DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURVEY COMPLETED
		345468	B. WING		C 01/19/2018
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE	
LIBERTY	COMMONS REHABILITA	TION CENTER		I RACINE DRIVE LMINGTON, NC 28403	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 000	INITIAL COMMENTS		F 000		
	No deficiencies were complaint investigation event ID K9FT11.	e cited as a result of on survey on 1/19/18 for			
F 550 SS=D			F 550		2/16/18
	self-determination, an access to persons an	Rights. ght to a dignified existence, nd communication with and d services inside and cluding those specified in			
	with respect and dign resident in a manner promotes maintenance	and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and			
	access to quality care severity of condition, must establish and m practices regarding tr	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.			
		right to exercise his or her f the facility and as a citizen			
	resident can exercise	cility must ensure that the his or her rights without h, discrimination, or reprisal			
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE
Electroni	cally Signed				02/10/2018

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.

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				FOF OMB N	ED: 02/21/201 RM APPROVEI IO. 0938-039
	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:		· /			(X3) DATE SURVEY COMPLETED C	
		345468	B. WING			0	1/19/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	COMMONS REHABILITA			12	21 RACINE DRIVE		
				N	VILMINGTON, NC 28403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Continued From page	e 1	F	550			
	from the facility.						
	free of interference, of reprisal from the facil rights and to be supp exercise of his or her subpart. This REQUIREMENT by: Based on record rev interviews, the facility dignified manner by f doors or ask permiss 13 residents (Residen Findings included: 1-Record review reve admitted to the facility diagnoses which inclu- and Hypertension.	sident has the right to be coercion, discrimination, and ity in exercising his or her orted by the facility in the rights as required under this ⁻ is not met as evidenced iew, observations and staff failed to maintain care in a ailing to knock on resident's ion to enter rooms for 2 of nt #26 and Resident #15). ealed Resident #26 was y on 5/14/2013 with uded Parkinson's Disease			The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all feder and state regulations the facility has t or will take the actions set forth in this plan of correction. The plan of correct constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F550 1. Plan for correcting specific deficiencies	ral aken ion	
	11/11/2017 indicated moderately cognitivel				The process that led to deficiency cite The facility failed to maintain care in a dignified manner by failing to knock o	ed. a n	
	8:30AM, 9:50AM, 10: Nursing Assistant (N4 #26's room without kr	onducted on 1/18/2018 at 20AM and 11:30AM of A) #1 entering Resident nocking, announcing ermission to enter the room.			residents doors or ask permission to e rooms for 2 of 13 residents. The facility administrator and resident have the expectation that all employe must knock on the resident's door and ask permission prior to entering the ro	s es d	
	1/18/2018 at 2:30PM of the need to knock	ducted with NA #1 on . NA #1 indicated awareness prior to entering residents' he must have forgotten to			2. Procedure for implementing the acceptable plan of correction.		

Facility ID: 943308

					FOR	D: 02/21/2018 M APPROVED D. 0938-0391
F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
	345468	B. WING _				C / 19/2018
OVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
OMMONS REHABILITA	TION CENTER					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
knock. An interview was com Nursing (DON) on 1/1 DON stated the exper- knock prior to entering 2-Record review reve admitted to the facility which included Conge Chronic Kidney Disea Review of the most re Minimum Data Set (M dated 10/19/2017 rev moderately cognitivel extensive assistance Living (ADLs). Observations were co 8:30AM, 9:50AM, 10: Nursing Assistant (N# #15's room without kr entrance or asking per An interview was con 1/18/2018 at 2:30PM. of the need to knock p rooms. NA #1 stated knock. An interview was con Nursing (DON) on 1/1 DON stated the exper-	ducted with the Director of 18/2018 at 2:43PM. The ctation was for all staff to g residents' rooms. aled Resident #15 was y on 4/5/2012 with diagnoses estive Heart Failure and ase. ecent comprehensive IDS) for a significant change ealed Resident #15 was y impaired and required with all his Activities of Daily onducted on 1/18/2018 at 20AM and 11:30AM of A) #1 entering Resident hocking, announcing ermission to enter the room. ducted with NA #1 on . NA #1 indicated awareness prior to entering residents' he must have forgotten to ducted with the Director of 18/2018 at 2:43PM. The ctation was for all staff to	F	550	 On 02/08/2018 an in-service education was begun to all full time, part time, a as needed staff. Topics included: All staff must knock on a resident door prior to entering the room even in door is open. All staff must ask permission prior entering the resident's room. This information has been integrated the standard orientation training and in required in-service refresher courses all staff and will be reviewed by the Q Assurance process to verify that the change has been sustained. Monitoring Procedure to ensure the plan of correction is effective and specific deficiency cited remains correction in compliance with regulatory requirements. The Assistant Unit Manger or designed will monitor procedures for resident's rights weekly x 2 weeks then monthly months using the Residents rights/pri Quality Assurance monitor. Monitoring include auditing staff for knocking and asking permission to enter a resident' room prior to entering. Reports will be presented to the weekly Quality Assurance will be monitared as appropriate. Compliance will be monitared as appropriate. 	nd f's f the r to into n the for uality hat that ected ee x 3 vacy g will s trator s tored ed at g.	
	S FOR MEDICARE & F DEFICIENCIES CORRECTION OVIDER OR SUPPLIER OMMONS REHABILITA SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page knock. An interview was con Nursing (DON) on 1/ ² DON stated the expe knock prior to enterim 2-Record review reve admitted to the facility which included Conge Chronic Kidney Disea Review of the most re Minimum Data Set (M dated 10/19/2017 rev moderately cognitivel extensive assistance Living (ADLs). Observations were co 8:30AM, 9:50AM, 10: Nursing Assistant (N/ #15's room without kr entrance or asking pe An interview was con 1/18/2018 at 2:30PM of the need to knock rooms. NA #1 stated knock. An interview was con Nursing (DON) on 1/ ² DON stated the expe	CORRECTION IDENTIFICATION NUMBER: 345468 OMMONS REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 knock. An interview was conducted with the Director of Nursing (DON) on 1/18/2018 at 2:43PM. The DON stated the expectation was for all staff to knock prior to entering residents' rooms. 2-Record review revealed Resident #15 was admitted to the facility on 4/5/2012 with diagnoses which included Congestive Heart Failure and Chronic Kidney Disease. Review of the most recent comprehensive Minimum Data Set (MDS) for a significant change dated 10/19/2017 revealed Resident #15 was moderately cognitively impaired and required extensive assistance with all his Activities of Daily Living (ADLs). Observations were conducted on 1/18/2018 at 8:30AM, 9:50AM, 10:20AM and 11:30AM of Nursing Assistant (NA) #1 entering Resident #15's room without knocking, announcing entrance or asking permission to enter the room. An interview was conducted with NA #1 on 1/18/2018 at 2:30PM. NA #1 indicated awareness of the need to knock prior to entering residents' rooms. NA #1 stated he must have forgotten to	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 345468 OWIDER OR SUPPLIER 345468 B. WING	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A BUILDING_ 345468 OWIDER OR SUPPLIER 345468 B. WING	SPOR MEDICARE & MEDICAID SERVICES DEFICIENCIES CONSERCTION (x) PROVIDERSUPPLIERCIA IDENTIFICATION NUMBER OWDER OR SUPPLIER OMMONS REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 knock. An interview was conducted with the Director of Nursing (DON) on 11/8/2018 at 2:43PM. The DON stated the expectation was for all staff to knock prior to entering residents' rooms. 2-Record review revealed Resident #15 was admitted to the facility on 4/5/2012 with diagnoses which included Congestive Heart Failure and Chronic Kidney Disease. 2-Record review revealed Resident #15 was admitted to the facility on 4/5/2012 with diagnoses which included Congestive Heart Failure and Chronic Kidney Disease. 2-Record review revealed Resident #15 was admitted to the facility on 4/5/2012 with diagnoses which include Congestive Heart Failure and Chronic Kidney Disease. 8. 30AM, 9:50AM, 10:20AM and 11:30AM of Nursing Assistant (NA) #1 entering Resident #15's room without knocking, announcing entrance or asking permission to enter fre room. An interview was conducted with NA #1 on 1/18/2018 at 2:30PM. NA #1 indicated awareness of the need to knock prior to entering residents' room xNA #1 stated he must have forgotten to knock. 3. Monitoring Procedure to ensure 1 the plan of correction is effective and specific difficiency cited remains corre and/or in compliance with reguiatory requirements. Norsin	TENT OF HEALTH AND HUMAN SERVICES FOR FOR MEDICARE & MEDICALD SERVICES ONB NO CORRECTION (X1) PROVIDERSUMPLEMENTA (X2) MULTIPLE CONSTRUCTION (X2) MULT

Event ID: K9FT11

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/21/2018 FORM APPROVED OMB NO. 0938-039
			, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345468	B. WING		C 01/19/2018
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
LIBERTY	COMMONS REHABILITA	TION CENTER		21 RACINE DRIVE VILMINGTON, NC 28403	
(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 APP DEFICIENCY)	OULD BE COMPLETION
F 550	Continued From page	2.3	F 550	 Health Information Manager, and Dietary Manager. 4. The title of the person responsible implementing the plan of correction The Administrator is responsible to implementation and completion of acceptable plan of correction. 	nsible for on. for
F 584 SS=E	CFR(s): 483.10(i)(1)-(§483.10(i) Safe Environ The resident has a rig comfortable and home but not limited to rece supports for daily livin The facility must prov §483.10(i)(1) A safe, a homelike environment use his or her persona possible. (i) This includes ensure receive care and serve physical layout of the independence and do (ii) The facility shall ex- the protection of the roor theft. §483.10(i)(2) Housek	onment. what to a safe, clean, elike environment, including iving treatment and ig safely. ide- clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can ices safely and that the facility maximizes resident the sources of the extent estimation of the safety risk. A constraints of the safety risk. A constraint of th	F 584		2/16/18
	§483.10(i)(3) Clean b in good condition; §483.10(i)(4) Private	ed and bath linens that are closet space in each			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/21/2018 /I APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345468	B. WING				
	ROVIDER OR SUPPLIER	TION CENTER	1	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 21 RACINE DRIVE VILMINGTON, NC 28403	<u> </u>	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 584	§483.10(i)(5) Adequate levels in all areas; §483.10(i)(6) Comfor- levels. Facilities initia 1990 must maintain a 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observation interviews and record maintain a safe environ- monitoring and maint temperatures at or be of 10 bathrooms check temperatures (rooms 412, 405) over 3 halls Findings included: A review of the medic #28 was admitted 9/2 stroke, epilepsy, anxi- day Minimum Data S- noted the resident to needed extensive ass Daily Living with the p- persons. On 1/16/2018 at 3:10 bathroom of Residem hot. At 3:35 PM the M- checked the hot water bathroom sink with hi	ecified in §483.90 (e)(2)(iv); te and comfortable lighting table and safe temperature lly certified after October 1, a temperature range of 71 to maintenance of comfortable is not met as evidenced n, staff and resident review, the facility failed to onment for residents by not aining hot water elow 116 Fahrenheit (F) in 7 cked for hot water 103, 202, 204, 205, 212, s. cal record revealed Resident t2/2017 with diagnoses of ety and depression. The 14 et (MDS) date 10/6/2017 be cognitively intact and sistance for all Activities of ohysical help of one to two PM, the hot water in the t #28 was found to be very faintenance Director	F	584	F584 1. Plan for correcting specific deficie The process that led to deficiency citer The facility failed to maintain safe hot water temperature at or below 116 degrees F in 7 of 10 bathrooms. On 01/17/2018 the maintenance direct was in the process of correcting the hot water temperature when it was discover to be greater than 116 degrees F. The Maintenance Director was able to adjuding the hot water temperatures to below 1 degrees F. On 01/18/2018 the maintenance director adjusted the hot water temperature to below 116 degree F. The Director of Nursing began in-servicing all nurses and nurse aidest test water on their wrist prior to using the water and in-service dalert residents to turn on both hot and cold water at the same time. In-service education will be completed by 02/16/2018.	d. tor ot ered ist 16 es s to the o	

Facility ID: 943308

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	-	ID HUMAN SERVICES				FOR	D: 02/21/20 [,] M APPROVE <u>D. 0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		345468	B. WING			01	/19/2018
NAME OF PI	ROVIDER OR SUPPLIER		1	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	•	
LIBERTY COMMONS REHABILITATION CENTER				RACINE DRIVE			
			WIL	MINGTON, NC 28403			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 584	Continued From page	e 5	F 5	584			
		been dealing with this for a					
		nce Director stated he takes			2. Procedure for implementing the		
		n a few rooms on each hall			acceptable plan of correction.		
	every week and had				n-service education was provided to		
	-	100 hall. The Maintenance			Maintenance Director on 1/18/2018 b	by the	
		was going to lower the		4	Administrator. Topics included:		
	temperature of the wa	ater and left the room.		•		•	
	0 4/40/0040 -+ 4:00				and entered into TELS Team Electro		
		PM the bathroom sink hecked in other rooms and			Library System (Building Managem	ent	
		1 212 was 118 F. Room 205			System for Senior Living) Always follow the manufacturer		
	was 132 F. Room 20				guidelines for calibration to ensure		
					accurate readings		
	On 1/16/2018 at 4:12	PM the bathroom sink		•	To test water: Use a hand		
	temperatures were cl	necked as follows: Room		t	hermometer, turn on hot water fauce	et and	
	202 was 130 F. Roor	n 412 was 140 F. Room 405			hold thermometer under water for 30		
	was 128 F.				seconds, read and record temperatu	re	
				6	and turn off faucet		
		PM the Maintenance		• r	If water registers above 116 deg		
		temperature of the hot water hroom with his calibrated			⁻ then adjust the temperature until th correct measurements are obtained.	le	
	thermometer and it w				Document your corrective action	is and	
				l r	e-measurement.		
	On 1/17/2018 at 9:30	AM, the hot water in		•			
		room was noted to be very		t	emperature to less than 116 degree	s F	
		e Director was paged to			hen notify staff and alert residents n	ot to	
	check the actual wate				use the affected area and notify the		
		r checked the temperature at			administration. Corrective action sho	uld	
		F. The Maintenance Director			be initiated immediately. Document		
		re was a little low and he			n-service to staff and obtain signatur Notify the administrator of all rea		
	was still dealing with			•	hat are above 116 degrees F.	ungs	
	 On 1/17/2018 at 11⋅0	0 AM NA #1 was interviewed		'	המנ מופ מסטיפ דוס עכעוככא ר.		
	and stated she had for			(On 02/08/2018 the Director of Nursin	a	
		resident's bathrooms. NA			began In-service education to all full	-	
		careful about running the			part time, and as needed staff nurses		
	hot water.	C C			nurse aides on how to test water for		
					emperature for resident and staff sa	fety.	
	On 1/18/2018 at 10:4	8 AM the Maintenance		E	Education will be completed by		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/21/2 FORM APPRO OMB NO. 0938-0
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		(X3) DATE SURVEY COMPLETED C
		345468	B. WING		01/19/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	DE
	COMMONS REHABILITA			121 RACINE DRIVE	
				WILMINGTON, NC 28403	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETI E APPROPRIATE DATE
F 584	Continued From page	<u>- 6</u>	F 584	1	
		hot water in Resident #28's	1 30-	02/16/2018.	
				Topics included:	
	On 1/19/2018 at 9:55	AM, in an interview, the		Testing water on the inner arr	n before
	Maintenance Director	r stated when he checked		using it on a patient is the pro	oper way to
		/16/2018 in Resident #28's		test the temperature. If it fee	
		adjust the temperatures for		turns your skin red then do no	
		Maintenance Director anyone, nor did he shut off		the patient and notify the mai staff immediately by contactir	
		e was working on it. The		directly if they are in the facili	
		r also said that he had been		after hours by paging them.	-
		er and the meter for a week		able to contact maintenance	-
		gh temperature, and the		your nurse on call for further	
		vare of a problem with the		The following procedure is to	
	meter.			for testing hot water temperat	-
	In an interview, on 1/	19/2018 at 10:55 AM, the		hand prior and during patient whirlpools or using sinks.	snowening,
		stated when he found out		1. Turn water in desired loc	ation on.
	•	g too hot, the staff were		Allow water to run 3 minutes	
	-	ding water that was too hot.		testing with hand. Note: While	-
	When asked for the c			water to run, you can use this	s time to
		inistrator stated it was not a		gather supplies, etc.	
		staff signatures, the staff		2. Note if there is any stear	
		ursing Assistants (NAs)and I check the water and if it		After 3 minutes, place your w arm under the flow of water for	
	was too hot to notify t			seconds and test the tempera	
	Administrator noted t	•		water. If the temperature is in	
		ot to turn on the hot water		use the thermometer (located	
	only. The Administrat			nurses station) supplied to te	
		would be done daily until two		temp. Do this by placing the t	
	-	v acceptable temperatures		under the flow of water and w	
		Administrator stated his water temperatures would be		than 116 degrees F., then no	
	safe.			maintenance and your nurse	
				Do not use the water.	
		8 AM, NA #2 stated he had		3. Proceed with the bath if	after the hand
		and 1/17/2018, but had not		or thermometer test is comple	
		bout being careful with the		temperature is safe. Note: Wi	0 0
	hot water.			shower, you are to periodical	ly do the

Facility ID: 943308

	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/21/2018 MAPPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345468	B. WING			01	C / 19/2018
	ROVIDER OR SUPPLIER	TION CENTER		12	REET ADDRESS, CITY, STATE, ZIP CODE 1 RACINE DRIVE ILMINGTON, NC 28403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 584	been told to be carefu was very hot to notify On 1/19/2018 at 11:1	1 AM, NA #3 stated he had JI with the hot water and if it	F	584	hand test throughout the shower. Example: If giving a 3-minute showe should recheck the water by doing th hand test approximately half way thr 4. When giving a whirlpool, do the test, fill the whirlpool up, then do the test again prior to placing the patient the water. This information has been integrated the standard orientation training and required in-service refresher courses all Maintenance Directors and all nur staff and will be reviewed by the Qua Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure the plan of correction is effective and specific deficiency cited remains corr and/or in compliance with regulatory requirements. Daily 01/17/2018 thru 01/31/208 the maintenance director tested hot wate temperatures to ensure compliance. Administrator will monitor TELS Tear Electronic Library System (Building Management System for Senior Livin weekly for 2 weeks and monthly for months for recording of water temperatures are noted >116 degr Any negative findings will immediate addressed. In addition to this, the administrator will randomly test 5 res area water temperatures weekly for weeks then monthly for 3 months. Reports will be presented to the week Quality Assurance committee by the Administrator to ensure corrective actions	e ough. hand hand in finto in the for rsing ality that that that rected er The m ng) 3 taken ees F. ly be sident 2 ekly	

Event ID: K9FT11

Facility ID: 943308

If continuation sheet Page 8 of 30

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION		
			A. BUILDING		COMPLETED	
		345468	B. WING		01/19/2018	
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
IBERTY	COMMONS REHABILITA			121 RACINE DRIVE		
				WILMINGTON, NC 28403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE COMPLETIC	
F 584	Continued From page	28	F 58	 initiated as appropriate. Complible monitored and ongoing audiprogram reviewed at the weekly Assurance Meeting. The weekly Assurance Meeting is attended Administrator, Director of Nursi Coordinator, Therapy, Health Ir Manager, and the Dietary Mana The title of the person respimplementing the plan of correct The Administrator is responsible implementation and completion acceptable plan of correction. 	ting y Quality y Quality by the ng, MDS nformation ager. ponsible for ction. e for	
F 684 SS=D	Quality of Care CFR(s): 483.25		F 684		2/16/18	
	applies to all treatmen facility residents. Bas assessment of a resid that residents receive accordance with profe practice, the compre- care plan, and the resident	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered				
	Based on record revi interviews the facility for meals as recomm Therapist for 1 of 1 re resulted in the failure	iew, observations and staff failed to provide supervision ended by the Speech esidents reviewed which to monitor the resident for al consumption (Resident #		F684 1. Plan for correcting specific d The process that led to deficien The facility failed to provide sup for meals as recommended by Speech Therapist for 1 of 1 res	ncy cited. Dervision the	
	Findings included:			On 01/18/2018 the supervised room list was updated to includ		

Event ID: K9FT11

Facility ID: 943308

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/21/2018 MAPPROVED D. 0938-0391
STATEMENT (T OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		345468	B. WING				0 19/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	COMMONS REHABILITA			12	21 RACINE DRIVE		
LIDERT				W	VILMINGTON, NC 28403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 684	included Parkinson's	3 with diagnoses which Disease and Hypertension.	F	684	 Procedure for implementing the acceptable plan of correction. The Assistant Unit Managers will audition 	t all	
	11/11/2017 indicated moderately cognitivel	Minimum Data Set dated Resident #26 was y impaired and required all Activities of Daily Living			current residents' charts to review for orders stating the resident must be supervised with meals and will ensure order is set up to fire to the eMAR for nurses to sign off at each meal. This w be complete by 02/16/2018. Based of	vill	
	12/13/2017 revealed	26's Care Plan updated the resident to be at a a mechanically altered and ventions included:			this audit, residents identified as need supervision will have a supervised me task fired to POC (Point of Care Documentation) by the Assistant Unit Manager who will also ensure all care	ing als	
	dietary and safety nee -Check mouth after m debris. Report to nurs remove debris.	ed of resident's special eds. neal for pocketed food and se. Provide oral care to at in an upright position, to			plans and kardex reflect any supervisi ordered for meals. This will be comple on 02/16/2018. On 02/08/2016 the Director of Nursing began in-service education to all (full t part time and as needed) nurses and	ite I	
	eat slowly, and to che -Monitor/document/re MD PRN for difficulty mouth, prolonged swa	w each bite thoroughly port to nurse/dietitian and swallowing, holding food in allowing time, repeated ughing, throat clearing,			 nurse aides. Education will be comple by 02/16/2018. Topics included: Supervision of meals means that nurse aide, nurse or trained feeding assistant must be present during the 		
	drooling, pocketing fo	od in mouth tness of breath, choking, lung congestion			 resident's entire meal. How to know when a resident requirement supervision of meals. How to document that resident 	uires	
		•			 received the supervision. When a new recommendation fro Speech Therapist is received for supervision of meals, the Assistant Ur Manger will enter the order and set it u fire to the eMAR for all meals, care pla 	nit up to	
	observed sitting up in across his lap. The re	AM, Resident #26 was bed with the over-bed table sident's breakfast tray was			the required supervision, add to karde and task to the nurse aides.	x	
	on the over-bed table	and the resident was			This information has been integrated i	nto	

Facility ID: 943308

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		MEDICAID SERVICES			OMB NO. 09	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SUR COMPLET	
	CONTRACTION		A. BUILDING	G		
		345468	B. WING		C	
	ROVIDER OR SUPPLIER	545466		STREET ADDRESS, CITY, STATE, ZIF		2018
	ROVIDER OR SUPPLIER			121 RACINE DRIVE	CODE	
LIBERTY	COMMONS REHABILITA	ATION CENTER		WILMINGTON, NC 28403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE CC	(X5) OMPLETIO DATE
F 684	Continued From pag	e 10	F 68	34		
		staff member in the room. A		the standard orientation t	raining and in the	
		n was made of Resident #26		required in-service refres	-	
		50AM to 10:20AM. At		all Nurses, nurse aides, a		
	9:50AM, Nursing Ass	sistant (NA) #1 entered the		Feeders and will be revie		
	room and asked the	resident if he was ready to		Quality Assurance proces	ss to verify that	
		shook his head no and lifted		the change has been sus	stained.	
		e room and left the resident				
		eating breakfast. NA #1		3. Monitoring Procedur		
		ain at 10:20AM, removed the		the plan of correction is e		
	resident's breakfast t	ray and left the room.		specific deficiency cited r		
	An interview was sor	ducted with the facility		and/or in compliance with	n regulatory	
		nducted with the facility		requirements.	nor or dogingoo	
		T) on 1/18/2018 at 11:15AM. sident #26 was discharged		The Assistant Unit mana will monitor supervision of		
		services on 10/12/2107 with		residents during meals d		
		endations fir the staff to		Friday for 2 weeks then r		
		meals, provide verbal cues		months using the Reside		
		allow strategies to decrease		Quality Assurance monitor	-	
		ion risk. The ST indicated		include ensuring a nurse	•	
	-	e training for the staff. The		trained feeding assistant		
	-	service Training Form dated		during the meal for the re		
	-	ent #26 which included a		designated. Reports will		
	0 01	handout for staff. Attached to		the weekly Quality Assur		
		vas a signature sheet dated		by the Administrator to er		
		I's signature was observed		action initiated as approp		
	on the signature she	et.		Compliance will be monit		
				ongoing auditing program		
		nducted with NA #1 on I. NA #1 revealed Resident		weekly Quality Assurance	•	
		ar assigned hall and he was		weekly Quality Assurance attended by the Administ		
		needed. NA # 1 indicated		Nursing, MDS Coordinate		
		d cueing to eat. NA #1 stated		Health Information Mana		
		rvice for Resident #26 on		Dietary Manager.	30., 414 110	
		eals but that was a long time		4. The title of the perso	on responsible for	
		I the resident did not have to		implementing the plan of	-	
		eals anymore. NA #1 stated				
		ng in the computer or written		The Administrator is resp	onsible for	
	anywhere which prov			implementation and com		
		changes in care was just		acceptable plan of correct		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/21/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345468	B. WING		C 01/19/2018
	ROVIDER OR SUPPLIER	TION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 121 RACINE DRIVE WILMINGTON, NC 28403	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 684 F 689 SS=E	popped in on the resi most of the time. NA the resident for break know why. An interview was com Nursing (DON) on 1/ DON stated the expec- check the Kardex ever instructions and need the most recent care the expectation was f supervised for meals recommendations. Free of Accident Haz CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensu- §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on observatio interviews and record maintain safe hot wat 116 Fahrenheit (F) in	to shift. NA #1 indicated he ident and cued him to eat #1 revealed he did not cue data and stated he did not inducted with the Director of 18/2018 at 2:43PM. The inducted with the Director of the Stance devices to be inducted with the Director of the stance devices to prevent in the staff and resident in the staff and resident in the staff and resident in the staff and resident in the staff and r	F 68		ed.
		cal record revealed Resident 22/2017 with diagnoses of		On 01/17/2018 the maintenance dire was in the process of correcting the h water temperature when it was disco	not

Event ID: K9FT11

Facility ID: 943308

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM): 02/21/20 ⁻ / APPROVE). 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ISTRUCTION		LETED
		345468	B. WING				C 19/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREE	TADDRESS, CITY, STATE, ZIP CODE	•	
	COMMONS REHABILITA			121 R/	ACINE DRIVE		
				WILM	INGTON, NC 28403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 689	Continued From page	e 12	F 68	89			
	stroke, epilepsy, anxi				be greater than 116 degrees F. The	-	
					aintenance Director was able to adj		
	The 14 day Minimum	n Data Set (MDS) date			e hot water temperatures to below		
		resident to be cognitively			egrees F. On 01/18/2018 the		
		tensive assistance for all			aintenance director adjusted the ho		
	-	ing with the physical help of			ater temperature to below 116 degre	ees	
	one to two persons.				The Director of Nursing began		
	In an interview, on 1/	16/2018 at 3:05 PM			-servicing all nurses and CNA's to te ater on their wrist prior to using the	est	
		she had not noticed the hot			ater and in-serviced alert residents	'n	
		n being very hot. The hot			rn on both hot and cold water at the	-	
		and was found to be very			ame time. Education will be complet		
	hot. At 3:35 PM the N	Maintenance Director		by	/ 02/16/2018.		
	checked the hot wate				Procedure for implementing the		
		is calibrated thermometer			cceptable plan of correction.		
	-	.6 F. The Maintenance			-service education was provided to		
		been dealing with this for a			aintenance Director on 1/18/18 by t	he	
		ance Director stated he peratures in a few rooms on		A	dministrator. Topics included: Hot water should be tested week	b.	
		ty each week and had found		ar	nd entered into TELS Team Electror	-	
		ires and adjusted the valve.			brary System (Building Manageme		
		rector stated he was going to			ystem for Senior Living)		
		e of the water and left.			Always follow the manufacturer		
				gı	uidelines for calibration to ensure		
	On 1/16/2018 at 4:01	PM the bathroom sink		ac	ccurate readings		
	temperatures were c			•	To test water: Use a hand		
	Room 220 was 110 F				ermometer, turn on hot water fauce	t and	
	Room 217 was 110 F				old thermometer under water for 30	_	
	Room 214 was 112 F				econds, read and record temperatur nd turn off faucet	e	
	0n 1/16/2018 at 4⋅09	3 PM the bathroom sink		ai	If water registers above 116 degr	- ees	
	temperatures were cl			F	then adjust the temperature until the		
	Room 212 was 118 F				prrect measurements are obtained.	-	
	Room 205 was 132 F			•	Document your corrective actions	sand	
	Room 204 was 134 F	=.		re	-measurement.		
				•	If you are not able to adjust the		
		2 PM the bathroom sink			mperature to less than 116 degrees		
	temperatures were cl				en notify staff and alert residents no	ot to	
	Room 202 was 130 F			us	se the affected area and notify the		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 02/21/2018 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY IPLETED
		345468	B. WING _			01	C I/ 19/2018
NAME OF P	ROVIDER OR SUPPLIER	·		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS REHABILITA	TION CENTER			1 RACINE DRIVE ILMINGTON, NC 28403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI> TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	Room 412 was 140 F Room 405 was 128 F On 1/16/2018 at 5:50 Director checked the in Resident #28's bat thermometer and it w On 1/17/2018 at 9:30 Resident # 28's bath hot. The Maintenance check the actual wate Maintenance Director 10:30 AM to be 99.7 stated the temperatur was still dealing with On 1/17/2018 at 11:0 and stated she had for considered too hot in #1 indicated she was hot water. On 1/18/2018 at 10:4 Director checked the bathroom to be 97.8 I On 1/19/2018 at 9:55 Maintenance Director the temperature on 1. bathroom, he went to the mixing valve. The stated he did not tell a the water because he Maintenance Director working with the boile	PM the Maintenance temperature of the hot water hroom with his calibrated ras 111.7 F. AM, the hot water in room was noted to be very e Director was paged to er temperature. The r checked the temperature at F. The Maintenance Director re was a little low and he the issue. 0 AM NA #1 was interviewed bund hot water she resident's bathrooms. NA careful about running the 8 AM the Maintenance hot water in Resident #28's	F	589	administration. Corrective action sho be initiated immediately. Document in-service to staff and obtain signatu • Notify the administrator of all rea- that are above 116 degrees F. On 02/08/2018 the Director of Nursin began In-service education to all full part time, and as needed staff nurse nurse aides on how to test water for temperature for resident and staff sa This education will be completed by 02/16/2018. Topics included: Testing water on the inner arm befor using it on a patient is the proper wa test the temperature. If it feels too h turns your skin red then do not use if the patient and notify the maintenan- staff immediately by contacting them directly if they are in the facility or if i after hours by paging them. If you a able to contact maintenance then no your nurse on call for further instruct The following procedure is to be follo for testing hot water temperatures by hand prior and during patient showe whirlpools or using sinks. 5. Turn water in desired location of Allow water to run 3 minutes prior to testing with hand. Note: While waitin water to run, you can use this time to gather supplies, etc. 6. Note if there is any steam prese After 3 minutes, place your wrist or in arm under the flow of water for 5-8	res. adings ng time, s and fety. e y to ot or t on ce t is re not tify ions. owed y ring, n. g for o nt.	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/21/2018 1 APPROVED): 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345468	B. WING			01/	, 19/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
LIBERTY	COMMONS REHABILITA	TION CENTER			21 RACINE DRIVE		
		-		W	/ILMINGTON, NC 28403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From page	e 14	F	689	use the thermometer (located at each		
	facility Administrator s about the water being reeducated about find When asked for the d reeducation the Admi formal in-service with "huddled" with the Nu told them they should was too hot to notify t Administrator noted th residents were told no only. The Administrat temperature checks w weeks of consistently were recorded. The A expectation was the w safe. On 1/19/2018 at 11:0 worked on 1/15/2018 been told anything at hot water. On 1/19/2018 at 11:1	nistrator stated it was not a staff signatures, the staff ursing Assistants (NAs)and I check the water and if it their supervisor. The he alert and oriented of to turn on the hot water or indicated that would be done daily until two acceptable temperatures administrator stated his water temperatures would be 8 AM, NA #2 stated he had and 1/17/2018, but had not bout being careful with the 1 AM, NA #3 stated he had al with the hot water and if it			use the thermometer (located at each nurses station) supplied to test the wa temp. Do this by placing the thermome under the flow of water and wait for th reading to stabilize. If the temp is great than 116 degrees F., then notify maintenance and your nurse supervise Do not use the water. 7. Proceed with the bath if after the or thermometer test is completed and temperature is safe. Note: When givin shower, you are to periodically do the hand test throughout the shower. Example: If giving a 3-minute shower, should recheck the water by doing the hand test approximately half way throut 8. When giving a whirlpool, do the h test, fill the whirlpool up, then do the h test again prior to placing the patient in the water. This information has been integrated i the standard orientation training and in required in-service refresher courses f all Maintenance Directors and all nurs staff and will be reviewed by the Quali Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure tha the plan of correction is effective and f specific deficiency cited remains correct and/or in compliance with regulatory requirements. Daily 01/17/2018 thru 01/31/208 the	eter e tter or. hand g a you ugh. and and n n to n the for ing ty at hat	
					maintenance director tested hot water temperatures to ensure compliance. T Administrator will monitor TELS Team Electronic Library System (Building		
	67(02-99) Previous Versions Obs	solete Event ID: K9ET1			cility ID: 943308		Page 15 of 30

Event ID: K9FT11

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	MENT OF HEALTH AN S FOR MEDICARE &	MEDICAID SERVICES			FORM APPROVEI OMB NO. 0938-039		
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C		
		345468	B. WING		01/19/2018		
NAME OF PR	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
	COMMONS REHABILITA	TION CENTER		121 RACINE DRIVE WILMINGTON, NC 28403			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION		
F 689	Continued From page	e 15	F 68	9 Management System for Senior Liv system weekly for 2 weeks and mo for 3 months for recording of water temperatures and corrective action if temperatures are noted >116 deg Any negative findings will immedia addressed. In addition to this, the administrator will randomly test 5 m area water temperatures weekly fo weeks then monthly for 3 months. Reports will be presented to the we Quality Assurance committee by th Administrator to ensure corrective initiated as appropriate. Compliand be monitored and ongoing auditing program reviewed at the weekly Qu Assurance Meeting. The weekly Qu Assurance Meeting is attended by Administrator, Director of Nursing, Coordinator, Therapy, Health Inform Manager, and the Dietary Managel 4. The title of the person responsible implementing the plan of correction The Administrator is responsible fo implementation and completion of acceptable plan of correction.	onthly s taken grees F. tely be esident r 2 eekly le action ee will juality uality the MDS mation r. ele for n.		
F 756 SS=D	Drug Regimen Revie CFR(s): 483.45(c)(1)	w, Report Irregular, Act On (2)(4)(5)	F 75		2/16/18		
		imen Review. ug regimen of each resident least once a month by a					
	§483.45(c)(2) This re of the resident's medi	view must include a review ical chart.					
	§483.45(c)(4) The ph	armacist must report any					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 02/21/2018 RM APPROVED NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED C
		345468	B. WING			0	1/19/2018
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS REHABILITA	TION CENTER					
				vv	ILMINGTON, NC 28403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 756	Continued From page	9 16	F	756			
	irregularities to the at	tending physician and the					
	-	ctor and director of nursing,					
	(i) Irregularities include	st be acted upon. de, but are not limited to, any					
		riteria set forth in paragraph					
	(d) of this section for						
		noted by the pharmacist st be documented on a					
	separate, written repo						
		nd the facility's medical					
		of nursing and lists, at a t's name, the relevant drug,					
		e pharmacist identified.					
		vsician must document in the					
	resident's medical rec	cord that the identified reviewed and what, if any,					
		n to address it. If there is to					
		nedication, the attending					
	physician should doct the resident's medica	ument his or her rationale in I record.					
	§483.45(c)(5) The fac	ility must develop and					
	-	procedures for the monthly					
		that include, but are not s for the different steps in					
		s the pharmacist must take					
	when he or she identi	fies an irregularity that					
	This REQUIREMENT	n to protect the resident. is not met as evidenced					
	by: Based on record revi	ew and staff interviews the			F756		
		ete an abnormal involuntary			1. Plan for correcting specific defici	ency.	
		essment for 1 of 3 residents			The process that led to deficiency of	ited.	
	reviewed (Resident #	53).			The facility's failed to complete an		
	Findings included:				Abnormal Involuntary Movement So		
	Record review reveal	ed Resident #53 was			(AIMS) assessment for 1 of 2 reside	ents.	
	admitted to the facility				On 01/19/2018, the AIMS was com	pleted	

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STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
			A. BUILDING			С
		345468	B. WING		0	1/19/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	COMMONS REHABILIT			121 RACINE DRIVE		
LIDERT				WILMINGTON, NC 28403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 756	Continued From pag	le 17	F 75	6		
		luded Dementia with	175	for resident # 53 by the Assistan	t l Init	
		ce and Mood Disorder.		Manger.	t Of Int	
	Record review of the	Admission Minimum Data		2. Procedure for implementing	the	
	Set (MDS) dated 12/	11/2017 indicated Resident		acceptable plan of correction.		
		gnitively impaired extensive				
		ctivities of Daily Living		On 02/08/2018, an in-service ed		
	(ADLs).			was provided to the Director of N and two Assistant Unit Mangers	0	
	Review of the asses	sments revealed no		Nurse Consultant on the frequen		
	assessment for the a			AIMS testing. Topics included:		
		r possible side effects from		New admissions who have		
	the drug.			antipsychotic drug orders and Re	eglan and	
	-			residents in the Facility for whom	n an	
				antipsychotic drug or Reglan is c		
		December 2017 and		shall be tested prior to starting th		
		cians orders revealed		medication, then every 6 months	6	
	Resident #53 receive			thereafter.		
	antipsychotic) twice	a day.		This information has been integr	ated into	
	Record review of the	e initial pharmacy review		the standard orientation training		
		ber 2017 indicated Resident		required in-service refresher cou		
		abnormal involuntary		the Director of Nursing and Assis		
		essment (AIMS) completed		Mangers and will be reviewed by	/ the	
	on admission.			Quality Assurance process to ve	rify that	
				the change has been sustained.		
		e monthly medication			4	
		ted 1/12/2018 indicated the the medical record and listed		3. Monitoring Procedure to ens		
		ons for the AIMS to be		the plan of correction is effective specific deficiency cited remains		
	completed.			and/or in compliance with regula		
				requirements.	···· / J	
	Record review of the	Psychiatry Initial Visit note				
	dated 1/16/2018 rev	ealed a recommendation to		The Director of Nursing or design	nee will	
	obtain a current AIM	S.		monitor the completion of AIMs		
				assessment using the AIMs Qua		
		nducted with the Director of		Assurance tool weekly for 2 wee		
	- · · ·	(19/2018 at 9:53AM. The		monthly for 3 months. Monitoring		
	DON revealed if the	ICSINGHT WAS ON ALL		include auditing 5 residents who	ait	

Facility ID: 943308

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/21/2018 MAPPROVED D. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345468	B. WING _				C / 19/2018
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	COMMONS REHABILITA			12	1 RACINE DRIVE		
				W	ILMINGTON, NC 28403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 761 SS=D	completed the AIMS of months. The DON indi- implemented a new a included the need for residents admitted pri- form did not have a sy AIMS were completed expectation was for re- medications to have a admission and every Label/Store Drugs an CFR(s): 483.45(g)(h) §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the of applicable. §483.45(h) Storage of §483.45(h)(1) In accor Federal laws, the faci- biologicals in locked of	tion, the Unit Managers on admission and every 6 dicated the facility dmission checklist which an AIMS, however the ior to the initiation of the new ystem in place to ensure the d. The DON stated the esidents on antipsychotic an AIMS completed on 6 months. d Biologicals (1)(2) of Drugs and Biologicals a used in the facility must be e with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized	F 7	756	receiving anti-psychotics or Reglan for completion of an AIMs assessment eve 6 months. Reports will be presented to weekly Quality Assurance committee b the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at weekly Quality Assurance Meeting is attended by the Administrator, Director Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. 4. The title of the person responsible implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	ery the yy the e	2/16/18

If continuation sheet Page 19 of 30

	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		CONSTRUCTION		D. 0938-039 SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· /			COMF	PLETED	
		345468	B. WING				C / 19/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LIBERTY	COMMONS REHABILITA	ATION CENTER			21 RACINE DRIVE VILMINGTON, NC 28403			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	CORRECTION (X5)		
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION	
F 761	Continued From page	e 19	F	761				
-		cility must provide separately						
	•	affixed compartments for						
		drugs listed in Schedule II of						
	U	Drug Abuse Prevention and						
	Control Act of 1976 a	and other drugs subject to						
	· ·	the facility uses single unit						
		ution systems in which the						
		nimal and a missing dose can						
	be readily detected.	T is not met as evidenced						
	by:	i is not met as evidenced						
		on, staff interview and record			F761			
		led to dispose of expired			1. Plan for correcting specific deficie	encv.		
		o of two medication storage			The process that led to deficiency ci			
	rooms reviewed.							
	Findings included:				The facility's failed to dispose of exp medications from 2 of 2 medication	bired		
	On 1/18/2018 at 6:05	5 PM the medication storage			storage rooms.			
		hall was checked. The			On 01/17/2018, the Assistant Unit			
	-	d to have 1 box of single			Manager removed the expired			
		neumovax 23. The box			Pneumovax 23 and Influenza from t	he 2		
	•	ose vials with the lot number			medication rooms.	-1		
		expiration date of 11 Jan			On 1/22/18, the Central Supply Dire			
	located on the outsid	piration date were also e of the box			audited the two medication rooms for expired medication and expired sup			
					2. Procedure for implementin	-		
	On 1/18/2018 at 6:20) PM the medication storage			acceptable plan of correction.			
		hall was checked. The						
	refrigerator contained	d 1 box of influenza marked			On 2/9/18, the Director of Nursing			
		x was unopened and had a			provided an in-service education to			
		06 and an expiration date of			Central Supply Director. Topics incl			
	03 Jun 2017.				Weekly when stock medications			
	In on interview or 44	10/2019 at 10:15 AM tha			supplies are shelved in the medicati			
		19/2018 at 10:15 AM, the tated her expectation was			rooms, the Central Supply Director v			
	÷	tated her expectation was cations would be disposed of.			audit existing stock and medication refrigerators for expired items. Older			
		ator was present also and			will be moved to the front of the sup			
	stated his expectatio				allow for use before expiration date.			
	Stated his expectation	n was me same						

Facility ID: 943308

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	MENT OF HEALTH AN S FOR MEDICARE &		-			FOF	ED: 02/21/2018 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA	. ,		(X3) DA	TE SURVEY MPLETED
		345468		B. WING		0	C 1/19/2018
NAME OF PI	ROVIDER OR SUPPLIER	1			STREET ADDRESS, CITY, STATE, ZIP CO		
LIBERTY	COMMONS REHABILITA	TION CENTER			121 RACINE DRIVE		
					WILMINGTON, NC 28403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 761	Continued From page	Snacks at Bedtime		F 76	1 the standard orientation trairequired in-service refreshe Central Supply Director and reviewed by the Quality Asse process to verify that the chosen sustained. 3. Monitoring Procedure to the plan of correction is effere specific deficiency cited rem and/or in compliance with reger requirements. The Assistant Unit Manger of will monitor the completion of Storage Room Quality Assume weekly for 2 weeks then more months. Monitoring will incluit 100% of all medication roor medications. Reports will be the weekly Quality Assurance by the Administrator to ensuration initiated as appropriate Compliance will be monitore ongoing auditing program reveekly Quality Assurance N weekly Quality Assurance N the title of the person r	ning and in the r courses for l will be surance ange has ensure that ective and that hains corrected egulatory or designee of Medication irance tool onthly for 3 ude auditing ms for expired e presented to cce committee ure corrective ite. ed and eviewed at the Meeting is or, Director of Therapy, r, and the esponsible for irrection. sible for ition of the	2/16/18
SS=D	CFR(s): 483.60(f)(1)-			F 00			2/10/10
FORM CMS-256	7(02-99) Previous Versions Obs	solete	Event ID: K9FT11		Facility ID: 943308	If continuation she	eet Page 21 of 30

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M				FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		COMP	PLETED
	345468	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE 121 RACINE DRIVE WILMINGTON, NC 28403 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY COMMONS REHABILITAT			121 RACINE DRIVE		
LIBERT & COMMONS REPABILITAT	HON CENTER		WILMINGTON, NC 28403		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
F 809 Continued From page	21	F	809		
 §483.60(f) Frequency §483.60(f)(1) Each rest facility must provide at regular times comparate the community or in at needs, preferences, rest §483.60(f)(2)There must hours between a substoreakfast the following nourishing snack is set hours may elapse betwine and breakfast the group agrees to this mission of scheduled meal set the resident plan of cat This REQUIREMENT by: Based on resident intrecord review the facilit breakfast for resident and failed to offer bed resident (Resident #20) Findings included: The resident was record rehabilitation with a di 2 (DM 2), End Stage F Anemia, Gastro-Esopi (GERD), and fracture and on her left ankle. 	of Meals sident must receive and the t least three meals daily, at able to normal mealtimes in ccordance with resident equests, and plan of care. ust be no more than 14 stantial evening meal and g day, except when a erved at bedtime, up to 16 ween a substantial evening e following day if a resident neal span. e, nourishing alternative to be provided to residents n-traditional times or outside rvice times, consistent with are. is not met as evidenced terview, staff interview and lity failed to provide leaving early for dialysis		F809 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility's failed to provide breakfa resident leaving early for dialysis and failed to offer bed time snack for 1 of	1 etary g of rsis ff to	

Facility ID: 943308

If continuation sheet Page 22 of 30

		MEDICAID SERVICES				OMB NC I	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				-			C
		345468	B. WING				19/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				1:	21 RACINE DRIVE		
	COMMONS REHABILITA	TION CENTER		v	VILMINGTON, NC 28403		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETIC DATE
F 809	Continued From page	e 22	F	309			
		nitively intact and could			from the facility for dialysis on Tuesday		
		eds to the staff. The resident			Thursday, and Saturday. For resident		
	needed set up for me	als and in need of			#264 a bedtime snack will be offered		
	assistance for transfe	ers. The care plan indicated			every evening by the resident's nurse		
	the resident was sche				aide.		
	Tuesday, Thursday, a	and Saturday.			2. Procedure for implementing the acceptable plan of correction.		
	During an interview w	/ith Resident #264 on					
		stated the facility did not			Beginning on 02/05/2018, in-service		
		akfast (bag meal or meal to			education was provided to all (full time,		
	-	dialysis at 5:45 AM this			part time and as needed) nurses, nurse		
	morning (1/18/18). S	he stated her dialysis was			aides, transportation coordinator and		
		A and was back in the facility			dietary staff. Education will be complete	ed	
		stated that since she was			by 02/16/2018. Topics included:		
	-	y, there were times that they			The transportation coordinator will		
	-	And for evening snacks, she			communicate to the applicable nursing		
	-	time in the last 6 days. She kes receiving bedtime			staff and dietary when residents have scheduled appointments. A list will be		
	snacks.	kes receiving bedurne			placed at the nurse's station and one w	/ill	
	Shacks.				be given to the dietary manager. If the		
	Record review on a lo	og for meals provided by the			scheduled appointment time will cause		
	Director of Nursing (E	•			the resident to miss a meal the		
		e were no recorded meals			transportation coordinator will note bes	ide	
	for the following dates				the resident name "provide bag meal".		
	1. 1/13/18 - no brea				The dietary staff will be responsible		
		akfast and lunch recorded			for preparing the bag meal and placing	it	
		akfast and lunch recorded			in the nourishment refrigerator for the		
	4. 1/17/18 - no brea				resident.		
	5. 1/18/18 - no brea was marked resident	akfast recorded and lunch			The nurse aide is responsible for providing the bag meal to the resident		
					prior to leaving the facility.		
	During an interview w	vith the Unit Supervisor on			 Dietary will provide snacks at bed 		
		he stated the nursing staff			time for all residents. Snacks will be		
		on admission to write the			located in the nourishment refrigerator	on	
		send it to the kitchen. She			the unit.		
	further stated that the	e transportation staff was			• The nurse aide is responsible for		
		t the meal to be taken with			offering a snack to each resident.		
	the resident when the	ey go to dialysis.			Documentation in POC (Point of Care		
					documentation) should reflect that the		

Facility ID: 943308

If continuation sheet Page 23 of 30

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·			1 Y /	IPLETED
							С
		345468	B. WING			0	1/19/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
				121	RACINE DRIVE		
	COMMONS REHABILITA	ATION CENTER		WIL	MINGTON, NC 28403		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETIC
F 809	Continued From page	e 23	F 80	09			
	An interview with the	transportation staff on			snack was offered and accepted by th	ne	
	1/19/18 at 8:52 AM, s	she stated she knew the			resident, declined, or the resident is a		
		hedule was changed last			tube feeder.		
		ut she forgot to request the			This information has been integrated		
	meal the day before 1/18/18.	the dialysis appointment for			the standard orientation training and i required in-service refresher courses		
	1/10/10.				all staff and will be reviewed by the Q		
	An interview with the	kitchen supervisor on			Assurance process to verify that the	aanty	
		evealed she just found out			change has been sustained.		
		ut early for dialysis. The			3. Monitoring Procedure to ensu	re	
	-	starts at 6 AM and there was			that the plan of correction is effective	and	
		breakfast on 1/17/18 a day			that specific deficiency cited remains		
	before the appointme	ent.			corrected and/or in compliance with		
	An interview with the	kitchen manager on 1/19/19		'	regulatory requirements.		
		ed there was no request to		-	The Director of Nursing or designee v	vill	
		st for this resident on 1/17/18			monitor meal and snack delivery wee		
	for 1/18/18 dialysis d	ay. She further stated that			for 2 weeks then monthly for 3 month	-	
		request this morning about			using the meal and snack delivery Qu	-	
		change for Resident #264.			Assurance monitor. Monitoring will inc		
		at evening snacks were put			ensuring residents with early morning		
	out in the nursing sta	ition around 6-7 PM.			appointments receive their breakfast to prior to leaving for the appointment ar		
	The night shift nurse	that worked with resident			that residents are offered a bed time	iu	
		e resident went to dialysis			snack. Reports will be presented to the	e	
		elephone. She stated that			weekly Quality Assurance committee		
	resident was offered	breakfast on 1/18/19 but			the Administrator to ensure corrective		
	refused.				action initiated as appropriate.		
		ere reviewed from admission			Compliance will be monitored and		
	1/12/18 up to 1/19/18	en of resident's refusal for			ongoing auditing program reviewed a weekly Quality Assurance Meeting. T		
	meals or bedtime sna				weekly Quality Assurance Meeting. T		
					attended by the Administrator, Directo	or of	
	The morning shift Nu	rse #2 working on 1/18/18			Nursing, MDS Coordinator, Therapy,		
	was interviewed on 1	/18/18 at 4:43 PM, stated			Health Information Manager, and the		
		left before she got in the			Dietary Manager.	_	
	-	know if she had a bag			4. The title of the person responsible	for	
	breakfast.			i	implementing the plan of correction.		

Facility ID: 943308

ATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	0. 0938-039
ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345468		IDENTIFICATION NUMBER:	A. BUILDING	. BUILDING		PLETED
		B. WING	01	C / 19/2018		
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		/10/2010
LIBERTY	COMMONS REHABILITA	TION CENTER		21 RACINE DRIVE VILMINGTON, NC 28403		
(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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 809	The Nursing Aide (NA night shift was called 1/18/19 and was unsu number was restricted DON stated she got ti when she tried to call All three NA's (NA #6 the meal logs were m telephone on 1/19/18 remember the details The meal logs were til remember what was of During the interview w stated that a bag mea requested a day befo resident. She further s was not sent with the	A) #5 that worked during via telephone twice on uccessful. Her telephone d and didn't go through. The he same call restriction on 1/19/18. , #7, #8) working at the time issing were interviewed via and all stated they don't what happened at that time. he only way they can consumed by the resident. with the DON on 1/18/19 she al for dialysis should be re and sent out with the stated that the breakfast that resident was unacceptable. vening snacks were usually	F 809	The Administrator is responsible for implementation and completion of acceptable plan of correction.		
F 865 SS=D	CFR(s): 483.75(a)(2) §483.75(a) Quality as improvement (QAPI) §483.75(a)(2) Presen Survey Agency no lat promulgation of this re §483.75(h) Disclosure A State or the Secreta disclosure of the reco	essurance and performance program. It its QAPI plan to the State er than 1 year after the egulation; e of information. ary may not require ords of such committee ch disclosure is related to ch committee with the	F 865			2/16/18

Facility ID: 943308

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/21/2018 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345468	B. WING				C / 19/2018
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
LIBERTY	COMMONS REHABILITA	TION CENTER			21 RACINE DRIVE /ILMINGTON, NC 28403		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ïх	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
F 865	Continued From page §483.75(i) Sanctions. Good faith attempts b and correct quality de a basis for sanctions. This REQUIREMENT by: Based on observatio interviews, the facility Assurance Committee implemented procedu interventions placed to of accident hazards. This deficiency was of following a recertificat and subsequently rec the current recertificat deficiency was in the safe/clean/comfortabl (F584). This deficience facility's current recer continued failure of the surveys of record sho inability to sustain an Program. The findings included This tag is cross-refer 483.10 Resident Righ staff and resident inter the facility failed to m temperatures at or be out of 10 bathrooms of	e 25 by the committee to identify eficiencies will not be used as is not met as evidenced ins, record reviews, and staff i's Quality Assessment and e failed to maintain ures and monitor these to ensure the facility was free bited on February 9, 2017 tion and complaint survey bited on January 19, 2018 on tion survey. The repeat area of le/homelike environment by was recited during the tification survey. The ne facility during 2 federal bw a pattern of the facility's effective Quality Assurance the facility during 2 federal by a pattern of the facility's effective Quality Assurance the facility during 2 federal by a pattern of the facility's effective Quality Assurance		865	F865 1. Plan for correcting specific deficient The process that led to deficiency cite The facility's Quality Assurance Committee (QA) failed to maintain the implemented procedures and monitor these interventions placed to ensure facility was free of accident hazards. re-citing of F371 during the last year federal survey history showed a patter the facility's inability to sustain an effer QA program. On 01/17/2018 the maintenance direct water temperature when it was discor- to be greater than 116 degrees F. The Maintenance Director was able to adj the hot water temperatures to below degrees F. On 01/18/2018 the maintenance director adjusted the how water temperature to below 116 degrees F. The Director of Nursing began in-servicing all nurses and CNA's to the water on their wrist prior to using the water and in-serviced alert residents turn on both hot and cold water at the same time. Education will be completed by 02/16/2018. The administrator ensured that daily	ncy. ed. the The of ern of ective ctor iot vered e ust 116 t ees est to	
	412, and 405) over 3					r	

Facility ID: 943308

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM OMB NO.	APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M		PLE CONSTRUCTION	(X3) DATE SI	(X3) DATE SURVEY COMPLETED	
		345468	B. WING		C 01/19	9/2018	
NAME OF P	ROVIDER OR SUPPLIER	·	•	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
				121 RACINE DRIVE			
LIBERT	COMMONS REHABILITA	TION CENTER		WILMINGTON, NC 28403			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 865	2/9/17 this regulation remain free of accide to use the assigned to which resulted in an in An interview was con Administrator on 1/19 Administrator stated to monthly and included Nursing (DON), the M the department head audits and reports from were brought to the o	was cited for failure to nt hazards when staff failed otal lift to transfer a resident njury.	F 86	 temperatures to ensure compliar compliance was reached as individent temperatures at 116 degree below. Procedure for implementing tracceptable plan of correction. In-service education was provide Maintenance Director on 01/18/2 the Administrator. Topics include Hot water should be tested of and entered into TELS Team Electibrary System (Building Manages) System for Senior Living) Always follow the manufactur guidelines for calibration to ensure accurate readings To test water: Use a hand thermometer, turn on hot water for seconds, read and record temperand turn off faucet If water registers above 116 adjust the temperature until the of measurements are obtained. Document your corrective a re-measurement. If you are not able to adjust temperature to less than 116 the staff and alert residents not to us affected area and notify the administration. Corrective action be initiated immediately. Documer in-service to staff and obtain sigrines revice to staff and obtain sigrines reviced by the Clinical Nurse 	cated by bees F or he ed to the 2018 by ed: weekly ectronic gement urer re aucet and or 30 erature then correct ctions and the en notify se the should ent natures. Il readings		

Event ID: K9FT11

Facility ID: 943308

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/21/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345468	B. WING		C 01/19/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
				21 RACINE DRIVE	
			V	VILMINGTON, NC 28403	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 865	F PROVIDER OR SUPPLIER FY COMMONS REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 865	Consultant to ensure that when water temperatures are noted or reported to above 116 degrees F that the followin measures are immediately taken and documented including in-services of s and residents. The administrator is als notify the Regional Director for hot wat temperatures that are noted above 11 degrees F that are not able to be immediately corrected. • Hot water should be tested week and entered into TELS (Team Electron Library System Building Managemer System for Senior Living) • Always follow the manufacturer guidelines for calibration to ensure accurate readings • To test water: Use a hand thermometer, turn on hot water fauced hold thermometer under water for 30 seconds, read and record temperature and turn off faucet • If water registers above 116 then adjust the temperature until the correct measurements are obtained. • Ensure corrective actions and re-measurement are documented. • If you are not able to adjust the temperature to less than 116 then not staff and alert residents not to use the affected area and notify the administration. Corrective action shou be initiated immediately. All in-service must be documented and ensure all applicable staff receive the in-service. • The administrator is notified of all readings that are above 116.	be g taff so to ter 6 ly nic nt and e ct ify s ld s

Facility ID: 943308

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/21/2018 FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
	345468		B. WING		C 01/19/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	LIBERTY COMMONS REHABILITATION CENTER			121 RACINE DRIVE			
				WILMINGTON, NC 28403			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION		
F 865	Continued From page	28	F 86	 This information has been integ the standard orientation training required in-service refresher cor all Maintenance Directors and Administrators and will be revier Quality Assurance process to ver the change has been sustained Monitoring Procedure to ensis the plan of correction is effective specific deficiency cited remains and/or in compliance with regular requirements. The Administrator will monitor T Electronic Library System (Bui Management System for Senior system weekly for 2 weeks and for 3 months for recording of wat temperatures and corrective act if temperatures are noted >116 Any negative findings will imme addressed. In addition to this, th administrator will randomly test area water temperatures weekly weeks then monthly for 3 month Reports will be presented to the Quality Assurance committee by Administrator to ensure correction initiated as appropriate. Complia be monitored and ongoing audition program reviewed at the weekly Assurance Meeting. The weekly Assurance Meeting is attended Administrator, Director of Nursin Coordinator, Therapy, Health In Manager, and the Dietary Mana 4. The title of the person respois implementing the plan of correction 	a and in the urses for wed by the erify that ure that e and that s corrected atory TELS Team Iding Living) monthly ater tions taken degrees F. diately be ne 5 resident y for 2 ns. e weekly y the ve action ance will ting / Quality / Quality by the ng, MDS formation ager. nsible for		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	02/21/2018 APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED		
345468			B. WING			C 01/19/2018		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
LIBERTY	COMMONS REHABILITA	TION CENTER		121 RACINE DRIVE WILMINGTON, NC 28403				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPE DEFICIENCY)		E ME	(X5) COMPLETION DATE	
F 865	Continued From page	29	F	865				
					The Administrator is responsible for implementation and completion of the acceptable plan of correction.			

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