	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
			A. BUILDING	3		С
		345207	B. WING		0	4/05/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E	
	COMMONS N&R CTR OF	COLUMBUS CTY				
				WHITEVILLE, NC 28472		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	0		
F 000	An unannounced recertification survey and complaint investigation was conducted onsite 03/14/22 - 03/17/22 and remotely through 03/18/22. The surveyor returned to the facility on 04/05/22 to obtain additional information, therefore the exit date was changed to 04/05/22. The facility was found to be in compliance with CFR §483.73, Emergency Preparedness. Event ID #4GD411.		F 00	0		
	deficiency. Immediate Jeopoardy	v was identified at:				
		760 scope and severity (K) 756 scope and severity (J)				
	Tag F760 constituted Care.	Substandard Quality of				
	and was removed on	for F756 began on 02/03/22				
F 641	An extended survey v Accuracy of Assessm		F 64	.1		4/14/22
-	-	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
	SILLOTORO ORT ROVIDER/	SOLUCIENTE RECEIVANCE S SIGNATURE		IIILE		(,) DITL

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.

		ND HUMAN SERVICES MEDICAID SERVICES				FORM): 04/28/2022 /I APPROVED). 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		SURVEY LETED	
		345207	B. WING					
	ROVIDER OR SUPPLIER	COLUMBUS CTY		14	TREET ADDRESS, CITY, STATE, ZIP CODE 402 PINCKNEY STREET /HITEVILLE, NC 28472			
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 641 SS=D	§483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on record rev facility failed to accur Set (MDS) quarterly a refusal of care and fa	of Assessments. accurately reflect the is not met as evidenced iew and staff interviews, the ately code a Minimum Data assessment for behaviors for iled to accurately code an speech and falls for 2 of 18	F	641	F-641 Accuracy of Assessments Corrective actions for Resident #3 Specific deficiency for Resident #3 wa resolved on 04/11/22 by the facility Minimum Data Set Coordinator who modified and corrected the coding for question E0800 – rejection of care on assessment with Assessment Referen Date of 02/26/22. This corrected			
	04/06/21. Diagnoses depression and vasce behaviors. The Minimum Data S assessment dated 02 was severely cognitiv section for rejection of was exhibited. Review of the Medica (MAR) for February 2 Resident #3 refused evidenced by docume indicated drug refuse	ular dementia without et (MDS) quarterly 2/26/22 revealed Resident #3 vely impaired. The behavior of care indicated no behavior ation Administration Record 2022 revealed on 02/22/22 the following medications as			assessment was re-submitted and accepted into state database on 04/11 in MDS Batch #2012. Corrective actions for Resident #87 Specific deficiency for Resident #87 w resolved on 04/11/22 by the facility Minimum Data Set Coordinator who modified and corrected the coding for questions B0600: Speech Clarity; B07 Makes Self Understood and J1800/190 Falls on assessment with Assessment Reference Date of 02/09/22. This corrected assessment was re-submitted and accepted into state database on 04/11/22 in MDS Batch #2012. Corrective action for residents with the potential to be affected by the alleged deficient practice.	as 00: 00:		
	Ferrous Sulfate 325 r 0.4 mg one capsule o tablet daily, Insulin D Potassium Chloride 2	ng 1 capsule daily, Flomax daily, Furosemide 40 mg one etemir 16 units at bedtime, 20 milliequivalents 2 packets rate 25mg one tablet daily,			All residents have the potential to be affected by the alleged deficient praction A 100 % audit of all current residents we have had a Minimum Data Set assessment completed within the past	who		

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				PLE CONSTRUCTION		NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	G	· · · ·	OMPLETED
		345207	B. WING			C 04/05/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	04/03/2022
				1402 PINCKNEY STREET		
IBERTY	COMMONS N&R CTR O	F COLUMBUS CTY		WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 641	Continued From pag	e 2	F 64	11		
		grams daily, multivitamin one	10-	days 03/11/22-04/11/22	was completed in	
	tablet daily, and Flon			order to identify if the fol		
	-	both nares twice daily.		were coded accurately:		
		,		B0600 – speech cla	arity	
	An interview with Me	dication Aide #2 on 03/16/22		B0700 – makes sel		
	at 1:35 PM revealed	the resident refused his		E0800 – rejection o	f care	
		and if he refused the		• J1800/1900 - falls		
		Id document the number "2"				
	in the MAR as she di	id on 02/22/22.		Any resident who is ider		
	An interview was son	ducted with the MDC Nurse		inaccurate coding of any		
		nducted with the MDS Nurse PM. The MDS nurse stated		the above questions will of that assessment com		
		complete portions of the		immediately by the facili	•	
		recording behaviors for		Set Coordinator. This a		
		stated she would review the		completed by the facility		
	nurse's notes, physic			Set Nurses and facility S		
		tes, physician orders and the		Director and was comple		
	MAR to determine if	a resident was refusing care.				
		orted she would ask the		Audit results are:		
	-	sident was refusing care.				
		ewed the February MAR and		22 of 22 residents r		
		e missed seeing the refusal		noted to have accurate	coding of B0600	
	documentation when			speech clarity.		
		OS nurse stated the behavior hibited should have been		0 of 22 residents re identified as having inaction		
		e quarterly assessment.		B0600 speech clarity.		
		nducted with Social Worker		21 of 22 residents r		
		at 10:49 AM via phone. SW		identified as having accu	-	
		responsible for a portion of		B0700 makes self-unde		
		he behavior section. SW #1		1 of 22 residents re		
		eak to the resident and		identified as having inac		
		s and speak with the family the resident has had any		B0700 makes self-unde	151000.	
		tated the MDS nurse would		19 of 22 residents r	eviewed were	
		as well in the daily meeting if		identified as having acc		
		instrating any refusal of care		E0800 rejection of care.	-	
		SW #1 was not aware the		3 of 22 residents re		
	resident was refusing			identified as having inac		

Facility ID: 923086

		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 04/28/2022 DRM APPROVED NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		ATE SURVEY OMPLETED
		345207	B. WING				C 04/05/2022
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				14	02 PINCKNEY STREET		
LIBERTY	COMMONS N&R CTR OF	F COLUMBUS CTY		w	HITEVILLE, NC 28472		
(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 641	Continued From page	e 3	F 64	41			
					E0800 rejection of care.		
	An interview with the	Administrator on 03/17/22 at			-		
		e expected the MDS nurse			21 of 22 residents reviewed were		
		mpleting assessments uld have reflected the refusal			identified as having accurate coding J1800/1900 falls.	of	
	of medication.				1 of 22 residents reviewed were		
		admitted to the facility from			identified as having inaccurate coding	g of	
		2. Her diagnoses included in			J1800/1900 falls.		
		istory of traumatic brain					
	injury at birth.				All residents who were identified as		
	The Minimum Data S	et (MDS) admission			having inaccurate coding for any of the above areas had a modification to the		
		2/09/22 revealed Resident			affected assessment completed in or		
		aving clear speech, could			for the coding to be corrected and	401	
		cood and could understand			affected assessments were re-submi	tted	
	others. No BIMS (brie	ef interview for mental			to state database. This was complet	ed by	
	status) was assessed	d. The MDS was coded as			the facility Minimum Data Set Nurse	on	
		rely or never understood.			04/12/2022.		
	She had acute menta						
		and disorganized thoughts.			Systemic Changes		
		two-person assistance with			On 04/12/22, the Regional Minimum		
	activities of daily livin	g.			Set Consultant completed an in-servi training for the facility Social Services		
	The MDS discharge	assessment dated 02/09/22			Director and Minimum Data Set Nurs		
	due to Resident #87				that included the importance of thoro		
		Resident #87 was coded on			reviewing each resident's medical re	•••	
	•	o falls had occurred since			in order ensure that the assessment		
	admission.				coded accurately. Special emphasis	was	
					placed on the following areas of the		
	Review of Resident #				Minimum Data Set assessment:		
		2/04/22 at 05:06 AM nurse			B0600 – Speech Clarity and B0700 –		
		oom, Resident (#87) was			Makes Self Understood: In order to b		
		throom straight up beside of were noted during the			able to code these questions accurat and to reflect the resident's current a	-	
		ent, and resident stated no			to communicate, the assessing nurse	-	
		ssisted back up and now in			should make all attempts to interact v		
	bed.				the resident. Interacting with the resi		
					will give the best indications of any		
	An interview was con	ducted on 03/17/22 at 8:48			difficulties with speech and ability to i	make	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 04/28/2022 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345207	B. WING			C /05/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	ME OF PROVIDER OR SUPPLIER BERTY COMMONS N&R CTR OF COLUMBUS CTY X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	COLUMBUS CTY		1402 PINCKNEY STREET WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	AM with MDS Nurse #87's admission asse 02/09/22 which was t discharged to the hos #87's speech was no was not easily unders should have coded S instead of coding Res speech, and being ea understands others w inaccurate at the time 02/09/22. She stated management section record to see the resi would show a history stated she did not loo progress notes which on 02/03/22 during th stated she should hav had a fall after admis was coded in error. An interview was com PM with the Director indicated the MDS as	#2. She stated Resident essment was conducted on he day Resident #87 was spital. She stated Resident t completely clear, and she stood. She stated she ection B to reflect that sident #87 as having clear asily understood, and which she stated was e of the assessment on she reviewed the risk in the electronic medical dent's historical data which of falls in the facility. She ok in Resident #87's showed that a fall did occur e look back period. She we coded that Resident #87 sion and stated the MDS ducted on 03/16/22 at 02:44 of Nursing (DON). She	F 641	themselves understood. E080 Rejection of Care must also be accurately. In order to code thi correctly, the assessor must the review the resident's medical re see if there is evidence of reside behaviors in the documentation assessor should review the pro- notes, medication administration as well as the daily point of car documentation completed by th aide in order to determine if the had any episodes of rejecting of the 7 day assessment reference lookback timeframe. Based on of the resident's record, the asse must then code the presence of frequency of any behavior doct during the lookback timeframe. J1800/1900 – Falls should accor reflect whether the resident has falls during the specified timefra assessing nurse must conduct review of the resident's record Click Care in order to ascertain not they have had a fall. Revie risk management portal in Poin Care as well as the progress more resident's record should guide assessing nurse as to whether taken place during the assess lookback timeframe. Based on information reviewed, the asses then code Section J1800 and 1 if the resident was documented a fall, and as to whether any ty was sustained as a result of fall This information has been integ the standard orientation training	a coded is question oroughly ecord to dent h. The ogress on record a ne nursing a resident care during a date he review sessor of and umented urately s had any ame. The a thorough in Point a whether or a date of the to be sin the the a fall has nent a sor should 900 as yes d as having pe of injury l(s). grated into	

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Facility ID: 923086

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
AND PLAN O	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		0.45007			С
	ROVIDER OR SUPPLIER	345207	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	04/05/2022
NAME OF P	ROVIDER OR SUPPLIER			1402 PINCKNEY STREET	
LIBERTY	COMMONS N&R CTR C	OF COLUMBUS CTY		WHITEVILLE, NC 28472	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTIO
F 641	Continued From page	ge 5	F 641		re that and that orrected llatory begin ments ent to cy, 800 – – falls ensure ive and ins the cs and will be ctor of n for ated as the nit y, Health hager for of

Event ID: 4GD411

Facility ID: 923086

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/28/2022 M APPROVED O. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	СОМ	E SURVEY PLETED
		345207	B. WING				C / 05/2022
NAME OF PI	ROVIDER OR SUPPLIER	•	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS N&R CTR OF	F COLUMBUS CTY		14	402 PINCKNEY STREET		
		002011200 011		N	/HITEVILLE, NC 28472		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	e 6	F	677			
F 677 SS=D		or Dependent Residents	F	677			4/14/22
	out activities of daily is services to maintain gersonal and oral hygersonal and or section and the section of the sectio	is not met as evidenced ins, staff interviews, and ility failed to assist a vith eating for 1 of 21 or activities of daily living 2). I: mitted to the facility on es to include adult failure to im Data Set (MDS) 5/22 indicated Resident #22 vely impaired. She was			The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all federa and state regulations the facility has tak or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F677 1. Corrective action for resident(s) affected by the alleged deficient practice Resident # 22 was not assisted with he meal intake by staff on 3/16/2022 for breakfast meal. On 3/16/2022 the CNA task was updated to reflect the required meal assistance by the Nurse Consulta 2. Corrective action for residents with the potential to be affected by the alleged deficient sistence. All residents in the facility who require assistance with meals have the potentiat to be affected.	l ken on e: r A d int. he	
	eating. Review of the electro	nic medical record (EMR)			On 04/14/2022, the Director of Nurses (DON), Unit Support Nurses, and the Minimum Data Set Nurse (MDS Nurse))	

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			0.00			IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	E SURVEY IPLETED
			A. BOILDING			С
		345207	B. WING		0	4/05/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		
				1402 PINCKNEY STREET		
LIBERTY	COMMONS N&R CTR OF	- COLUMBUS CTY		WHITEVILLE, NC 28472		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	Continued From page	ə 7	F 67	7		
	for Resident #22 reve			initiated an audit of all current	residents to	
		a regular diet, pureed		identify residents who require		
	texture, thin consister			with meals. The audits were c		
				04/14/2022. Each resident ide	entified as	
		500 Hall meal cart on		needing assistance with meal		
		revealed Resident #22's		task was updated to notify sta		
	-	vered and had not been		require assistance with meals		
	removed from the me	eal cart.		residents who require assistan		
	An interview was con	ducted with Nurse Aide (NA)		meals had their care plan and updated to reflect the need for		
		0 AM. She stated she was		assistance by the MDS Nurse		
		all that day. She further		and Kardex updates were con		
	stated she had not fe	-		04/14/2022.		
		g. She indicated the NA on				
	the 500 Hall was sup	posed to have fed her				
		esponsible for 3 rooms on		3. Measures/Systemic chang		
		rooms included Resident		prevent reoccurrence of allege	ed deficient	
	#22's room.			practice:		
				Education:		
	An interview was con			On 3/16/2022, the DON initiat		
		A) #1 on 3/16/22 at 11:25 was usually the CMA on the		following education to all Licer Nurses, Registered Nurses (R		
		stated she had not fed		Licensed Practical Nurses (LF	•	
		ast that morning and her tray		Medication Aides, Medication	,	
		d from the meal cart. She		Certified Nursing Assistants (
		ve a NA working with her on		time, part time, agency, and F	RN staff:	
	the 500 Hall that day,	, so she was only assigned 1				
		and this was not Resident		Ensuring residents receiv	e a meal	
		ed when she worked with a		tray		
		ey were responsible for 3		Ap of 02/25/2022 and of the	hour	
		Il including Resident #22's that since Resident #22 was		As of 03/25/2022, any of the a identified employee who has r		
		ssignment she didn't think		this education will not be allow		
		for feeding her that morning.		until the training has been con		
		g · · · · · · · · · · · · · ·		The in-service will be incorpor		
	An interview was con	ducted with NA #2 on		new employee facility orientat		
	3/16/22 at 11:07 AM.	She stated she was working				
		lay. She indicated Resident		4. Monitoring Procedure to er		
	#22's favorite meal w	as breakfast because she		the plan of correction is effect	ve and that	

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
					С
		345207	B. WING		04/05/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY		402 PINCKNEY STREET VHITEVILLE, NC 28472	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 677	Continued From page	8	F 677		
	#22 breakfast that more Resident #22's meal for meal cart and when so breakfast tray in her r already been fed. She Resident #22 that more wasn't an NA on the St An interview was con 3/16/22 at 11:12 AM. loved breakfast espect stated she had not fee breakfast that mornin An interview was con 3/16/22 at 11:18 AM. supposed to try to fee She further stated she breakfast that mornin An interview was con Nursing (DON) on 3/1 stated Resident #22 w by staff with eating at the NAs on the 400 H Resident #22 becaus 500 Hall. She further not a system in place been fed. An interview was con Administrator on 3/18 she expected depend	oom, she thought she had e stated she would have fed rrning if she had known there 500 Hall. ducted with CMA #4 on She stated Resident #22 cially grits. She further d Resident #22 her g. ducted with Nurse #6 on She stated the staff was ed Resident #22 her meals. e had not fed Resident #22 g. ducted with Director of 16/22 at 2:00 PM. She was supposed to be assisted every meal. She indicated lall should have fed e there was not a NA on the stated there was currently to identify if a resident had ducted with the //22 at 9:05 AM. She stated lent residents to be assisted		specific deficiency cited remains co and/or in compliance with regulatory requirements. The DON or designee will monitor compliance utilizing the F677 Qualit Assurance Tool weekly for 2 weeks monthly x 3 months or until resolved the QA committee. The DON will me to ensure that dependent residents receive assistance with meal intake receive a tray. Reports will be press to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be mo and the ongoing auditing program reviewed at the weekly Quality Assu Meeting or until deemed not necess compliance with ADL Care. The we QA Meeting is attended by the Administrator, DON, MDS Coordina Therapy Manager, Health Informatio Manager, and the Dietary Manager. Date of Compliance: 04/14/2022	y ty then d by onitor and ented nitored urance sary for ekly ator, on
F 756 SS=J		w, Report Irregular, Act On	F 756		4/14/22

Facility ID: 923086

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROV OMB NO. 0938-03		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMP		
		345207	B. WING				05/2022	
NAME OF P	ROVIDER OR SUPPLIER	ALTH AND HUMAN SERVICES FC CARE & MEDICAID SERVICES OMB CARE & MEDICAID SERVICES OMB CARE & MEDICAID SERVICES OMB CARE & MEDICAID SERVICES OMB CARE & MEDICAID SERVICES STREET ADDRESS, CITY, STATE, 2IP CODE 1402 PINCKNEY STREET WHITEVILLE, NC 28472 MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) TAG TORY OR LSC IDENTIFYING INFORMATION) F 756 F 756	•					
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE	
F 756	§483.45(c) Drug Regi §483.45(c)(1) The dru must be reviewed at I licensed pharmacist. §483.45(c)(2) This re- of the resident's medi §483.45(c)(4) The pha- irregularities to the att facility's medical direct and these reports mu (i) Irregularities included drug that meets the co (d) of this section for a (ii) Any irregularities re- during this review mu separate, written report attending physician and director and director co- minimum, the resident and the irregularity the (iii) The attending phy resident's medical reco- irregularity has been taken be no change in the m physician should doct the resident's medical §483.45(c)(5) The fac- maintain policies and drug regimen review to limited to, time frames the process and steps when he or she identi- requires urgent action	imen Review. ag regimen of each resident east once a month by a view must include a review cal chart. armacist must report any tending physician and the ctor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist st be documented on a ort that is sent to the nd the facility's medical of nursing and lists, at a it's name, the relevant drug, e pharmacist identified. visician must document in the cord that the identified reviewed and what, if any, n to address it. If there is to nedication, the attending ument his or her rationale in I record. sility must develop and procedures for the monthly that include, but are not is the pharmacist must take fies an irregularity that n to protect the resident.	F	756				

Facility ID: 923086

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/28/2022 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	СОМ	E SURVEY PLETED
		345207	B. WING _				/05/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	COMMONS N&R CTR OF			14	402 PINCKNEY STREET		
LIDERT				W	/HITEVILLE, NC 28472		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	Based on record revi Consultant Pharmacis the facility failed to ac recommendations con Pharmacist's initial M (MRR) to follow up or Phenobarbital an anti treatment of Epilepsy causes seizures) resu 12 doses of the medic whose medications w #87). Immediate Jeopardy facility failed to act up Pharmacist's initial M entry for the Phenoba doses. Resident #87 04:30 AM on 02/09/2 administer the neede	iew, staff interviews, the st, and Physician interviews et upon the intained in the Consultant edication Regimen Review in an order entry for icconvulsant used in the (a brain disorder that ulting in failure to administer cation for 1 of 1 resident vere reviewed (Resident began on 02/03/22 when the	F	756	This removal plan is submitted as required under State and/or Federal la The submission of this removal plan of not constitute an admission on the pa the facility or community as to the accuracy of the surveyors' findings or conclusions drawn therefrom. Submission of this removal plan also not constitute an admission that the findings constitute a deficiency or that scope and severity regarding the deficiency cited are correctly applied. changes to the facility's or community policies and procedures should be considered subsequent remedial measures as that concept is employe Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The facility / community submit	loes rt of the does the Any 's d in f	
	correct dose of the ar Dilantin. Immediate J 03/27/22 when the fa implemented an acce Jeopardy removal. Th compliance at a lowe to ensure monitoring effective. Findings included. Resident #87 was ad home on 02/02/22. H part; Epilepsy, and hi injury at birth. Resident #87's active	nticonvulsant medication, eopardy was removed on cility provided and eptable plan of Immediate he facility remains out of r scope and severity of "D" systems put in place are mitted to the facility from her er diagnoses included in story of traumatic brain			this removal plan with the intention the be inadmissible by any third party in a civil or criminal action against the facility/community or any employee, agent, officer, director, attorney, or shareholder of the facility/community affiliated entities. The Removal Plan F756: The entity's removal plan must include following: Identify those recipients who have suffered, or are likely to suffer, a serior adverse outcome as a result of the noncompliance. Resident # 87 was admitted on 2/2/20	at it ny or e the ous	Program 11 of 44

Facility ID: 923086

If continuation sheet Page 11 of 44

		MEDICAID SERVICES				OMB NO. 09	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE SUR COMPLETE	
			A. BUILDING			с	
		345207	B. WING			04/05/2	022
NAME OF P	ROVIDER OR SUPPLIER				CITY, STATE, ZIP CODE	04/05/2	022
				1402 PINCKNEY ST			
LIBERTY	COMMONS N&R CTR O	F COLUMBUS CTY		WHITEVILLE, NC			
(X4) ID	-	ATEMENT OF DEFICIENCIES	ID	-	VIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIA DEFICIENCY)	-	MPLETIOI DATE
F 756	Continued From page	e 11	F 75	6			
	Phenobarbital 32.4 m	ngs (milligrams) take 2		and had an c	order for Phenobarbital. Th	ne	
	tablets by mouth twic			phenobarbita	al was started on 2/8/2022,		
					ed in 12 missed doses. On	ו I	
		d 02/03/22 documented by			resident had a seizure		
		st #1 who completed the			utes and the physician ntin 100 mg and		
	initial Medication Reg	irsing to follow up on the			al 30 mg now which were		
	order entry for Pheno				. The resident's vital signs	\$	
					normal limits and oxygen	-	
f	A review of Resident	#87's medication orders			as 97 % on room air. The		
	•	ant's Pharmacists (#1) MRR			narmacist completed the		
		22 - 02/08/22 there was no			egimen review on 2/3/2022	2.	
	-	r entry for Phenobarbital			mended that the facility	Th:_	
	32.4 mgs.				the Phenobarbital order. 1 pleted because the Directo		
	Review of the Medica	ation Administration Record			d not get the report via em		
		ry 2022 revealed from			nined that the Director of	an.	
	admission on 02/02/2				not receive the email due to	oa	
	Phenobarbital 32.4 m	ngs 2 tablets twice a day was		blocked ema	il account. This was		
		Resident #87 resulting in 12			3/17/2022. An additional		
		rder was not entered on the			as that the Director of		
	MAR until 02/08/22.			0	not validate that the		
	A progress note doci	imented by Nurse # 3 dated		or addressed	egimen review was receive I.	u	
		I revealed at 04:30 AM					
		seizure lasting 2 minutes,		On 3/25/2022	2, the director of nursing		
		n to give Dilantin 100 mgs		reviewed the	medication regimen review		
		tal 40 mgs now, and we			dmissions from 3/16/2022	to	
		me dose of the medication			All residents audited had a		
		it was in from pharmacy of			egimen review completed.		
		ualing 40 mgs, and recheck veek. Residents (#87) vital			ations were reviewed by th ursing to ensure that	ie –	
	signs are within norm	. ,			ations were addressed and		
		room air, no seizure activity			were obtained from the		
		ponsible Party) aware of			o errors were identified.		
	seizure and new orde						
					iction the entity will take to		
		note, and summary of stay			cess or system failure to		
	dated 02/09/22 - 02/1	6/22 for Resident #87		prevent a sei	rious adverse outcome fror	m	

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	S FOR MEDICARE &		0	E 0010		<u>MB NO. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X:	3) DATE SURVEY COMPLETED
			A. BUILDING	·····		С
		345207	B. WING			04/05/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE	
				1402 PINCKNEY STR	EET	
	COMMONS N&R CTR OF			WHITEVILLE, NC 2	28472	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CC	DER'S PLAN OF CORRECTION DRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 756	Continued From page	e 12	F 75	6		
		at 9:57 PM Resident #87		-	curring, and when the	
	was evaluated follow	ing a seizure at nursing		action will be c	-	
	(Resident #87) was a	post ictal since that time.		On 3/25/2022	the Vice President of	
		rival, but unable to provide			serviced the Director of	
	• ·	stems due to cognitive			ithin three business days	
	impairment secondar				mission that the medicatior	1
	disorder. Upon exam	ination Resident 87's		regimen reviev	v should be received and	
	general appearance	-			clarification or corrective	
		ute distress. She would			mended by the pharmacist	
		muli but then immediately			ressed with the physician a	s
		would look at you with			e medication regimen	
	management of seizu	ent #87 was admitted for			eceived within three the Director of Nursing	
		and pneumonia. A hospital		-	the pharmacy and request	
		evealed (Resident #87)			be completed. The	
		and was unable to consume			vas also trained that in the	
		time. On 02/14/22 (Resident			Director of Nursing, they	
		(nothing by mouth), was		should ensure	that the medication	
	unable to consume a	nything orally, family decided		regimen reviev	v is received and they	
		rtificial nutrition. A note dated		should work wi	ith the nurses to initiate	
	02/14/22 revealed tw				corrective action. When the	9
		g of fever. A neurology note			nducts the medication	
	dated 02/15/22 revea			-	(MRR) for all newly	
		m) showed intermittent and slowing suggestive of a			nts (within 3 business sultant pharmacist will call	
		epsy, also has pneumonia.			Nursing, or the	
		evealed (Resident #87) had			f Director of Nursing is not	
		sive on a daily basis, and if			e facility Charge Nurse if	
	-	ement in mental status			tor is not available. The	
		ng in (residents) usual			rmacist will call until he/she	e
		ven EEG x 2 not showing			disciplines to ensure the	
	· ·	mmend transferring for			acted upon timely. This	
		toring to rule out subclinical			completed by the Vice	
		as discharged to another			perations, in collaboration	
	hospital for EEG mor	away at her home March			nacist Manager, 3/26/22 to inication by the consultant	
	2022.	away at their northe March			mmediate for high risk	

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		MEDICAID SERVICES			OMB NO. 0938-	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345207	B. WING		C 04/05/2022	
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
LIBERTY	COMMONS N&R CTR O	F COLUMBUS CTY		1402 PINCKNEY STREET WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COR		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLE TE APPROPRIATE DAT	
F 756	Continued From page	e 13	F 75	56		
F 130	A phone interview wa 3:53 PM with Nurse # Resident #87's assig seizure. She stated s Resident #87 having prior to that night. Nu seizure and after the (Phenobarbital and D her vital signs were s another resident on li received an order to a Resident #87 when s she had to borrow from received an order to a following morning. She why the Phenobarbitat Resident #87 but state pharmacy that night a didn't receive a return pharmacy. A phone interview wa 04:18 PM with the Co She stated she condum MRR for Resident #83 she sent a nursing no Phenobarbital order. MRR was completed Resident #87's progra- follow up on the Pheno- she also sent an ema- recommendations to review. She stated the follow up with the Pheno- A follow up phone interview was pheno- she stated she stated the follow up phone interview was pheno- she also sent an ema- recommendations to review. She stated the follow up phone interview was pheno- pheno- she stated the pheno- she also sent an ema- recommendations to review. She stated the pheno- she stated the pheno- Resident #87's prografication to review. She stated the pheno- she stated the pheno-	as conducted on 03/15/22 at #3. She stated she was ned nurse on the night of the she was not aware of any seizures at the facility irse #3 stated after the medications were given Dilantin) she slept well, and stable. She stated she had iquid Phenobarbital, and she give liquid Phenobarbital to she had the seizure which on another resident, and she start Phenobarbital the ne stated she was not sure al was not available for ted she did call the after calling the physician but n phone call from the as conducted on 03/16/22 at onsultant Pharmacist (#1). ucted the initial admission 7 on 02/03/22. She stated obte to follow up on the She stated after the initial , she entered a note in ess notes on 02/03/22 to nobarbital order and stated ail with the notes and the facility on the day of the erecommendation read to enobarbital order entry.		recommendations for follow through calling facility leade of Nursing, Administrator, of licensed leadership team/ch communicate recommendat effective 3/26/22. On 3/25/2022, the Director of serviced the nurse leadersh within three business days a admission that the medication review should be received at Any clarification or corrective recommended by the pharm be addressed with the physic needed. If the Director of N absent, the administrator with medication regimen review On 3/25/2022, the Quality A admission checklist that is the completed the next business admission was updated by the administrator. The update if to include validating that the regimen review has been ref 3/25/2022, the Director of N educated the nurse leaders changes to the admission cl All education regarding vertif physician orders was initiated clinical consultant and comp active licensed staff, includin aides, medication techs, liced staff on or before 3/25/22, b clinical consultant, MDS RN Nursing.	rship (Director r Clinical harge nurse to tion(s) directly, of Nursing in ip team that after a new on regimen and reviewed. e actions hacist should ician as ursing is Il provide the to the nurse Assurance o be s day after the ncluded a line e medication decived. On ursing on the hecklist. fication of ed 3/17 by the oleted for all ng medication ensed nursing y either the , or Director of	
	04/05/22 at 12:15 PM #1. She stated the in	1 with Consultant Pharmacist		All other education, includin ensuring MRRs are received upon was completed by the	d and enacted	

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			()(0)			NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			()	TE SURVEY
			A. BUILDING	<u> </u>		С
		345207	B. WING			
	ROVIDER OR SUPPLIER	545207		STREET ADDRESS, CITY, STATE, Z		04/05/2022
	NOVIDER OR SOFFLIER			1402 PINCKNEY STREET		
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY		WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 756	Continued From page	e 14	F 75	56		
	saw the Phenobarbita	al order on the orders that		President of Operations	on 3/26/22 with	
	were scanned into the	e electronic medical record		the Director of Nursing a		
	and put a note in the	resident's progress note to		Administrator. The Lice		
	-	nobarbital order entry. She		Administrator and the M	IDS RN were	
	stated she also sent t	he pharmacy		added to the MRR elect	ronic distribution	
	recommendation via	email to the DON (Director		list 3/25/22, which also i	includes the	
		me day which included to		Director of Nursing. Th		
		cation order which was the		Manager was notified or		
		onducting initial MRR's. She		expand the distribution l		
		ake a recommendation		on 3/25/22 as complete		
	regarding the Dilantin	order.		President of Operations		
	.			previously, all high-risk		
		ducted on 03/16/22 at 02:44		reviews by the consultation	-	
	indicated that she wa	of Nursing (DON). She		be communicated throu validate receipt and follo		
		st's (#1) note contained in		Monitoring Procedure to	-	
		02/03/22 that noted to		plan of correction is effe		
		nobarbital order. She stated		specific deficiency cited		
		ugh her emails after the		and/or in compliance wi		
		RR and did not see an email		requirements.	an regulatory	
		ations. She indicated the		The DON or designee w	vill monitor	
		cist's initial MRR should have		compliance utilizing the		
		ng the medication review.		Quality Assurance Tool		
				weeks then monthly x 3	months or until	
		ducted on 03/17/22 at 1:00		resolved by the QA com		
		n. He stated not receiving		will monitor to ensure th		
		d Resident #87's threshold		orders are entered acco	-	
	-	er 4-5 days of not having the		physician ordered admis		
	medication which led	to her having a seizure.		and ensure that the Initi		
	The Administructure	a patified of the large - list-		(Medical Record Review	, .	
		s notified of the Immediate		within 72 hours of admis		
	Jeopardy via prione c	on 03/25/22 at 4:45 PM.		be presented to the wee Assurance committee b		
	Immediate leonardu	Removal Plan:		ensure corrective action	•	
	Immediate Jeopardy	completion date: 03/27/22		appropriate. Compliance		
		completion date. 03/21/22		and the ongoing auditing		
	1 Identify those recipi	ents who have suffered, or		reviewed at the weekly		
		serious adverse outcome as		Meeting or until deemed		
	a result of the noncor			compliance with ADL Ca		

Facility ID: 923086

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/28/2022 M APPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345207	B. WING				C / 05/2022
NAME OF PF	ROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				14	402 PINCKNEY STREET		
LIBERTY	COMMONS N&R CTR OF			v	VHITEVILLE, NC 28472		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	order for Phenobarbit started on 2/8/22, wh doses. On 2/9/22 the lasting 2 minutes and Dilantin 100 mg and F which were administer signs were within nor saturation was 97 %	dmitted on 2/2/22 and had an cal. The phenobarbital was ich resulted in 12 missed resident had a seizure the physician ordered Phenobarbital 30 mg now ered. The resident's vital mal limits and oxygen on room air. The consultant	F	756	QA Meeting is attended by the Administrator, DON, MDS Coordinato Therapy Manager, Health Information Manager, and the Dietary Manager. Completion date: 3/27/2022.		
	review on 2/3/22. It w facility follow up on th was not completed be Nursing did not get th determined that the D receive the email due This was corrected of cause was that the D	d the medication regimen ras recommended that the re Phenobarbital order. This ecause the Director of re report via email. It was Director of Nursing did not to a blocked email account. In 3/17/22. An additional root irector of Nursing did not ication regimen review was d.					
	medication regimen r from 3/16/22 to 3/25/2 a medication regimen Recommendations w of Nursing to ensure to	ere reviewed by the Director that recommendations were ications were obtained from					
	process or system fai adverse outcome fror when the action will b	-					
	serviced the Director	President of Operations in of Nursing that within three new admission that the			niithu IDu 022086 Manuari		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345207	B. WING				C 105/2022
NAME OF P	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY			1402 PINCKNEY STREET WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 756	and reviewed. Any cla actions recommended be addressed with the medication regimen re- three business days, should contact the ph- review be completed. trained that in the abs Nursing, they should regimen review is rec- with the nurses to init action. When the pha- medication regime re- admitted patients (wit consultant pharmacis Nursing, or the Admir Nursing is not availab Nurse if the Administr consultant pharmacis reaches stated discip clarification is acted u- was completed by the Operations, in collabo Manager, 3/26/22 to e the consultant pharma- high-risk medication r recommendations for calling facility leaders Administrator, or Climi team/charge nurse to recommendation(s) d On 3/25/22, the Direct the nurse leadership is business days after a medication regimen re- and reviewed. Any cla	eview should be received arification or corrective d by the pharmacist should e physician as needed. If the eview is not received within the Director of Nursing armacy and request that the The administrator was also sence of the Director of ensure that the medication eived, and they should work iate follow up and corrective rmacist conducts the view (MRR) for all newly hin 3 business days), the t will call the Director of ole, or the facility Charge ator is not available. The t will call until he/she lines to ensure the upon timely. This education e Vice President of oration with the Pharmacist ensure communication by acist is immediate for eviews that have follow up required, through hip (Director of Nursing, ical licensed leadership communicate irectly, effective 3/26/22.	F	756			

Facility ID: 923086

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345207	B. WING				05/2022
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY			1402 PINCKNEY STREET WHITEVILLE, NC 28472		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 756	be addressed with the Director of Nursing is will provide the medic nurse manager on du On 3/25/22, the Qual checklist that is to be business day after ad administrator. The up include validating that review has been rece Director of Nursing ec on the changes to the Completion date: 3/2 regarding verification initiated 3/17/22 by th completed for all activ medication aides, me nursing staff on or be clinical consultant, MI Nursing. All other education, in MRRs are received at completed by the Vice 3/26/22 with the Direc Licensed Administrator Administrator and the MRR electronic distrit also includes the Dire Pharmacist Manager expand the distributio 3/25/22 as completed Operations. As stated medication reviews by	e physician as needed. If the absent, the administrator ation regimen review to the ty for review. ity Assurance admission completed the next mission was updated by the date included a line to the medication regimen ived. On 3/25/22, the ducated the nurse leaders e admission checklist. 7/22 - all education of physician orders was e clinical consultant and re licensed staff, including dication techs, licensed fore 3/25/22, by either the DS RN, or Director of cluding method for ensuring nd enacted upon was e President of Operations on cor of Nursing and the or. The Licensed MDS RN were added to the pution list 3/25/22, which ctor of Nursing. The was notified on 3/25/22 to n list and validated on by the Vice President of previously, all high-risk y the consultant pharmacist through phone call to	F	756			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/28/2022 FORM APPROVED OMB NO. 0938-0391		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345207	B. WING		C 04/05/2022		
	ROVIDER OR SUPPLIER	F COLUMBUS CTY	14	TREET ADDRESS, CITY, STATE, ZIP CODE 402 PINCKNEY STREET /HITEVILLE, NC 28472			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION		
F 756	responsible for ensur F756 have been impl Facility alleges Imme removed 03/27/22. The Immediate Jeop 03/27/22. A sample of staff that pharmacy staff were in-servicing related to staff interviewed state training including in-p materials, regarding to procedures related to procedures related to procedures had been pharmacists MRR pro- the opportunity to inte understanding of the presented. A review of to correct the deficient Facility policies and p to address the deficient The audit form that w the systems put in pla- reviewed.	g Home Administrator is ring the plan of correct for lemented and completed. ediate Jeopardy was ardy was removed on the included nurses, and interviewed regarding the deficient practice. All ed they received in-service person education and written	F 756		4/14/22		
SS=K	CFR(s): 483.45(f)(2) The facility must ensu §483.45(f)(2) Reside medication errors. This REQUIREMENT by: Based on record rev	-		This removal plan is submitted as required under State and/or Federal la			

Facility ID: 923086

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/28/2 FORM APPROV OMB NO. 0938-03
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345207	B. WING _		C 04/05/2022
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STAT	E, ZIP CODE
LIBERTY	COMMONS N&R CTR O	F COLUMBUS CTY		1402 PINCKNEY STREET WHITEVILLE, NC 28472	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION (X5) IVE ACTION SHOULD BE COMPLETIC EED TO THE APPROPRIATE FICIENCY)
F 760	Physician interviews, transcribe a medicati resulting in failure to medication (Phenoba used in the treatment disorder that causes a medication order u failure to administer a medication Dilantin (p prevent seizures) wh having a seizure and hospital for 1 of 1 res 87). Immediate Jeopardy facility failed to transf into the electronic me admission and failed the Phenobarbital so could be filled by the missed doses. The fail anticonvulsant medic failure to administer to anticonvulsant medic failure to administer to anticonvulsant medic Jeopardy was remov facility provided and plan of Immediate Je remains out of compl severity of "E" to ens in place are effective Findings included. 1a.) Resident #87 was	the facility 1.a) failed to on order upon admission administer 12 doses of a arbital) an anticonvulsant t of Epilepsy (a brain seizures). b) failed to clarify pon admission resulting in 4 doses of the anticonvulsant prescribed to treat and ich resulted in the resident being transported to the sident reviewed (Resident # began on 02/02/22 when the cribe the Phenobarbital order edical record (EMR) upon to obtain a hard script for that the medication order pharmacy resulting in 12 acility failed to clarify an on order for Dilantin upon n 4 missed doses. Resident eizure on 02/09/22 at 04:30 ure to administer the needed cation, Phenobarbital, and the correct dose of the station, Dilantin. Immediate ed on 03/26/22 when the implemented an acceptable copardy removal. The facility liance at a lower scope and ure monitoring systems put	F 7	The submission of the not constitute an adm the facility or commu accuracy of the surve conclusions drawn the Submission of this re- not constitute an adm findings constitute an scope and severity re- deficiency cited are of changes to the facilit policies and procedu considered subseque measures as that con Rule 407 of the Fede Evidence, correspon civil procedure and s inadmissible in any p basis. The facility / of this removal plan with be inadmissible by a civil or criminal action facility/community or agent, officer, director shareholder of the fa affiliated entities. The Removal Plan F	eyors' findings or the herefrom. emoval plan also does nission that the deficiency or that the egarding the correctly applied. Any y's or community's irres should be ent remedial ncept is employed in eral Rules of ding state rules of should be proceeding on that community submits h the intention that it ny third party in any n against the any employee, or, attorney, or iscility/community or 760: plan must include the ents who have v to suffer, a serious a result of the dmitted on 2/2/2022 henobarbital and barbital was started o AM, which resulted

Facility ID: 923086

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	OF DEFICIENCIES	MEDICAID SERVICES			CONSTRUCTION	OMB NC	
	CORRECTION	IDENTIFICATION NUMBER:				· /	PLETED
				-			с
		345207	B. WING			04/05/2022	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		00/2022
				14	02 PINCKNEY STREET		
LIBERTY	COMMONS N&R CTR OF	F COLUMBUS CTY		W			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 760	Continued From page	e 20	F 76	50			
		. Her diagnoses included in			2/7/2022, which resulted in 4 missed		
		istory of traumatic brain			doses. On 2/9/2022 the resident had a	а	
	injury at birth.	2			seizure lasting 2 minutes and the		
					physician ordered Dilantin 100 mg and		
	Resident #87's active	•			Phenobarbital 30 mg now which were		
		lity on 02/02/22 revealed			administered. The resident's vital signs	S	
		ngs (milligrams) take 2			were within normal limits and oxygen		
	tablets by mouth twic	e a day.			saturation was 97 % on room air.		
	Review of the Medica	ation Administration Record			A root cause analysis was conducted b the nurse consultant on 3/15/2022.	y	
		ry 2022 revealed from			The Phenobarbital was not entered into	`	
		08/22 Phenobarbital 32.4			the electronic health record on admissi		
	-	day was not administered to			and a hard script was not received. Th		
		ig in 12 missed doses. This			admitting nurse stated in an interview t		
		d on the MAR until 02/08/22.			she did not receive the second page of the photocopied orders that the family	:	
	An interview was con	ducted on 03/16/22 at 01:45			provided. The FL-2 was not used for the		
	PM with Nurse #5 the	e admission nurse on duty			admission process. The Dilantin order		
		vas admitted to the facility.			was entered into the electronic health		
		ed the medication orders			record by the admission nurse. The		
		cture but stated she didn't			photocopied medication list provided by		
	recall seeing page 2				the family stated that the Dilantin 100 n	-	
		She stated she wasn't aware t received Phenobarbital until			cap should be given "2caps Sunday the	u	
	now. She stated if sh				Friday and 1 cap by mouth 2x daily on Saturday". The information provided in		
		she would have sent a			quotes is the exact language from the		
		ician to get a hard script to			medication list. The nurse entered into	1	
		cause pharmacy would not			the electronic health record that 2		
		hout a hard script since it			capsules should be given one time a da	•	
		lication. She stated she			Sunday thru Friday and 2 capsules twic	ce a	
		initialed by the medication			day on Saturday.		
		e orders but stated the copy			On 2/7/2022 the physician was contact	ed	
		ent #87's medical record s on it. She stated a second			by the nurse because the family had questioned the dosing. The physician		
	nurse double checke				then ordered Dilantin 100 mg 2 capsule	es	
		ere entered accurately and			twice a day on Monday, Tuesday,		
		he order as well, but she			Wednesday, Thursday, Friday and		
		that second nurse was that			Sunday. Dilantin 100 mg twice a day c	n	
		hat day. She stated it was an			Saturday. The root cause of this error		1

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/28/2022 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345207	B. WING				C / 05/2022
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				14	402 PINCKNEY STREET		
LIDERIT	COMMONS N&R CTR OF			W	/HITEVILLE, NC 28472		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	Continued From page	a 21		760			
1 700	- 19	521	F	100			
	error.				that the order did not indicate the	l thio	
	Δ care plan dated 02	/03/22 revealed Resident			frequency for Sunday thru Friday and was not clarified by the nurse.	i uns	
		rder with a risk for injuries.			The consultant pharmacist completed	the	
		to remain free from injury			medication regimen review on 2/3/20		
	-	ivity through the next 90			It was recommended that the facility		
	days. Interventions in				follow up on the Phenobarbital order.	This	
		as ordered by the physician,			was not completed because the Direct	ctor	
		ocument side effects and			of Nursing did not get the report via e		
	effectiveness.				It was determined that the Director of		
					Nursing did not receive the email due	e to a	
	The Minimum Data S	2/09/22 revealed Resident			blocked email account. This was corrected on 3/17/2022. An additionation	_	
	#87 had acute menta				root cause was that the Director of	al	
		and disorganized thoughts.			Nursing did not validate that the		
		two-person assistance with			medication regimen review was recei	ved	
	activities of daily livin	-			or addressed.		
		-			On 3/25/2022, all new admissions fro	m	
	An interview was con	ducted on 03/15/22 at 4:30			3/16/2022 to 3/25/2022 were audited	to	
		ons Coordinator. She stated			ensure medications were entered into		
		mitted from home not from a			electronic health record according to	the	
	•	since she was admitted from			new admission orders. This review,		
		ive a hard script to get the			including verifying that the orders we		
		n the day of admission. She d her role as the admission			complete (includes medication name dose, number of tablets, and frequen		
	-	021 and she should have			and that there were no incomplete	су,	
		t from the physician on the			(pending confirmation) medication or	ders.	
		d she didn't which was an			If the resident had a controlled substa		
	-	e stated when Resident #87's			order, the Director of Nursing ensured		
	family member talked				the nurses had the necessary medica	ations	
		prior to the seizure, she sent			in the facility meaning that hard script	ts	
	a message to the phy	-			had been obtained. This audit was		
		cript. She stated the morning			completed by the Director of Nursing		
		e seizure the family and the			3/25/2022. No errors were identified.		
		ed, and the physician wrote a			On 3/25/2022, the Director of Nursing		
		order because there was no			reviewed the medication regimen rev for all new admissions from 3/16 to	iew	
	phenobarbital for her	administered. She stated she			3/25/2022. All residents audited had	а	
		ne in at 8:00 AM that morning			medication regimen review.	a	
	mas a nuise and call	is in at 0.007 in that morning			moded of regiment review.		

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(22)	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			. ,	MPLETED
						С
		345207	B. WING			4/05/2022
NAME OF PR	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZI	P CODE	
	COMMONS N&R CTR OF			1402 PINCKNEY STREET		
				WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 760	Continued From page	22	F 76	50		
	following the seizure	and Resident #87 was post		Recommendations were	reviewed by the	
		a seizure), she was asleep,		Director of Nursing to en	-	
	and had no distress.			recommendations were		
		and Administrator asked the		clarifications were obtain	ned from the	
		the resident sent to the		physician. No errors we		
		il after lab results were		Specify the action the er	•	
	-	nted to wait for lab reports,		alter the process or syste		
		nily asked to have resident		prevent a serious advers		
	sent to the hospital fo	or further evaluation.		occurring or recurring, a	nd when the	
	A phone interview we	a conducted on 02/16/22 at		action will be complete.	for all licenced	
	11:46 AM with Pharm	s conducted on 03/16/22 at		On 3/17/2022, education practical nurses, medica		
		spensed from the pharmacy		registered nurses was in		
	for Resident #87 whe			facility clinical consultant	-	
		2 for 64.8 mg one tablet by		included all full time, par		
		he stated the pharmacy		needed staff. The facility		
		d medications without a hard		agency. Education inclu		
	script, but no hard co	pies were sent on 02/02/22.		the FL-2 for admission n	nedications if	
		bital was sent for Resident		received from the home,		
	#87 on 02/09/22.			admission orders to ens	•	
				complete and clearly ind		
	-	s conducted on 04/05/22 at		and frequency, that the p		
		armacy Manager. He stated		be called for clarification	-	
	the pharmacy did not	receive an order for 02/22 for Resident #87. He		confusing orders, and th contact the physician for		
		is for the resident were filled		that are needed. All nev	•	
		s entered into the residents		orders will be verified wit		
	-	harmacy received an order		physician by the Admiss	•	
		Resident #87 on 02/09/22.		and then the charge nur		
				orders in the electronic of		
	An interview was con	ducted on 03/16/22 at 02:44		(Point Click Care) after f	-	
		of Nursing (DON). She		orders were reviewed wi	th physician and	
	-	he nurses to notify the		verified as accurate.		
	physician for a hard s			As of 3/25/2022 nine sta		
		ne the order was received at		not attended the in-servi	-	
	-	medications could be filled		are either as needed em		
	and sent from pharma	acy. She stated the the second nurse that		medical leaves. The Dir will ensure that any of th	-	
	aumission nurse and			WILL ADDITE TEAT ONLY AT th		

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		MEDICAID SERVICES					<u>0. 0938-03</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	· /	E SURVEY PLETED	
			7. 001201110	°			С	
		345207	B. WING			04/05/2022		
NAME OF P	ROVIDER OR SUPPLIER	•	•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY		1402 PINCKNEY STREET WHITEVILLE, NC 28472				
		ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(XE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
F 760	Continued From page	e 23	F 76	50				
	should have identified	d the Phenobarbital order			by 3/25/2022, will not be allowed to wo	rk		
	and obtained a hard s	script.			until the training is completed.			
					On 3/25/2022, the Vice President of			
		ducted on 03/17/22 at 1:00			Operations in serviced the Director of	_		
		n. He stated not receiving			Nursing that within three business days			
		d Resident #87's threshold er 4-5 days of not having the			after a new admission that the medicat regimen review should be received and			
		to her having a seizure.			reviewed by a licensed pharmacist. Ar			
					clarification or corrective actions	.,		
	b.) Resident #87's ac	tive medication list upon			recommended by the pharmacist shoul	ld		
		ity on 02/02/22 revealed			be addressed with the physician			
		ilantin) 100 mg capsules			immediately. If the medication regime	n		
		lay - Friday and 1 capsule by			review is not received within three			
	mouth twice a day on	Saturday.			business days the Director of Nursing should contact the pharmacy and requi	oct		
	Review of the Medica	ation Administration Record			that the review be completed. The	631		
		y 2022 for Resident #87			administrator was also trained that in the	пе		
		odium (Dilantin) 100 mg			absence of the Director of Nursing, he/			
		he order was entered to give			should ensure that the medication			
) by mouth one time a day			regimen review is received, and they			
		lay, Wednesday, Thursday,			should work with the nurses to initiate			
		jive 1 capsule twice a day on			follow up and corrective action same da	ay.		
	mgs) was documente	. Dilantin 2 capsules (200			The Director of Nursing or clinical designee, will ensure all newly admitter	Ч		
		day on 02/03/22, 02/04/22,			residents have an MRR within 3 busine			
		22. The medication order			days, if the MRR is not received via the			
	was corrected on 02/				electronic delivery, the Director of			
					Nursing, the Administrator, and/or clinic	cal		
		d 02/09/22 at 9:41 AM (late			designee will reach out to the consultant	nt		
	entry) documented by				pharmacist to ensure review has been			
	Coordinator revealed				completed and recommendations are			
		family stated Resident #87 Dilantin) two capsules twice			received. The Director of Nursing and the Administrator were educated on			
		s two capsules once a day.			3/25/22 regarding procedure for ensuri	na		
		uuuuuuuuuuuuuuuuuuuuuuuuuuuuuuuu			all MRR's are validated as received an			
	An interview was con	ducted on 03/15/22 at 4:30			enacted on, this education was comple			
		ons Coordinator. She stated			by the Vice President of Operations.			
		mitted from home not from a			On 3/25/2022, the Director of Nursing i			
	hospital. She stated s	she talked to Resident #87's			serviced the nurse leadership team that	it		

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OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
COMPLETED	
C 04/05/2022	
ATE (X5) COMPLETION DATE	
RR will bred cred nce y for y	
IRR I W	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345207	B. WING				C 105/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY			1402 PINCKNEY STREET WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	WARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION FICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DRY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE	
F 760	well, but she could no nurse was that check An interview was com PM with the DON. Sh order did not indicate Sunday - Friday dose order, the order shoul nurse on the day of a expected the nurses of clarification when med incomplete or unclear A progress note docu 02/09/22 at 05:49 AM resident (#87) had a so ordered per physician now and Phenobarbit could borrow a one-tii until it was in from phi- equaling 40 mgs, and one week. Residents normal limits, and oxy room air, no seizure a (Responsible Party) a orders. A review of the Dilant at the facility revealed (micrograms per millil mcg/ml). There was m Phenobarbital levels of levels were drawn at resulted in 11.7 mcg/m	d would initial the order as at recall who that second ed behind her that day. ducted on 03/16/22 at 02:44 e stated since the Dilantin the frequency for the and was an incomplete d have been clarified by the dmission. She stated she to notify the physician to get dication orders were to give Dilantin 100 mgs al 40 mgs now, and we me dose of the medication armacy of 10 mls (milliliters) recheck Dilantin level in (#87) vital signs are within gen saturation is 97% on activity at this time. RP ware of seizure and new in level drawn on 02/09/22 a result of 6.8 mcg/ml iter- normal range 10-20 to physician order to draw on 02/09/22. Phenobarbital the hospital on 02/09/22 and ml (normal range 15-40	F	760			
	dated 02/09/22 - 02/1						

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/28/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345207	B. WING			_		C 05/2022
NAME OF PI	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
	COMMONS N&R CTR OF				1402 PINCKNEY STREET			
					WHITEVILLE, NC 28472	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	was evaluated followi and had been post ict #87) was awake and arrival, but unable to systems due to cogni of seizure disorder. U 87's general appearan nourished, with no ac awake with verbal stir fall back asleep. She painful stimuli. Reside management of seizu Phenobarbital levels, note dated 02/11/22 r remained somnolent a anything orally at the #87) remained NPO (unable to consume an decided against any t note dated 02/14/22 r breakthrough seizures neurology note dated (electroencephalograf bilateral sharp waves known history of epile The neurology note re become more respon there was no improve despite all levels bein therapeutic range, giv seizures. Resident wa hospital for EEG mon Resident #87 passed 2022.	at 9:57 PM Resident #87 ng seizure at nursing home tal since that time. (Resident alert to surroundings upon provide accurate review of tive impairment and history pon examination Resident nce was lethargic, well ute distress. She would muli but then immediately would look at you with ent #87 was admitted for tres, Dilantin and and pneumonia. A hospital evealed (Resident #87) and was unable to consume time. On 02/14/22 (Resident nothing by mouth), was nything orally, and family ype of artificial nutrition. A evealed two brief s in the setting of fever. A 02/15/22 revealed EEG m) showed intermittent and slowing suggestive of a epsy, also has pneumonia. evealed (Resident #87) had sive on a daily basis, and if ement in mental status g in (residents) usual ren EEG x 2 not showing nmend transferring for toring to rule out subclinical as discharged to another itoring on 02/16/22. away at her home March	F	760				
	A phone interview wa	s conducted on 03/15/22 at						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345207	B. WING				05/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY			1402 PINCKNEY STREET WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	3:53 PM with Nurse # Resident #87's assign seizure. She stated si Resident #87 having prior to that night. She fine all night until that aide was in front of th seizure started but sh aide it was. She state in pain, and she could after the seizure and given (Phenobarbital and her vital signs we had another resident she received an order to Resident #87 when she had to borrow fro received an order to s following morning. Sh check her vital signs a to assess her during f stable. Resident #87 when she left after he she was not sure why available for Resident the pharmacy that nig but didn't receive a re pharmacy. She indica coordinator or the nur resident was admitted admission orders. An interview was cor PM with the Physician Phenobarbital and red Dilantin dose the resid lowered Resident #87 activity after 4-5 days	3. She stated she was ned nurse on the night of the he was not aware of any seizures at the facility e stated the resident was point and stated a nurse e resident's door when the he did not recall which nurse d you could ask if she was d say yes. Nurse #3 stated after the medications were and Dilantin) she slept well, ere stable. She stated she on liquid Phenobarbital, and r to give liquid Phenobarbital in she had the seizure which m another resident, and she stated she continued to and she would wake her up the night and she was was still sleeping at 7:00 AM er shift ended. She stated v the Phenobarbital was not t #87 but stated she did call ght after calling the physician turn phone call from the ated the admissions ree on the hall when the d would have entered the and ucted on 03/17/22 at 1:00 n. He stated not receiving ceiving only half of the dent received at home "s threshold for seizure	F	760			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345207	B. WING _				C / 05/2022
NAME OF P	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY			1402 PINCKNEY STREET WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 760	Continued From page	2 8	F	760			
		as notified of the Immediate on 03/25/22 at 4:45 PM.					
	Immediate Jeopardy F760: Removal plan	Removal Plan: completion date: 03/26/22					
		ents who have suffered, or serious adverse outcome as npliance;					
	orders for Phenobarb	arted on 2/9/22 at 04:30 AM,					
	resulted in 4 missed of resident had a seizur physician ordered Dil Phenobarbital 30 mg administered. The res	e lasting 2 minutes and the antin 100 mg and					
	A root cause analysis nurse consultant on 3	was conducted by the 3/15/22.					
	electronic health reco script was not receive stated in an interview second page of the p family had provided. the admission proces entered into the elect admission nurse. The provided by the family	as not entered into the ord on admission and a hard ed. The admitting nurse that she did not receive the hotocopied orders that the The FL-2 was not used for es. The Dilantin order was ronic health record by the e photocopied medication list y stated that the Dilantin 100 e given "2caps Sunday thru					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345207	B. WING				C 105/2022
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY			1402 PINCKNEY STREET WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 760	Friday and 1 cap by n The information provi language from the me entered into the electric capsules should be gi thru Friday and 2 cap Saturday. On 2/7/22 the physician mg 2 capsules twice a Wednesday, Thursda Dilantin 100 mg twice root cause of this error indicate the frequency and this was not clarif The consultant pharm medication regimen re recommended that th Phenobarbital order. because the Director report via email. It wa Director of Nursing di to a blocked email act on 3/17/22. An additio Director of Nursing di medication regimen re addressed. On 3/25/22, all new a 3/25/22 were audited entered into the electri according to the new review, including verifi complete (included m	nouth 2x daily on Saturday". ded in quotes is the exact edication list. The nurse ronic health record that 2 iven one time a day Sunday sule twice a day on an was contacted by the mily had questioned the n then ordered Dilantin 100 a day on Monday, Tuesday, y, Friday, and Sunday. a day on Saturday. The or is that the order did not y for Sunday thru Friday, fied by the nurse. hacist completed the eview on 2/3/22. It was e facility follow up on the This was not completed of Nursing did not get the s determined that the d not receive the email due count. This was corrected onal root cause was that the d not validate that the eview was received or dmissions from 3/16/22 to to ensure medications were ronic health record admission orders. This fying that the orders were edication name, dose, d frequency, and that there	F	76			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI	E SURVEY PLETED
		345207	B. WING			04	C / 05/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY			1402 PINCKNEY STREET WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	χ (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (E				PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	substance order, the that the nurses had the the facility meaning the obtained. This audit we Director of Nursing or identified. On 3/25/22, the Director medication regimen referred and clarification regimen referred by the ensure that recomme and clarifications were physician. No errors were that recomme from 3/17/22, education the process or system fail adverse outcome from when the action will be On 3/17/22, education ail was initiated by the faeducation included all needed staff. The face Education included at the dimission medication how to review admisss they are complete and and frequency, that the called for clarification orders, and that they for any hard scripts the admitted orders will be physician by the Admithe charge nurse will	the resident had a controlled Director of Nursing ensured the necessary medications in that hard scripts had been vas completed by the the 3/25/22. No errors were tor of Nursing reviewed the eview for all new admissions All residents audited had a eview. Recommendations Director of Nursing to indations were addressed, e obtained from the were identified. The entity will take to alter the lure to prevent a serious in occurring or recurring, and e complete. The for all licensed practical des and registered nurses acility clinical consultant. The I full time, part time and as ility does not utilize agency.	F	760			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/28/2022 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345207	B. WING		_		C 05/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	•	
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY					
				VHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page	31	F 760				
	first ensuring the order physician and verified	rs were reviewed with					
	as needed employees Director of Nursing wi staff who have not co training by 3/25/22, w until the training is co On 3/25/22, the Vice serviced the Director	e because they are either s or on medical leaves. The Il ensure that any of the nine mplete the in-service ill not be allowed to work mpleted. President of Operations in of Nursing that within three					
	medication regimen re and reviewed by a lice clarification or correct by the pharmacist sho physician immediately review is not received the Director of Nursin pharmacy and reques completed. The admin that in the absence of	t that the review be histrator was also trained the Director of Nursing,					
	with the nurses to initiaction same day. The clinical designee will eresidents have an MF the MRR is not received delivery, the Director Administrator, and/or out to the consultant phas been completed areceived. The Director Administrator were expregarding the procedure of the	eived, and they should work ate follow up and corrective Director of Nursing or ensure all newly admitted R within 3 business days, if ed via the electronic of Nursing, the clinical designee will reach oharmacist to ensure review and recommendations are r of Nursing and the					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/28/2022 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE	
		345207	B. WING				C 1 05/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	COMMONS N&R CTR OF			1	1402 PINCKNEY STREET		
LIDERT	COMMONS Nak CIK OF			N	WHITEVILLE, NC 28472		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 760	education was comple Operations. On 3/25/22, the Direct the nurse leadership to business days after a medication regimen re and reviewed. Any cla actions recommended be addressed with the the Director of Nursin administrator will prov- review to the nurse m Completion date: 3/2 The Licensed Nursing responsible for ensuri F760 have been imple Facility alleges Immed removed 03/26/22. The Immediate Jeopa 03/26/22. The Removal Plan of validated on 04/05/22 A sample of staff that aides, and pharmacy regarding in-servicing practice. All staff inter in-service training incl and written materials, and procedures relate administration, that in medications, and ens	eted by the Vice President of tor of Nursing in serviced team that within three new admission that the eview should be received arification or corrective d by the pharmacist should e physician immediately. If g is absent, the ride the medication regimen anager on duty for review. 6/22 g Home Administrator is ng the plan of correct for emented and completed. diate Jeopardy was ardy was removed on Immediate Jeopardy was included nurses, medication staff were interviewed related to the deficient viewed stated they received uding in-person education regarding the facility policy ed to medication	F	760			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/28/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345207	B. WING		C 04/05/2022
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY		02 PINCKNEY STREET HITEVILLE, NC 28472	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETION
F 760 F 761 SS=E	understanding of the presented. A review of to correct the deficient Facility policies and p to address the deficient The audit forms that w	t with dialogue to ensure in-services that were of all documents developed it practice was completed. rocedures that were revised int practice were reviewed. were developed to monitor in place were effective were d Biologicals	F 760 F 761		4/14/22
	§483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of §483.45(h)(1) In accor Federal laws, the faci biologicals in locked of temperature controls, personnel to have accor §483.45(h)(2) The face locked, permanently a storage of controlled the Comprehensive E Control Act of 1976 a abuse, except when the	of Drugs and Biologicals a used in the facility must be 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			
	be readily detected.	is not met as evidenced			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/2 FORM APPF OMB NO. 0938	ROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	Y
		345207	B. WING		C 04/05/202	22
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, Z	IP CODE	
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY		1402 PINCKNEY STREET WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMP TO THE APPROPRIATE DA	X5) PLETION ATE
F 761	Continued From page	e 34	F 7	61		
	facility failed to dispose of expired medication store 4 tablets in its of what the expiration da carts (100 Hall Medic Medication Cart) obset storage. Findings included: 1. An observation of with Certified Medica 03/16/22 at 8:30 AM individual packets of milligrams (mg) on st with an expiration of was a stock medication resident who was rec An interview with CM revealed she believed checked and cleaned stated she checked h insulin pens before an stated she did not has Loperamide Hydroch any resident so far or she missed seeing th 2. An observation of with CMA #3 on 03/10 individual packet of L mg on the medicatior of 12/2021 and 4 tabl which were not in the were unopened in an	the 100 Hall medication cart tion Aide (CMA) #2 on revealed there were 6 Loperamide Hydrochloride 2 ored in the medication cart 12/2021. This medication on to be used for any teiving it. A #2 on 03/16/22 at 8:30 AM d the medication carts were I on the night shift. CMA #2 ter stock medications and dministering them. CMA #2 ve to administer the oloride (allergy medicine) to in this shift on 03/16/22 so		The statements made of correction are not an ad not constitute an agreer alleged deficiencies. To remain in compliance and state regulations the or will take the actions is plan of correction. The prostitutes the facility's compliance such that all deficiencies cited have a corrected by the dates in F761 1. Corrective action for affected by the alleged of The Certified Medication the expired loperamide and the 4 tablets of Om tabs from the medication discarded it. This was coustified to be affected deficient practice. All residents who receive (OTC) medication have affected by the alleged of On 3/27/2022, the Nurs team completed an aud medication carts for the to ensure no OTC medi or stored without its originace and the medication carts for the to ensure no OTC medi completed by the Nurset Team. 3. Measures/Systemic	mission to and do nent with the e with all federal e facility has taken bet forth in this olan of correction allegation of alleged been or will be ndicated. resident(s) deficient practice : n Aide removed hydrochloride 2mg eprazole 20mg n cart and ompleted on residents with the by the alleged e Over the counter the potential to be deficient practice. e management it of all current following: audited cation was expired jinal ion date was not . This was Management	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345207	B. WING				C 05/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY					
			WHITEVILLE, NC 28472				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		TAG CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION DATE	
F 761	date. An interview with CM, revealed the medicati time per week, and sl checked them. CMA a medication cart she medications, make su when they were open that was opened has stated the Omeprazol out of their original bc away. She stated she did not have an expira stated she overlooked Loperamide Hydrochl both of these medicati medications that were residents, and she did on this shift. An interview was con Nursing (DON) on 03 DON reported she ex to be cleaned and che expiration dates of all medications are dated sure there were no lo the cart. The DON st should be checking the	A #3 on 03/16/22 at 9:15 AM on carts were checked one he believed the night nurses #3 stated when she was on would check for expired ire all insulins were dated ed and any other medication an opened date. CMA #2 that the box was thrown e did not realize the tablets ation date on them. CMA #2 d that there was an expired oride 2 mg. CMA #3 stated tions were stock e shared with all the d not administer them so far ducted with the Director of (17/22 at 4:10 PM. The pected the medication carts ecked to include checking medications, checking that d when opened, and making ose pills or spilled liquids on ated each nursing staff heir medications before dication and the night nurses check and clean on the night	F	761	 prevent reoccurrence of alleged deficient practice: Education: On 3/18/2022, the Director of Nursing initiated the following education to all Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPN Medication Aides, and Medication Tech full time, part time, agency, and PRN set. Med Cart and Ensuring medication are not expired Storing OTC medications in its original box for identification of expiratid date if the expiration date is not listed of the medication. Effective 4/12/2022, any of the above identified employees who have not received this education will not be allow to work until the training has been completed. The in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements. The DON or designee will monitor compliance utilizing the F761 Quality Assurance Tool weekly for 2 weeks the monthly x 3 months or until resolved by the QA committee. The DON will monito is effective and of expired drugs and OTC medications are stored in their original packaging a 	Ns), h's, staff: ns ion on wed tt hat cted en y tor ee s	
					the QA committee. The DON will moni- to ensure that the medication cart is fre of expired drugs and OTC medications	tor ee s	

Event ID: 4GD411

Facility ID: 923086

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/28/202 MAPPROVE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED C 04/05/2022		
		345207	B. WING				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1402 PINCKNEY STREET WHITEVILLE, NC 28472				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From page	≥ 36	F7	761	the weekly Quality Assurance committee by the DON to ensure corrective action initiated as appropriate. Compliance wi be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed no necessary for compliance with ADL Ca The weekly QA Meeting is attended by Administrator, DON, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 4/14/2022	is II y t re. the	
F 812 SS=F	Food Procurement,St CFR(s): 483.60(i)(1)(2 §483.60(i) Food safet The facility must -		F 8	312	Date of Compliance. 4/14/2022		4/14/22
	state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pu gardens, subject to co safe growing and food (iii) This provision doe from consuming food §483.60(i)(2) - Store,	ed satisfactory by federal, es. bod items obtained directly subject to applicable State ulations. s not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility. prepare, distribute and unce with professional					
	This REQUIREMENT by:	n and staff interviews the			The statements made on this plan of		

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		345207	B. WING	C 04/05/2022			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
				14	02 PINCKNEY STREET		
LIBERTY	COMMONS N&R CTR O	F COLUMBUS CTY		W	HITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<u> </u>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 812	Continued From page	e 37	F 8	12			
	1.5	re the sanitization solution	10	12	correction are not an admission to and	do h	
		1 three compartment sinks			not constitute an agreement with the	u uU	
	-	kets used to sanitize the			alleged deficiencies.		
	kitchen countertops v				To remain in compliance with all feder	al	
	manufacturer's recon			and state regulations the facility has ta			
	the potential to affect			or will take the actions set forth in this			
	served food.				plan of correction. The plan of correcti	ion	
				constitutes the facility's allegation of			
	Findings included:				compliance such that all alleged		
					deficiencies cited have been or will be	•	
	On 03/16/22 at 1:55 l				corrected by the dates indicated.		
	three-compartment s			F812			
		s was tested using test strips			1. For dietary services, a corrective		
	•	nanufacturer. The test strips			action was obtained on 3/16/2022.		
	-	as indicated on the box of			During initial walls through of the later	it	
	Dietary Manager.	ests were conducted by the			During initial walk through of the kitch was noted dietary services had failed		
	Dietary Manager.				test and confirm the sanitation strengt		
	During an interview w	vith the Dietary Manager on			the 3 compartment sink and a sanitation		
		she stated she did not know			bucket prior to use. The Dietary Service		
		three compartment sink was			Director drained the sanitation		
	not properly sanitized			compartment of the 3 compartment si	nk		
	Quat" sanitizer soluti			and refilled the sink manually adding			
		en the water was turned on to			sanitation solution; a test strip was use	ed to	
	-	orted the (5) test strips (each			indicate the correct ppm per manufact		
		ter for 90 seconds according			recommendations prior to use. The Pl		
		s instructions) that remained			cook dumped and refilled the sanitation	n	
		turned green indicating the			bucket manually adding sanitation		
		parts per million (ppm) or			solution; ppm was confirmed to be wit		
		solution suggested by the			the manufacture recommended ppm		
	-	ction of the tubing running			testing strip prior to use. Dietary staff	were	
		olution (light red in color) to ed the solution was not			alerted the automatic function of the	·0	
		ube when the water was			sanitation system was down and to us the manual function to obtain sanitation		
		ary Manager stated she did			solution.	/11	
		tomatic system was not					
		I would contact the supplier.			2. Corrective action for residents wit	h	
		d the water for sanitization			the potential to be affected by the alle		
		ater had tested 200 ppm the			deficient practice.	900	

Facility ID: 923086

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345207	B. WING			C 04/05/2022		
NAME OF P	ROVIDER OR SUPPLIER			SI	IREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY			102 PINCKNEY STREET HITEVILLE, NC 28472			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 812	day before but she dit test strip results. She checked the water tha confirmed the water that confirmed the water that confirmed the water that dishware that day and laying in the water. S spicket was turned or automatically be adde sink. On 03/16/22 at 2:15 F buckets used to sanit was tested. The test bucket for 90 seconds indicated on the box of During an interview w 2:15 PM she stated th buckets came from the the three-compartment contain sanitizing solut re-tested and the test green indicating the s	d not keep documentation of e stated she had not at day prior to use. She had been used to wash d a ladle was observed he stated every time the a sanitizer was supposed to ed no matter who filled the PM the water in three red ize the kitchen countertops strips submerged in each s did not turn color as of test strips. The water used in the red e same spicket used to fill nt sink and would not ution if the sink did not. She partment sink and manually tion. The water was strip immediately turned anitizing solution was 200 concluded the test strips	F	812	All residents have the potential to be affected by the alleged deficient practi On 3/16/2022, the Dietary Service Director and PM cook drained and refi the 3 compartment sink and all sanitat buckets; testing with test strips to ensu ppm was within the manufactures recommendation for use in the kitchen On 3/16/2022 the chemical supplier we contacted and the automatic function of the sanitation system was fixed. 3. Systemic changes In-service education was provided to a full time, part time, and as needed diel staff on 4/11/2022. Topics included: • Sanitation policies and regulations • Using testing strips, how to read testing strips, and understanding manufactures ppm recommendations prior to use of sanitation component of 3 compartment sink and sanitation buckets. If the automatic function of the sanitati system is noted to be broken; dietary are to alert the dietary manager immediately and then use the manual function of the sanitation system. This information has been integrated in the standard orientation training and in required in-service refresher courses f all staff and will be reviewed by the Qu Assurance process to verify that the change has been sustained.	lled ion ure as of all tary s. f the staff nto n the ior		

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	MEDICAID SERVICES			OMB NO. 0938-039 (X3) DATE SURVEY		
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			
	345207	B. WING				
ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
COMMONS N&R CTR OF	COLUMBUS CTY					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION		
Continued From page	≥ 39	F 812	procedures for proper sanitation pract weekly x 2 weeks then monthly x 3 months using the Dietary QA Audit. The Dietary QA Audit will include monitoring and testing sanitation strength of the 3 compartment sink and sanitation buck to confirm staff are following proper sanitation practices. Reports will be presented to the weekly Quality Assurance committee by the Dietary Service Director to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, ME	ices ne ng 3 sets the ne S		
CFR(s): 483.20(f)(5), §483.20(f)(5) Residen (i) A facility may not r resident-identifiable to (ii) The facility may re resident-identifiable to accordance with a co agrees not to use or o	483.70(i)(1)-(5) nt-identifiable information. elease information that is the public. elease information that is to an agent only in ntract under which the agent disclose the information	F 842		4/14/22		
	SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page Continued From page Resident Records - Ic CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (i) A facility may not r resident-identifiable to accordance with a co agrees not to use or o except to the extent t	CORRECTION IDENTIFICATION NUMBER: 345207 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 Continued From page 39 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5), Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	CORRECTION IDENTIFICATION NUMBER: A. BUILDING	CORRECTION IDENTIFICATION NUMBER: A BUILDING 345207 B. WING ROWDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) ID Continued From page 39 F 812 4. Quality Assurance monitoring procedures for proper sanitation pract weekly x2 weeks then monthly x 3 months using the Dietary QA 2048.TI Dietary QA 2048.TI		

Event ID: 4GD411

Facility ID: 923086

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345207	B. WING			04/05/2022		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	·		
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY			1402 PINCKNEY STREET WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 842	§483.70(i)(1) In accor professional standard must maintain medica that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The faci all information contair regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research p medical examiners, fu a serious threat to hea by and in compliance §483.70(i)(3) The faci record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme	dance with accepted s and practices, the facility al records on each resident ented; e; and ganized lity must keep confidential ned in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, <i>v</i> iolence, health oversight administrative proceedings, poses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when	F	842				

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/28/2022 MAPPROVED D. 0938-0391		
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	X2) MULTIPLE CONSTRUCTIONBUILDING			(X3) DATE SURVEY COMPLETED		
		345207	B. WING _			C 04/05/2022			
NAME OF PF	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE				
	COMMONS N&R CTR OF			14	402 PINCKNEY STREET				
LIDERT				W	/HITEVILLE, NC 28472				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 842	Continued From page	e 41	F 8	342					
	legal age under State								
	legal age ander otate	, iaw.							
	(i) Sufficient informati (ii) A record of the res	edical record must contain- ion to identify the resident; sident's assessments;							
	provided;	ive plan of care and services							
		y preadmission screening							
	and resident review e								
	determinations condu	s, and other licensed							
	professional's progre								
	(vi) Laboratory, radiol	logy and other diagnostic equired under §483.50.							
		is not met as evidenced							
	Based on observatio	ons, record review and staff			The statements made on this plan of				
	the Medication Admir	inaccurately documented nistration Record (MAR) lication Aide (CMA) #5			correction are not an admission to and not constitute an agreement with the alleged deficiencies.	do			
		als on the MAR that an			To remain in compliance with all federa	al			
		ication was administered for			and state regulations the facility has ta				
		wed for IV administration			or will take the actions set forth in this				
	(Resident #11).				plan of correction. The plan of correction constitutes the facility's allegation of	on			
	Findings included:				compliance such that all alleged deficiencies cited have been or will be				
		admitted to the facility on			corrected by the dates indicated.				
		s included, in part, surgical at toe and osteomyelitis			F842 1. Corrective action for resident(s)				
	(bone infection).	at เปีย ลาน บริเยียากังยี่ที่ไปร			affected by the alleged deficient practic	ce:			
					On 04/11/2022, the Director of Nursing				
		ealed orders were written on			audited the MAR (Medication				
		(antibiotic) 500 milligrams			Administration Record) for Resident #				
		y PICC (peripherally inserted			Corrections to the MAR were made on	l			
	central catheter) line	every 24 nours for eeks, flush PICC before and			04/12/2022. 2. Corrective action for residents with	the			
	•	with 5 cubic centimeters			potential to be affected by the alleged				
		and after IV infusion flush			deficient practice.				

Facility ID: 923086

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		345207	B. WING	C 04/05/2022			
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, Z	IP CODE		
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY		1402 PINCKNEY STREET WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE		
F 842	Continued From page	e 42	F 84	.2			
F 842	with 2 cc of 100 units, (blood thinning medic maintenance of PICC assess PICC line eac The Medication Admin March revealed on 03 Medication Aide (CM, initials for the adminis antibiotic, documente PICC line before and and documented her PICC line every shift first shift and the seco An interview was con phone on 03/17/22. On trained to give any She stated she was massess the IV access documented that she the MAR on 03/14/22 Set (MDS) Nurse #21 by documenting her in she administered the medication, and asses stated she should not initials on these order out these orders, and administered the medic line and assessed the An interview was con phone on 03/18/22 at reported she was wor	/milliliter (u/ml) of heparin cation) one time a day for cline, and an order to ch shift for signs of infection. Inistration Record (MAR) for B/14/22 the Certified A) #5 documented her stration of the Cubicin IV d her initials for flushing the after the antibiotic infusion, initials for assessing the for signs of infection on the ond shift. ducted with CMA #5 via CMA #5 reported she was y medications intravenously. tot trained to flush IV lines or site. CMA #5 stated she completed those tasks on because the Minimum Data told her to. CMA #5 stated nitials it looked as though medication, flushed the ssed the IV site. CMA #5 chave documented her to because she did not carry added MDS Nurse #2 dication, flushed the PICC e IV site.	F 84	 All current residents on 100/200/300/400 hall has be affected. On 04/11/20 Nursing audited all curres current MAR on the 100 for the past 7 days to au medications documente Medication Aide. 3. Measures/Systemic of prevent reoccurrence of practice: Education: On 3/18/2022, the DON following education to all Nurses, Registered Nurse Licensed Practical Nurse Medication Aides, full tir agency, and PRN staff: Documentation guid accurate documentation Effective 03/25/2022, ar identified employees what received this education to to work until the training completed. The in-service incorporated into the net facility orientation. Monitoring Procedure the plan of correction is specific deficiency cited and/or in compliance with the training complementation of the plan of correction is specific deficiency cited and/or in compliance with the training complementation of the plan of correction is specific deficiency cited and/or in compliance with the training complementation of the plan of correction is specific deficiency cited and/or in compliance with the compliance with the	ave the potential to 022 the Director of ent residents //200/300/400 halls udit for Intravenous d by the changes to falleged deficient initiated the II Licensed ses (RNs), es (LPNs), and ne, part time, delines to include no f the MAR. hy of the above to have not will not be allowed has been ice will be w employee e to ensure that effective and that remains corrected		
	antibiotic to be admin flushed the line when	e #2 stated she hung the istered to Resident #11, the antibiotic was done d the site before and after		requirements. The DON or designee w compliance utilizing the Assurance Tool weekly t	F842 Quality		

Facility ID: 923086

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/28/2022 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		345207	345207 B. WING				C / 05/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0.	
LIBERTY COMMONS N&R CTR OF COLUMBUS CTY					02 PINCKNEY STREET HITEVILLE, NC 28472		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	the infusion. Nurse # that she would go and had given the medica assessed the site and already signed it off. did not tell CMA #5 to being done and adde #5 not to document of nursing staff. An interview was com Nursing (DON) on 03 DON reported that it w practice for CMAs to a an IV, flush an IV or a should not have docu those tasks. The DO documentation and the	e 43 1 stated she told CMA #5 ead and document that she tion, flushed the line and 4 CMA #5 told her she had MDS Nurse #2 stated she a sign off those orders as d she should have told CMA in the MAR for another ducted with the Director of /18/22 at 10:34 AM. The was not within the scope of administer medications via assess an IV and the CMA mented that she completed N stated it was inaccurate the nurse who completed the one documenting in the	F 8	42	monthly x 3 months or until resolved the QA committee. The DON will mor to ensure that MAR documentation is accurate and Medication Aides have signed of Intravenous Medications. Reports will be presented to the weel Quality Assurance committee by the to ensure corrective action is initiated appropriate. Compliance will be moni and the ongoing auditing program reviewed at the weekly Quality Assur Meeting or until deemed not necessa compliance with ADL Care. The weel QA Meeting is attended by the Administrator, DON, MDS Coordinato Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 04/14/2022	itor not cly DON as tored ance ry for ly r,	

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