who receive medit the potential to be affected by the deficient practice. On 8/28/14 has begun using electronic me administration records, elimination after the sum of paper MAR is. The electric	n to and do th the all federal y has taken in this correction tion of d will be d. Affected acility histered hedication hediately Director of ign out for dministered Potentially cation have his alleged the facility dication ting the use	

Facility ID: 960494

	-	AND HUMAN SERVICES			OMB NO.	APPROVE 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED	
	345496		B. WING		08/1	08/14/2014	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	IP CODE		
LIBERTY COMMONS N&R ALAMANCE			791 BOONE STATION DRIVE BURLINGTON, NC 27215				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	D BE COMPLÉTIO	
 PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 13 medication pass without placing a signature i next to the medications administered to Reside #101. A record review of Resident #101 's MAR revealed Nurse #1 initialed that she administe Amitriptyline HCL (antidepressant) 25 mg. Th medication was ordered at bedtime and she vent observed administering the medication dut the 9:00 AM observation of medication pass. 2) Record review of Resident #102 's MAR for 8/1/2014 through 8/31/2014 included the 8:00 and 9:00 AM medications as Aspirin 81 mg b mouth in the morning; Ferrous Gluconate 328 by mouth one time a day; Glucotrol 2.5 mg by mouth one time a day; Glucotrol 2.5 mg by mouth one time a day; Miraplex 0.125 mg by mouth time a day; Norvasc 10 mg by mouth in the morning; Selegiline 5mg by mouth in the morning; Selegiline 5mg by mouth two times a day; Metoprolol 12.5 mg by mouth two times a day; Senna S 8.6-50 mg by mouth two times a day; Senna S 8.6-50 mg by mouth two times a day; Tylenol 325 mg 2 tabs by mouth two times a day; and Sinement 25-100 mg by mouth 4 tin a day. On 8/13/2014 at 10:08 AM Nurse #1 was 		thout placing a signature initial ions administered to Resident Resident #101 ' s MAR initialed that she administered antidepressant) 25 mg. The lered at bedtime and she was histering the medication during vation of medication pass. f Resident #102 ' s MAR for /31/2014 included the 8:00 AM cations as Aspirin 81 mg by ng; Ferrous Gluconate 325 mg a day; Glucotrol 2.5 mg by lay; Lisinopril 40 mg by mouth raplex 0.125 mg by mouth one c 10 mg by mouth in the 5 mg by mouth in the morning; mouth two times a day; by mouth two times a day; g by mouth two times a day;	F 51	4 the Director of Nursing of Development Coordinato Medication Administration Record (please see attact the week of 9/1/14 until v which entails the proper for medication immediate administered. Systemic Changes An in-service will be cond and 9/5/14 by the Directo Those who will attend are FT, PT, and PRN. Hospid not included because the medication administration Any in-house staff memb receive in-service training allowed to work until trair completed. The in-servic included: Proper Medicat Administration per facility policy and State and Fed This information has bee the standard orientation f required in-service refres all licensed personal and by the Quality Assurance that the change has beer Quality Assurance	or on the n Observation ched) beginning veek on 9/8/14 way to sign out ely after it is ducted on 9/4/14 or of Nursing. e all RNs, LPNs, ce providers were ey do not provide n in the facility. ver who did not g will not be ning has been be topics tion v and company eral Guidelines. n integrated into training and in the sher courses for will be reviewed Process to verify		
	observed completir placing a signature administered to Re included Aspirin, Vi Glucotrol, Lisinopril Colace, Metoperol, Artificial Tears and	ng a medication pass with out initial next to the medications sident #102. The medications tamin D3, Ferrous Gluconate, Mirapex, Norvasc, Selegline, Neurontin, Senna, Tylenol,		The Director of Nursing of Development Coordinato this issue using the "Surv Medication Administration monitoring will include ver technique and ability to for policy for Medication Administration attached monitoring tool. done daily for 2 nurses p nursing staff each week	or will monitor vey QA Tool for n". The prifying proper ollow proper ninistration. See This will be er day, 50% of		

Facility ID: 960494

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345496		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			0MB NO. 0938-039 (X3) DATE SURVEY COMPLETED 08/14/2014	
LIBERTY COMMONS N&R ALAMANCE						
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 514	revealed her plan medications she a the medication pas On 8/13/2014 at 2 Director of Nursing expectation was for	dent #102 ' s medications was to not sign off the dministered directly following ss but at a later time. :32 PM an interview with the g (DON) revealed her or nurses passing medications medication as administered	F 51	4 cover 100% of all nurses. This wi done weekly for 4 months or until by QOL/QA committee. Reports w given to the weekly Quality of Life committee and corrective action i as appropriate. Results of the au then be shared in the Quarterly C Meeting with the Medical Director verification of her attendance alor all members of the QA Team and Department Heads.	resolved vill be - QA nitiated dits will A with	

Facility ID: 960494

If continuation sheet Page 15 of 15