STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for 1 of 3 medication carts observed (200 hall medication cart). Findings included: During a continuous observation on 8/12/20 from 12:46 PM until 12:51 PM the 200-hall medication cart was against the wall between rooms [ROOM NUMBERS]. The lock on the medication cart was not engaged. During this time, multiple staff members walked by the unattended medication cart. The Medication Aide (#1) who was responsible for the medication cart was observed coming out of a resident's room further down the hallway. In an interview on 8/12/20 at 12:51 PM, Medication Aide #1 confirmed she was responsible for the 200-hall medication cart. She verified that the medication cart was unlocked by opening a drawer containing medications without using a key to unlock the cart. She stated she was assisting a resident in his room and was coming right back and stated she should not have left the medication cart unlocked and unattended. She acknowledged that she should have made sure the cart was locked before leaving it unattended. In an interview on 8/12/20 at 4:30 PM with the Director of Nursing, she stated that when a medication cart was not in use it should be kept locked for safety.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, staff interviews, record review and review of the facility's policies and procedures staff failed to implement the facility's COVID-19 Plan and Protocols for wearing the personal protective equipment (PPE) required for 2 of 2 staff (Housekeeper #1 and Nurse Practitioner #1) observed providing care and services to residents who were quarantined and on enhanced observation precautions. These failures occurred during the COVID-19 pandemic. Findings included: Centers for Disease Control (CDC) recommendation Titled: Preparing for COVID-19 in Nursing Homes (last updated June 25, 2020) recommends, If the facility has a quarantine (observation) unit which is used for new admissions or re-admissions whose COVID status is unknown. These residents should remain on observation for 14 days and CDC recommends healthcare personnel wear all recommended Personal Protection Equipment (PPE) when caring for these residents which would include gown, gloves, mask and eye protection (this would be contact + droplet + eye protection). Therefore, CDC recommends: For residents placed on an observation or quarantine unit, Health Care Provider (HCP) entering the resident's room should wear mask, gloves, gown and eye protection. The facility's Enhanced Precaution Policy Titled: COVID-19 Preparation and Response (last revised 03/10/2020) documented, Transmission based precautions initiated empirically to control the spread of infection. Combines Standard Precautions and Droplet precautions and includes wearing eye protection. Single use gowns should be used and discarded for all contact and enhanced precaution rooms. During observation on the 300 and 400 halls (quarantine halls), beginning at 10:50 AM on 08/12/20, multiple personal protection equipment (PPE) were observed in clear plastic containers outside residents' rooms, with enhanced observation precautions signs posted on doors. The enhanced observation precautions sign revealed the following: perform hand hygiene, surgical mask when entering room, eye protection when entering room, gown, gloves when entering room, private room and keep door closed, families and visitors - do not enter the room, and report to the nurses' station with questions. During a facility observation on 08/12/20 at 1:35 PM Housekeeper #1 was observed entering an enhanced observation precaution room on the 300 hall without eye protection. Housekeeper #1 was wearing a surgical mask and gloves. During an interview with Housekeeper #1 on 08/12/20 at 1:37 PM she stated she did not know she should have worn full PPE when on the enhanced observation precautions area. She said she was told that she only needed to wear full PPE while working on the COVID-19 area, and when she was on the enhanced observation precautions area, she only needed to wear a mask and gloves. She stated she did not know that she was supposed to wear full PPE when on the enhanced observation precautions halls. During facility observation on 08/13/20 at 2:46 PM Nurse Practitioner (NP) #1 was observed standing about a foot in front of a resident (who was sitting in a wheelchair by the window) in an enhanced observation precautions room on the 400 hall without eye protection, gown, or gloves when in the resident's room. NP #1 was wearing only a surgical mask. During an interview with NP #1 on 08/13/20 at 2:48 PM stated she should have worn full PPE on 08/13/20 at 2:46 PM when she was in the enhanced observation precautions room as required in the facility's enhanced precautions policies, which would have included mask, gown, gloves, eye protection, and she did not. She reported to the Director of Nursing (DON) that she had been good all the other times that day, and it was only with the one resident, on the quarantine hall that she did not don full PPE while in the resident's room. During an interview with the Administrator and Director of Nursing (DON) on 08/13/20 at 3:00 PM they stated Housekeeper #1 and NP #1 should have worn complete PPE required in the facility's COVID policies to help reduce chances of cross-contamination just in case residents or staff were indeed positive or began exhibiting signs and symptoms of respiratory illness. During an interview with the facility's Central Supply Manager (CSM) on 08/13/20 at 3:55 PM he stated the facility had plenty of PPE on hand: masks, gowns, gloves, goggles, face shields, and eye glasses.

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

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.