STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey and complaint investigation was conducted from 11/15/22 through 11/21/22. The facility was found to be in compliance with CFR 483.73 Emergency Prepardness. Event ID # 8Q6E11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted on 11/15/22 through 11/21/22. Event ID # 8Q6E11. The following intakes were investigated: NC00192142 and NC00192565. 2 of the 12 complaint allegations were substantiated with deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		1/5/23

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

Electronically Signed | 12/16/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, physician interview, pharmacist interview, and staff interviews, the facility failed to notify the physician that a resident who had a urinary tract infection (UTI) was prescribed a medication that was reported by the laboratory as resistant for 1 of 4 residents reviewed for UTIs (Resident #66). Findings included:	F 580	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 Resident #66 was admitted to the facility on 08/05/21. She had diagnoses that included a urinary tract infection and a neurogenic bladder. A quarterly Minimum Data Set (MDS) assessment dated 11/01/22 documented Resident #66 had intact cognition. She had an indwelling urinary catheter. Review of the physician orders for October 2022 revealed Resident #66 was ordered the antibiotic medication Bactrim DS (Sulfamethox/Trimethoprim) tablet 800-160 MG (Milligrams) every 12 hours for a UTI for 7 days on 10/16/22. Review of the electronic Medication Administration Record (eMAR) for Resident #66 for October 2022 documented she was administered the antibiotic Bactrim DS 800-160 MG every 12 hours for 7 days (14 doses) between 10/16/22 and 10/23/22. Review of a final laboratory report dated 10/16/22 for a urine culture and sensitivity documented Resident #66 had a urinary infection of >100,000 Escherichia coli, an organism that was resistant to the antibiotic Bactrim DS. This information was documented on page 2 of the laboratory report. On page 1 of the laboratory report Nurse #8 hand wrote a verbal order from the physician to administer Bactrim DS twice daily for seven days then recheck another urinalysis. In an interview with the physician on 11/18/22 at 1:38 PM he stated he was familiar with Resident #66. He reported the nurse had not told him the antibiotic Bactrim DS was documented as	F 580	compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 580 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to notify the physician that a resident who had a urinary tract infection was prescribed a medication that was reported by the laboratory as resistant for Resident #66. Corrective action for resident(s) affected by the alleged deficient practice: Resident#66 had Culture and Sensitivity report reviewed by provider on 11/17/22 with new order for Ertapenem initiated. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents with ordered Urinalysis and Culture reports are at potential risk of being affected by deficient practice. The Director of Nurses, Support Nurse (LPN) initiated an audit of 100% of all residents in the past 14 days that have had Urinalysis and Culture completed to ensure that correct antibiotic is ordered in comparison to the Culture and Sensitivity report. This will be completed by 12/22/2022. The Director of Nursing, Support Nurse completed corrective actions for the above residents including notification to Medical provider and patient representative and initiated medication error report.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 resistant on the 10/16/22 laboratory results. He stated had he known he would have ordered a different medication the organism was susceptible to. He commented it had not hurt Resident #66 to receive the antibiotic the organism was resistant to, but it was an unnecessary medication because it wouldn ' t kill the organism. He reported no problems were encountered because of it. In an interview with Nurse #8 on 11/18/22 at 5:41 PM she stated it was the responsibility of the floor nurse to report to the physician any laboratory results that were received. She reported she had taken the order for the antibiotic Bactrim DS for Resident #66 on 10/16/22. She noted she usually sent a copy of the laboratory report via fax to the physician. She could not recall this laboratory report or situation. She could not remember calling the results to the physician or taking the verbal order from the physician that she had handwritten on page one of the report. She did not know if the report had a second page. In an interview with Support Nurse #1 on 11/21/22 at 9:22 AM she stated she reviewed physician orders daily. She reviewed records to ensure labs were collected and sent, reviewed laboratory reports that were received and reviewed physician orders for appropriateness. Typically, the floor nurse would contact the physician and obtain an order. She stated she was not aware of the report results of 10/16/22 because it was a Sunday when the report came in and she only worked Monday through Friday. Normally on Mondays she would look at the Order Listing Report to view new orders and would then know to look for a follow up culture and sensitivity. She noted this situation happened a month ago and	F 580	On 12/22/2022 all residents were in compliance with physician notification and concerns. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/_20__/2022 the Director of Nurses began education of all full time, part time, as needed nurses and agency nurses and on the following topics: Prevention of medications errors. Medication errors and notification of the physician/RP. Documentation process for notification of the physician/RP. The DON will ensure that any of the above identified staff who does not complete the in-service training by 1/5/2023 will not be allowed to work until the training is completed. This in-service will be incorporated into the new employee facility orientation. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or LPN Support Nurse will monitor compliance utilizing the F580 Quality Assurance Tool by completing an audit weekly x 2 then monthly x 3 months or until resolved. The audit will include monitoring during Daily QOL(Monday-Friday) for compliance with the notification process by auditing residents with urinalysis and culture	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4 she could not recall what happened a month ago. In an interview with Pharmacist #1 on 11/21/22 at 12:12 PM she stated she reviewed the orders for Resident #66 on 10/22/22 and confirmed she had documented: "Antibiotics: Reviewed and following." She commented she had not realized the laboratory report had a second page and missed that the organism was resistant to the medication the resident was receiving, Bactrim DS. She noted had she seen the second page of the report she would have alerted the facility that the resident was on the wrong medication.	F 580	reports to ensure correct antibiotic ordered compared to the culture sensitivity report and that medical provider and patient representative where notified timely of any concerns. Reports will be presented to the Quality Assurance Committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and the Dietary Manager. Date of Compliance: 1/5/2023	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and esident and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of vision and hearing (Resident #32), nutrition (Resident #67), falls (Resident #75), and medications (Resident #84) for 4 of 29 residents reviewed for MDS assessments. Findings included.	F 641	F-641 Accuracy of Assessments Corrective actions for Resident #32 MDS assessment with ARD of 10/13/22 was modified by the MDS Consultant on 12/16/22 and corrections were made to Section B in order to accurately reflect that resident has hearing loss, wore hearing aids and had visual impairment at the time of the ARD of 10/13/22. This MDS was re-submitted to state database	1/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 5 1. Resident #32 was admitted to the facility on 7/6/17 with medical diagnoses which included in part dementia and hearing loss. Review of Resident #32's 8/13/22 care plan revealed a focus of communication problem related to hearing and vision deficits with interventions which included : Use communication techniques which enhance interaction: Allow adequate time to respond, Repeat as necessary, Do not rush, Request feedback, clarification from the resident, to ensure understanding, Face when speaking and make eye contact, Turn off TV/radio as needed to reduce environmental noise, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication, Ensure hearing aids are in place. Resident #32's 10/13/22 significant change MDS assessment indicated resident's hearing was adequate, hearing aids were not used and had adequate vision with glasses. Resident was cognitively intact. Interview on 11/15/22 at 11:30 AM with Resident #32 revealed resident had trouble with her vision despite having had eye surgery and wearing glasses. Resident #32 stated she had hearing loss and required hearing aids. A sign was posted in her room regarding applying her hearing aids daily. Interview on 11/21/22 at 11:10 AM with MDS Coordinator revealed that Resident #32's 10/13/22 significant change MDS should have been coded as impaired vision and hearing and wears hearing aids.	F 641	on 12/16/22 in batch 903. Corrective actions for Resident #67 MDS assessment with ARD of 9/8/22 was modified and corrected by the facility MDS Nurse on 11/21/22 and the resident's weight in Section K was corrected to reflect their accurate weight at the time of the ARD of the assessment. This MDS was re-submitted to state database in batch # 891 on 11/22/22. Corrective actions for Resident #75 MDS assessment with ARD of 10/4/22 was modified and corrected by the facility MDS Nurse on 11/18/22 and the resident's fall status in Section J was corrected to reflect that the resident had had falls during the ARD lookback timeframe. This MDS was re-submitted to state database in batch # 890 on 11/18/22. Corrective actions for Resident #84 MDS assessment with ARD of 8/1/22 was modified and corrected by the facility MDS Nurse on 11/21/22 and Section N was corrected in order to accurately reflect that the resident received diuretic medication during the ARD lookback timeframe. This MDS was re-submitted to state database in batch # 891 on 11/22/22. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of all current residents who have had a Minimum Data Set assessment completed within the past 30 days 11/15/22-12/15/22 will be completed in order to identify if the following questions were coded accurately:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 6 2. Resident #67 was admitted to the facility on 3/4/22 with diagnoses which included in part End Stage Renal Disease and dialysis dependent. Review of Resident #67's 9/4/22 care plan revealed a nutrition problem related to obesity and therapeutic diet with a goal of will not develop complications related to obesity and interventions included maintain diet as ordered. Review of Resident #67's weights recorded in the medical record revealed a weight of 398.15 pounds on 9/6/22. Review of resident's 9/8/22 quarterly minimum data set (MDS) assessment revealed resident was cognitively intact, independent with eating, had a weight of 184 pounds with no weight loss or gain and received a therapeutic diet. Interview on 11/21/22 11:16 AM with MDS Coordinator revealed that the weight that was recorded on the 9/8/22 Quarterly MDS assessment was incorrect. The MDS Coordinator further stated that the weight automatically populated from the weight that was recorded in Resident #67's medical record and that weight was later struck out as incorrect. She stated that the MDS was to have an accurate weight and should be checked for accuracy prior to finalization and transmission. 3. Resident #75 was admitted to the facility on 06/30/22 with diagnoses including non-Alzheimer's dementia, neuropathy (weakness, numbness, and pain resulting from	F 641	• B0200 – Hearing • B0300 – Hearing aid • B1000 – Vision • N410G – Medications (Diuretic) • J1800 – Falls This audit will be completed by the Regional MDS Consultant no later than 12/21/22. Any resident who is identified as having inaccurate coding of any one or more of the above questions will have a correction of that assessment completed immediately by the facility Minimum Data Set Coordinator. Any necessary MDS corrections will be completed and MDSs re-submitted by the MDS Consultant no later than 1/5/2023. Systemic Changes On 12/7/22, the Regional Minimum Data Set Consultant completed an in-service training for the facility Minimum Data Set Nurse that included the importance of thoroughly reviewing each resident's medical record in order ensure that the assessment is coded accurately. Special emphasis was placed on the following areas of the Minimum Data Set assessment: J1800 – Falls should accurately reflect whether the resident has had any falls during the specified timeframe. The assessing nurse must conduct a thorough review of the resident's record in Point Click Care in order to ascertain whether or not they have had a fall. Review of the risk management portal in Point Click Care as well as the progress notes in the resident's record should guide the assessing nurse as to whether a fall has taken place during the assessment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 7 nerve damage), mood disorder, and atrial fibrillation (irregular heart rhythm). The MDS admission assessment dated 07/07/22 revealed Resident #75 had falls prior to admission. Review of Resident #75's progress notes from 07/07/22 through 10/04/22 revealed Resident #75 had falls without injury on 07/09/22, 07/11/22, 07/15/22, and 08/02/22. Review of the MDS quarterly assessment dated 10/04/22 for Resident #75 indicated she had no falls since the prior MDS assessment. An interview was conducted on 11/18/22 at 10:30 AM with the MDS Coordinator. She reviewed Resident 75's quarterly MDS assessment dated 10/04/22 and indicated it was inaccurate regarding her falls. She stated the information had been missed in error. An interview was conducted on 11/18/22 at 2:30 PM with the Director of Nursing. She stated the MDS nurse was expected to review the residents' medical records and include accurate information. 4. Resident #84 was admitted to the facility on 07/25/22 and discharged with return not anticipated on 08/25/22. A review of the physician orders written on 07/30/22 revealed Furosemide (diuretic) 40 milligrams (mg) one tablet daily in the morning.	F 641	lookback timeframe. Based on the information reviewed, the assessor should then code Section J1800 to reflect if the resident had a fall during the ARD lookback time frame. The MDS nurse should also interview and assess the resident's visual and hearing function as well as assess whether the resident uses hearing aids. If possible, this assessment should be done directly with the resident. If unable to assess the resident, then the direct care staff members should be interviewed and the medical record thoroughly reviewed to determine accurate status of hearing and vision in order to be able to accurately code Section B for Hearing, Hearing Aid and Vision. The medical record should also be thoroughly reviewed in order to accurately code Section K200B for current weight at the time of the ARD of the MDS. If weights reviewed in resident's chart appear to be incorrect, then re-weights should be obtained and/or corrections to the recorded weights in the resident's chart should be made. The MDS needs to be thoroughly reviewed for accuracy prior to closing and locking the assessment. The medication administration record and progress notes and physician orders should be reviewed prior to MDS completion in order to accurately determine whether resident received diuretic medications or not so that Section N410G (diuretic) may be accurately coded. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 8 The Medication Administration Record (MAR) revealed Resident #84 received Furosemide 40 mg, one tablet by mouth in the morning on 07/30/22 and 07/31/22 during this look back assessment period. The MDS 5-day assessment dated 08/01/22 revealed Resident #84 was moderately cognitively intact and was coded as not receiving diuretic medication during this assessment period. An interview with the MDS Nurse on 11/21/22 at 1:25 PM revealed she did not accurately code Resident #84 for receiving a diuretic medication. The MDS Nurse reviewed the MAR and stated Resident #84 was on Furosemide and should have been coded as receiving a diuretic. She added, when completing the MDS assessments, she reviewed the physician orders, progress notes and the MARs and it was a complete oversite that she missed this. An interview with the Administrator on 11/21/22 at 4:40 PM revealed she expected the MDS assessments to be accurate because it was a reference point for the providers to have a clear picture of how to take care of the residents.	F 641	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Administrator or designee will begin auditing minimum data set assessments that have been completed for current residents during the past 30 days to determine if Section B0200 (hearing loss); B0300 (hearing aid); N410G (diuretic); B1000 (vision); J1800 (falls) and K200B (weight) were accurately coded in order to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and/or Director of Nursing. Date of Compliance: 1/5/2023	
F 655 SS=B	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		12/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 9 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 10 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement baseline care plans for admitted diagnoses of : 1)Gastrointestinal Bleed (GI Bleed) and anemia (low red blood cell count); and 2) dementia, mood disorder, and atrial fibrilliation (irregular heart rhythm)within 48 hours of admission for 2 of 29 residents (Resident #82 and Resident #75). Findings included: 1. Resident #82 was admitted to the facility on 10/24/22 with admitting diagnoses including, in part, gastrointestinal bleed, and anemia. The Minimum Data Set (MDS) admission assessment dated 10/31/22 revealed Resident #82 was moderately cognitively intact. Resident #82 was coded as having shortness of breath and always incontinent of bowel and bladder. A record review on 11/17/22 revealed there was no baseline care plan in place for Resident #82. An interview with the MDS Nurse on 11/17/22 at 10:18 AM revealed she was responsible for completing the baseline care plan within 48 hours and she thought it had been done, but she could not find it. She also stated the Kardex (care guide) should have been done as well and would have included the residents' admitting diagnoses, his diet, how he transferred, and if we was getting	F 655	F 655 Baseline Care Plan Corrective Actions for Resident #75: A corrective action was taken in order to ensure that the care plan for resident #75 was complete and accurately reflected the resident□s current level of functioning, special needs and interventions including history of falls, hearing loss, bowel and bladder incontinence, dementia, mood disorder, ADL needs and Atrial Fibrillation to ensure that staff members would be correctly guided in providing appropriate and safe care for resident. These items were added to the resident□s care plan on 7/20/22 by the facility MDS Nurse. Corrective Actions for Resident #82: Resident #82 discharged from facility prior to corrective action being taken. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all current residents who were admitted to the facility during the past 14 days will be completed in order to ensure that each resident has an appropriate and up to date baseline care plan in place that provides staff with complete and accurate information about the resident□s needs in order for them to be able to provide safe and quality care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 11	F 655		

therapy. She stated she did not know why the baseline care plan or the Kardex was not done or how they got missed.

An interview with Nurse #2 who was assigned to Resident #82 on 11/18/22 at 3:09 PM revealed Resident #82 was admitted to the facility due to a gastrointestinal bleed (GI Bleed). She stated the baseline care plan would have included his admitting diagnoses and interventions would have been put in place to monitor for signs and symptoms of bleeding. Nurse #2 reviewed Resident #82's record and was not able to find a baseline care plan. Nurse #2 stated interventions would have included to monitor for signs and symptoms of bleeding such as shortness of breath, abdominal pain, rectal bleeding or black tarry stools and a low blood pressure.

A follow up interview was conducted with the MDS Nurse on 11/21/22 at 2:29 PM. The nurse stated she found the baseline care plan dated 10/25/22 in a file on her computer desktop. The MDS nurse reviewed the baseline care plan which was noted to be only the physician orders that were written for Resident #82. The MDS Nurse felt the physician orders provided an adequate baseline care plan because it included the diagnoses, prescribed medications, the resident's diet, and how he transferred. The MDS Nurse confirmed there were no interventions put in place to monitor for signs or symptoms of a GI Bleed.

An interview was conducted with the Director of Nursing (DON) on 11/21/22 at 4:40 PM. The DON reported she expected the nursing staff to implement a baseline care plan within 48 hours to include the admitting diagnoses and interventions

for the resident. Audit will also include reviewing to ensure that the resident and/or their representative have received a review/summary of the baseline care plan as required. This audit will be completed by the Regional MDS Consultant no later than 12/21/22. All residents identified as not having a complete and thorough care plan that addresses current needs will have their care plans revised in order to provide that information necessary for staff to provide safe and quality care. Any resident identified as not having had the care plan summary reviewed with them or their representative will also have this completed by the Facility MDS Nurse no later than 12/23/22. These care plan corrections will be completed no later than 12/23/22 by the Regional MDS Consultant and the facility MDS Nurse.
Systemic Changes
On 12/7/22 the Regional Minimum Data Set Nurse Consultant provided in-service education to the facility Minimum Data Set Nurse on the requirements for Baseline Care Plan completion. This education included the importance of ensuring that all residents have a Baseline Care Plan implemented within the first 48 hours after admission to the facility. The Baseline Care Plan must include the minimum healthcare information necessary to properly care for a resident including, but not limited to following:
" Initial goals based on admission orders
" Physician orders
" Dietary orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 12 to monitor and care for the resident related to the admitting diagnoses. The DON stated using the physician orders was not a sufficient baseline care plan and more specific interventions should have been in place to monitor for a GI Bleed such as shortness of breath, vomiting, abdominal pain, black tarry stools, or change in vital signs to include increased heart rate or a low blood pressure. 2. Resident #75 was admitted to the facility on 06/30/22 with diagnoses including non-Alzheimer's dementia, neuropathy (weakness, numbness, and pain resulting from nerve damage), mood disorder, and atrial fibrillation (irregular heart rhythm). A nursing progress note dated 06/30/22 at 1:24 PM revealed Resident #75 had been admitted this day and arrived with her family. She had severe hearing loss and no hearing aids, a full upper denture, and a partial lower denture. She was unable to stand or walk and was incontinent of both bowel and bladder. She had a history of senile degeneration of the brain, dementia with sun-downing (dementia becoming more pronounced in the evening), a urinary tract infection, falls, and a femur fracture. She was calm, cooperative, and had no complaints of pain. Her skin was pale and intact. The Minimum Data Set (MDS) admission assessment dated 07/07/22 revealed Resident #75 had moderately impaired cognition and required extensive assistance with activities of daily living (ADLs). She had a history of falls prior to admission, incontinence, and received psychotropic medications. The care areas triggered (areas identified as actual or potential concerns) from the MDS assessment included	F 655	" Therapy services " Social services needs " PASARR recommendation, if applicable The educational material included the fact that the care plan is a tool used to communicate resident□s condition, special medical conditions that need close monitoring and observation such as GI bleeds, anemia, falls, cognitive loss, mood disorders, atrial fibrillation, hearing loss, use of hearing aids, ADL needs, bowel and bladder incontinence and needs associated, etc., needs, preferences, strengths, special needs to the interdisciplinary team and primarily frontline staff, and that in order to provide the highest quality of care possible and to ensure residents□ needs are met, the care plans must be person-centered and an accurate and current reflection of resident□s condition and needs. The resident and/or representative must receive a summary of the baseline care plan and have it reviewed with them by a nurse in order to ensure that they understand and agree with their plan of care. When the MDS Nurse is not going to be available to complete the baseline care plan for any reason, the facility must designate a backup nurse who will ensure that the baseline care plan is completed and reviewed with resident/representative as required. This information has been integrated into the standard orientation training for new Minimum Data Set Nurses. Monitoring Procedure to ensure that the plan of correction is effective and that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 13 delirium, dementia, ADL care, incontinence, communication, falls, and psychotropic medication use. Review of Resident 75's medical record from admission on 06/30/22 through 11/15/22 revealed no baseline care plan had been developed. An interview conducted with Resident #75's Responsible Party (RP) on 11/15/22 at 1:30 PM revealed no baseline care plan or summary had been reviewed or provided to them. An interview was conducted on 11/21/22 at 9:21 AM with the MDS/Care Plan Coordinator. She stated she was on vacation during the 48-hour period when Resident #75 was admitted on 06/30/22. She explained the staff member that typically covered for her was also on vacation during that time. She stated the baseline care plan that should have been provided typically included a printed copy of the order summary which would be reviewed with the resident or the RP. She stated the 48-hour baseline care plan was missed in error. A phone interview was conducted on 11/21/22 at 6:30 PM with the Director of Nursing (DON). She reported she expected the 48-hour baseline care plan that included the admitting diagnoses with interventions to monitor and care for the resident should have been developed within the required time frame and a summary provided to Resident #75's RP.	F 655	specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will conduct audits to ensure that all newly admitted residents have a Baseline Care Plan initiated within 48 hours of admission to facility and that the baseline care plan was reviewed with the resident and/or representative by a nurse. The Quality Assurance tool entitled Baseline Care Plans QA Tool will be completed weekly for 4 weeks then monthly for 2 months or until sustained compliance has been achieved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator and/or Director of Nursing is responsible for implementation and completion of the acceptable plan of correction. Compliance date: 12/23/22	
F 656 SS=B	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		12/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 14 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 15 section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop and implement a comprehensive person-centered care plan that addressed measurable goals and interventions to reflect the needs of the residents which were identified in the Minimum Data Set (MDS) assessment within 21 days of admission for 2 of 29 residents (Resident #82 and Resident #46) reviewed for care planning. Findings included: 1. Resident #82 was admitted to the facility on 10/24/22. Diagnoses included, in part, anemia, gastrointestinal bleed, chronic kidney disease, acute kidney failure, Parkinson's Disease, a fib, diabetes, insomnia, and glaucoma. The Minimum Data Set (MDS) admission assessment dated 10/31/22 revealed Resident #82 was moderately cognitively intact. Resident #82 was coded as having adequate vision. The mood interview revealed symptoms were present for feeling down, depressed, or hopeless, trouble falling or staying asleep, feeling tired or having little energy, poor appetite, and feeling bad about self. Resident #82 exhibited no behaviors. He was coded has having shortness of breath and always incontinent of bowel and bladder. Weight was recorded as 259 lbs. he had no falls, no pressure ulcers and received 7 days of antidepressants and diuretics. Resident #82 received oxygen therapy, physical, occupation and speech therapy. A record review revealed there was no	F 656	F 656 Develop/Implement Comprehensive Care Plan Corrective Actions for Resident #82. A corrective action was taken in order to complete the comprehensive care plan for Resident #82 on 11/17/22. This corrective action was completed by the facility Minimum Data Set Nurse. Corrective Actions for Resident #46. A corrective action was taken in order to complete the comprehensive care plan for Resident #46 on 11/18/22. This corrective action was completed by the facility Minimum Data Set Nurse. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all current residents who are were admitted to the facility within the past 30 days will be completed to ensure that they had a comprehensive care plan completed by their 21st day in the facility. This audit will be completed by the Regional Minimum Data Set Consultant and will be completed no later than 12/21/22. Any resident identified as not having a comprehensive care plan completed by their 21st day in the facility will have a comprehensive care plan completed no later than 12/22/22. A 100% audit of all current residents who have had a comprehensive Minimum Data Set assessment completed during the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 16 comprehensive care plan in place for Resident #82. An interview with the MDS Nurse on 11/17/22 at 10:18 AM revealed she was responsible for completing the comprehensive care plan by November 14 which would have been 14 days after the admission assessment. She stated she did not know why the comprehensive care plan was not done or how it was missed, and she would do it immediately. An interview was conducted with the Administrator on 11/21/22 at 4:40 PM. The Administrator stated she expected the comprehensive care plans to be completed within the 14 days of the assessment. The Administrator stated the care plan should have been completed to aid staff in knowing how to take care of the resident according to their plan of care. 2.Resident #46 was admitted on 10/26/22 with diagnoses to include; dementia, anxiety, chronic kidney disease, and dysphagia (difficulty swallowing). The MDS admission assessment dated 11/02/22 revealed Resident #46 had moderately impaired cognition. She required extensive assistance with bed mobility, supervision of one staff for transfers and limited assistance with activities of daily living (ADLs). She had occasional incontinence of bowel and bladder and had no pressure ulcers but was at risk for the development of pressure ulcers. She utilized a wheelchair and walker for mobility. Resident #46 had little interest or pleasure in doing things. Triggering conditions on the care area assessment (CAA) summary	F 656	past 30 days will be audited to ensure that triggered CAAs that state will be care planned have been followed through to and are reflected on the care plan. Any resident who is identified as not having a care plan for all triggered CAAs (that stated would be care planned) will have their care plan revised to include these triggered areas. This audit and corrective actions will be completed by the Regional MDS Consultant no later than 12/22/22. Systemic Changes On 12/07/22 the Regional Minimum Data Set Nurse Consultant provided in-service education to the facility Minimum Data Set Nurse on Comprehensive Care Plans. This education included the importance of ensuring that each resident□s care plan addressed actual problems, risk factors, resident strengths and preferences. The education emphasized that the care plan must communicate the resident□s current condition, needs, and preferences to the staff. The comprehensive care plan must be completed no later than 21 days after admission to the facility. The care plan must have ongoing revisions and updates as the resident□s condition changes. The education also included the importance of ensuring that resident care plans must be updated and accurately reflect the resident□s current nutritional status. The educational material included the fact that the care plan is a tool used to communicate resident□s condition, needs, preferences, strengths, special needs to the interdisciplinary team and primarily frontline staff, and that in order to provide the highest quality of care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 17 included Resident #46 required care planning in the areas of dementia, ADL assistance, incontinence, psychosocial wellbeing, and risk of pressure ulcer development. A review of the medical record on 11/17/22 revealed Resident #46's care plan dated 10/26/22 revealed focus areas regarding the use of ¼ side rails, code status, increased risk of falls, new admission status, and a focus area regarding accepting the facility as home. There were no care plans implemented for the triggering conditions identified in the MDS admission assessment regarding; dementia, ADL care, incontinence care, psychosocial wellbeing, and risk of pressure ulcers. During an interview conducted on 11/17/22 at 10:44 AM Nurse #6 stated Resident #46 had periods of confusion and required staff assistance with ADLs. She indicated Resident #46 was incontinent, and her skin was intact. She indicated Resident #46 received psychotropic medications. An interview was conducted on 11/18/22 at 9:21 AM with the MDS/Care Plan Coordinator. She stated she did not know how the care plans were not implemented for the areas triggered on the CAA summary from the MDS assessment. She indicated the care areas triggered on the admission assessment should have been care planned for Resident #46. She stated it was missed somehow and was an error and would be corrected immediately. A phone interview was conducted on 11/21/22 at 5:23 PM with the Director of Nursing (DON). She stated the MDS/Care Plan Coordinator was	F 656	possible and to ensure residents□ needs are met, the care plans must be person-centered and an accurate and current reflection of resident. Emphasis was placed on ensuring that the care plan includes triggered CAAs (that were marked as being carried through to the care plan. This information has been integrated into the standard orientation training for new Minimum Data Set Nurses. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will conduct audits to ensure that current residents who were admitted during the past 30 days have a comprehensive care plan that was completed by day 21 and to determine if CAAs triggered on the Admission MDS that stated that they would be carried through to the care plan were indeed reflected on the care plan. The Quality Assurance tool entitled Comprehensive Care Plans QA Tool will be completed weekly for 4 weeks then monthly for 2 months or until sustained compliance has been achieved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 18 expected to develop and complete comprehensive care plans within the required timeframe and guidelines for the areas triggered from the MDS assessment. She stated education would be provided.	F 656	Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator and/or Director of Nursing is responsible for implementation and completion of the acceptable plan of correction. Completion date: 12/22/22	
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		12/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 19 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to revise a care plan to address: 1a) a facility acquired pressure ulcer (Resident #9), 1b) the insertion of an indwelling urinary catheter (Resident #9), and 2) incontinence care and toileting (Resident #67) for 2 of 29 residents reviewed for care plans. Findings included: Resident #9 was admitted to the facility on 09/29/21. The Minimum Data Set annual assessment dated 09/29/22 revealed Resident #9 was cognitively intact. Resident was occasionally incontinent of bladder and frequently incontinent of bowel. 1a. On 10/20/22 a physician's order was written to clean right ankle with normal saline, pat dry, apply Anasept oil emulsion (antimicrobial wound treatment) and cover with dry dressing for wound care daily. Review of the Treatment Administration Record revealed from 10/20/22 through 11/16/22, Resident #9 had been provided wound care according to the physician order daily. A review of Resident #9's care plan on 11/15/22 revealed the last updated plan of care was on 10/19/22. There was no updated care plan in place for a pressure ulcer to the right ankle. An interview with the MDS Nurse on 11/21/22 at	F 657	F657 Care Plan Timing and Revision Corrective Action for Affected Residents Corrective Action for Resident #9: The care plan for resident #9 was revised in order to include the use of urinary catheter and the presence of a pressure ulcer to right ankle. The care plan was revised on 11/16/22 by the facility MDS Nurse to include the use of urinary catheter. The care plan was revised on 12/16/22 by the MDS Consultant to include the presence of a pressure ulcer to right ankle. Corrective Action for Resident #67: The care plan for resident #67 was revised in order to include the resident□s need for staff assistance with toileting and incontinence care. This care plan revision was completed on 12/16/22 by the MDS Nurse Consultant. The care plan was revised on 11/14/22 by the facility MDS Nurse in order to resolve/remove use of indwelling urinary catheter from the care plan Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be impacted by the alleged deficient practice. " A100% audit will be conducted on all current residents who currently have a urinary catheter in order to determine if these services are accurately reflected on the care plan. " A 100% audit of all current residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 20 1:22 PM revealed she did not update the care plan to reflect the current pressure ulcer for Resident #9. The MDS nurse stated the care plan should have been revised on 10/21/22 to include the care and management for the resident's pressure ulcer. The MDS Nurse stated anytime there was a new pressure ulcer it was discussed in the morning meeting, and at that time, she would update the care plan. The MDS Nurse added, she must have forgotten to update the care plan. 1b. A hospice progress note written on 10/28/22 revealed an indwelling urinary catheter was inserted. A review of Resident #9's care plan on 11/15/22 revealed the last updated plan of care was 10/19/22. There was no care plan in place to include an indwelling urinary catheter. An interview with the MDS Nurse on 11/21/22 at 1:22 PM revealed she did not update the care plan to reflect the indwelling urinary catheter for Resident #9. The MDS Nurse stated she would not wait until the next assessment to update a care plan and the care plan should have been revised on 10/28/22 to include the care and management for the resident's catheter. The MDS Nurse stated she did not know why the care plan was not updated to include the urinary catheter, but it could have been because there was no physician order. An interview was conducted with the Administrator on 11/21/22 at 4:40 PM. The Administrator stated she expected her nursing staff to ensure the care plans were updated to reflect the current needs of the resident.	F 657	who currently have pressure ulcer(s) will be completed in order to determine if these ulcers are reflected on the care plan. " A100% audit will be conducted on all current residents who currently require staff assistance with toileting and/or incontinence care in order to determine if these services are accurately reflected on the care plan. " A 100% audit of all current residents who have had an order to discontinue the use of urinary catheter during the past 90 days in order to ensure that the care plan was revised in order to remove this item. The above audits will be completed by the Regional MDS Consultant and will be completed no later than 12/21/22. Any resident whose care plan is identified as not accurately reflecting any of the above audited items will be revised in order to ensure that the care plan is accurate and current reflection of resident□s condition and needs. All corrections will be completed by the facility Minimum Data Set Nurse and/or the Regional MDS Consultant and will be completed no later than 12/22/22. Systemic Changes On 12/07/22, the Minimum Data Set Nurse Consultant in-serviced the facility Minimum Data Set Nurse on the importance of maintaining up to date care plans that are reflective of the resident□s current status and needs. Emphasis was placed on ensuring that care plans are individualized for each resident□s specific needs. This includes ensuring that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 21 2. Resident #67 was admitted on 3/4/22 with diagnoses which included in part Stage 5 chronic end stage kidney disease and dependence on renal dialysis. Resident was admitted with an indwelling catheter in place. Review of Resident #67's 9/8/22 quarterly minimum data set assessment (MDS) revealed resident was cognitively intact, required extensive assistance of 2 people with bed mobility, total assistance of 2 people with transfers and total assistance with toileting. Resident #67 was coded as had an indwelling catheter and incontinence of bowel. Review of Resident #67's physician orders revealed a 9/13/22 physician order to discontinue indwelling catheter. Review of resident's care plan revealed that the focus of indwelling catheter was removed from the care plan on 11/14/22. Review of Resident #67's care plan revealed that incontinence care, incontinence of bowel and bladder and toileting were not addressed. Observation and interview with Resident #67 on 11/15/22 at 1:00 PM revealed resident did not have a catheter in place, the catheter was removed in September and that assistance with toileting and incontinence care was required. Review of documentation in Resident #67's medical record revealed resident had daily episodes of incontinence and required extensive assistance with toilet hygiene. Interview on 11/21/22 at 9:05 AM with the Director of Nursing (DON) revealed that Resident #67's	F 657	care plan accurately reflects the presence of items such as urinary catheters, pressure ulcers and the level of staff assistance needed for ADL completion, including toileting and incontinence care. Frontline staff who provide direct care to residents rely on the care plan in order to provide safe and effective care. Therefore, it is critical that in addition to the routine quarterly assessment and care plan reviews and updates that are completed, that care plans also be updated and revised as a resident□s condition changes. Care plan updates and revisions is an on-going process. The education also emphasized the importance of resolving items from the care plan once those services or items are no longer relevant or active for the resident. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or designee will audit up to 5 current residents in order to determine if their care plan appropriately reflects any of the following items that the resident may have including: urinary catheter, pressure ulcer(s), need for assistance with toileting or incontinence care. The audit will also determine if residents who have had discontinuation of urinary catheter has had this item resolved from the care plan or not. This	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 22 indwelling catheter was discontinued on 9/13/22. DON further stated she expected care plans reflected accurate care needs of each resident and were updated and revised timely. Interview on 11/21/22 at 10:53 AM with Nurse # 7 revealed that Resident #67 was admitted on 3/4/22 with an indwelling catheter. Order was received on 9/13/22 to discontinue Resident #67's indwelling catheter. The catheter was removed, and orders were discontinued. Nurse #7 stated the MDS Coordinator was responsible for updating the care plan with changes. Interview on 11/21/22 at 11:16 AM with the MDS Coordinator revealed the catheter focus on the care plan was resolved on 11/14/22. MDS Coordinator stated the catheter was discontinued on 9/13/22 the catheter focus should have been removed from the care plan at that time. MDS Coordinator further stated that incontinence care and toileting should have been addressed in Resident #67's care plan.	F 657	will be done on weekly basis x 4 weeks then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 12/22/22	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		1/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 23 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews the facility failed to apply a left-hand splint for contracture management according to occupational therapy recommendations for 1 of 1 resident (Resident #24) reviewed for limited range of motion. Findings included. Resident #24 was admitted to the facility on 12/22/21 with diagnoses to include hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side. A care plan dated 01/12/22 revealed Resident #24 had an Activities of Daily Living (ADL) self-care performance deficit related to hemiplegia and limited mobility related to history of stroke. The goal of care included to receive staff assistance with all aspects of daily care to ensure that all needs were met. Interventions included in part; to encourage resident to participate to the fullest extent possible with each interaction, offer choices in daily care, and monitor, document, and report to nurse as needed any changes in ADL ability, any potential for improvement, and reasons for inability to perform ADLs.	F 688	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F688 The facility failed to apply a left-handed splint for contracture management according to occupational therapy recommendations for Resident # 24. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #24, on 11/ 17 /2022 the left-hand splint was applied by the Occupational Therapist. On 12/15/2022 the resident's task and orders were updated with application of the splint as recommended by occupational therapy. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 24 A review of the Occupational Therapy discharge summary for dates of service: 12/23/21 through 01/28/22 revealed Resident #24 can tolerate left hand and wrist orthosis for 6 hours (daily) with no complaints of pain, redness, or altered skin integrity to maximize positioning of left hand and wrist and to decrease risk for contractures. Skilled treatment interventions focused on education and training resident and caregivers in compensatory strategies, safety precautions and splinting/orthotic schedule in order to complete self-care skills and functional mobility. A review of the Occupational Therapy discharge summary for dates of service: 04/01/22 through 05/12/22 revealed Resident #24 can tolerate left hand and wrist orthosis for 6-8 hours (daily) with no complaints of pain or altered skin integrity to decrease risk of worsening contractures in left hand/wrist. Discharge recommendations revealed Resident #24 had a splinting program in place. A review of the physician orders from 01/28/22 through 11/21/22 revealed no splint device orders were in place for Resident #24. A review of the Treatment Administration Record from 01/28/22 through 11/21/22 revealed no documentation that Resident #24 had a left-hand splint applied daily. The Minimum Data Set (MDS) quarterly assessment dated 10/28/22 revealed Resident #24 had mildly impaired cognition. She had no rejection of care and required extensive assistance with ADLs. She had impaired range of motion on one side.	F 688	The DON/nurse manager audited all current residents with orders for splint use to ensure the splint was in place. This was accomplished by auditing orders and care plan task for those devices. Once it was determined who needed a splint the nurse manager ensured the device was in place, had an MD order, CNA task, and care plan. process will be completed by 01/05/2023. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/20/2022, the DON began in-service education to all full time, part time, and as needed nurses and CNA's and agency. Topics included: • The importance for applying splints as ordered by the MD. • Inspecting skin at least daily or more frequently as ordered for irritation, redness or skin breakdown. • What to do when the device cannot be located On 12/ 20 /2022 occupational therapy began education on splint application for all Nurses, CNA's. Med Aides and agency. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 25 An observation conducted on 11/15/22 at 2:22 PM revealed Resident #24 was observed lying in bed, she was alert and oriented to person, place, and time. There was a sign above her bed showing how to apply splints and it read to apply splint to left hand 4-6 hours per day. There was no splint in place to her left hand. Resident #24 stated she should be wearing the splint every day and staff had not been applying the splint and stated she did not know where the splint was. She stated she had not worn the splint in a while and she wanted to wear it to help keep her hand stretched. There was no hand splint observed in the room. An observation conducted on 11/16/22 at 1:30 PM of Resident #24 revealed she was not wearing the left-hand splint. Resident #24 stated staff had not applied the left-hand splint and it had been a while since she last wore the splint. During an interview conducted on 11/16/22 at 4:01 PM Nurse Aide #8 stated she routinely provided care to Resident #24 over the last three weeks after being reassigned to the 200 hall. She stated Resident #24 was supposed to wear the splint to her left hand daily. She stated she had not applied the splint because she had not been trained on applying splints. An observation conducted on 11/16/22 at 6:00 PM of Resident #24 revealed she was not wearing the left-hand splint. During an interview conducted on 11/17/22 at 10:44 AM Nurse #6 stated Resident #24 was alert and oriented to person, place, and time and could voice her needs. She stated Resident #24 had a	F 688	in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by January 5, 2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses will monitor compliance utilizing the F688 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. Monitoring will be rotated in order to include all ordered shifts and weekends. The Director of Nursing will monitor splint application, compliance and training on splint application. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance with splint application. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 01/05/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 26	F 688		

left-hand splint to be applied daily. She stated she saw the Occupational Therapist in with the resident this morning.

An observation conducted on 11/17/22 at 10:50 AM revealed Resident #24 was wearing a left-hand splint. Resident #24 stated the splint was put on her this morning.

During an interview on 11/17/22 at 1:01 PM the Occupational Therapist stated Resident #24 received therapy services initially from December 2021 through January 2022. He stated therapy ended in January 2022 and the discharge summary revealed to apply splint to left hand and wrist for 6 hours a day to decrease the risk of worsening contractures. He stated the splint should be applied to the resident's left hand daily for 4-6 hours and stated nursing staff were responsible for ensuring the splint was applied daily. He stated Resident #24 was picked up for therapy services again from 04/01/22 through 05/12/22 for additional support to reach maximum potential. He stated today he went to check Resident #24 for splints and could not find the left arm splint in her room, but eventually found it in the laundry room up on a shelf. He stated he retrieved the splint and placed it on the resident this morning. He stated there were backup splints in the therapy department to use when splints were being laundered. He stated nursing staff were educated by the therapy department in January and May 2022 on applying the splint to Resident #24 and stated there was a sign in sheet documenting the training. He stated new staff may not have been trained but therapy could provide training at anytime when notified. He stated he could not find the physician order for the splint for Resident #24 in the electronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 27 medical record. He stated therapy recommended ongoing use of the left-hand splint to prevent worsening of contractures but at this time he stated Resident #24's contracture had not worsened. He indicated he would see that the order was entered into Resident #24's electronic medical record. An interview was conducted on 11/18/22 at 2:30 PM with the Director of Nursing. She stated therapy usually obtained the orders for splint placement and was not aware the order was not put in Resident #24's electronic medical record. She indicated she expected the nursing staff to apply the splint daily to Resident #24 for contracture management.	F 688		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		1/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 28 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and physician interview the facility failed to identify that a resident (Resident #66) was prescribed and administered an antibiotic that was resistant to the organism based on laboratory test results for 1 of 4 residents reviewed for urinary tract infections; failed to initiate physician orders for a continuous indwelling urinary catheter to include the size of the catheter and orders to maintain and care for the catheter; and failed to cleanse the perineal area and catheter site in a manner to prevent contamination for 1 of 3 residents (Resident #9) observed for urinary catheters. Findings included: 1. Resident #66 was admitted to the facility on 08/05/21. She had diagnoses that included a urinary tract infection (UTI) and a neurogenic bladder.	F 690	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F690 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to identify that a resident (Resident #66) was prescribed and administered an antibiotic that was resistant to the organism based on laboratory test results. The facility failed to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 29 A quarterly Minimum Data Set (MDS) assessment dated 11/01/22 documented Resident #66 had intact cognition. She had an indwelling urinary catheter. Review of the physician orders for October 2022 revealed Resident #66 was ordered the antibiotic medication Bactrim DS (Sulfamethox/Trimethoprim) tablet 800-160 MG (Milligrams) every 12 hours for a UTI for 7 days on 10/16/22. Review of a final laboratory report dated 10/16/22 for a urine culture and sensitivity documented Resident #66 had a urinary infection of >100,000 Escherichia coli, an organism that was resistant to the antibiotic Bactrim DS. This information was documented on page 2 of the laboratory report. On page 1 of the laboratory report Nurse #8 hand wrote a verbal order from the physician to administer Bactrim DS twice daily for seven days then recheck another urinalysis. Review of the electronic Medication Administration Record (eMAR) for Resident #66 documented she was administered the antibiotic Bactrim DS 800-160 MG every 12 hours for 7 days (14 doses) between 10/16/22 and 10/23/22. Review of the final laboratory report for the follow up urinalysis culture and sensitivity collected on 10/24/22 and reported to the facility on 10/26/22 documented the resident continued to have >100,000 Escherichia coli in her urine. In an interview with Resident #66 at 12:30 PM on 11/15/22 she stated she thought she was on the wrong medication for her UTI. She questioned if the medication she was currently receiving was	F 690	initiate physician orders for a continuous indwelling urinary catheter to include the size of the catheter and orders to maintain and care for the catheter and failed to cleanse the perineal area and catheter site in a manner to prevent contamination for resident #9. Corrective action for resident(s) affected by the alleged deficient practice: On 11/17/2022 the resident (Resident#66) was started on Ertapenem Sodium Solution for 3 days. The laboratory report documented the infection was susceptible to the antibiotic Ertapenem. On 11/17/2022 orders were entered for Resident #9 to include catheter size and care. Resident #9 received appropriate catheter care by Nurse aide #1 after Nurse aide #1 was re-trained and observed by the Nurse Consultant on 11/ 18 /2022. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents requiring Foley Catheter are at risk to be affected by the alleged deficient practice. The Director of Nursing and / or nurse manager audited all current residents with a Foley catheter to ensure batch orders entered for those residents to include catheter size, securement device, care and diagnosis. This audit will be completed by 12/22/22. Corrective actions were put in place by Director of Nurses / Nurse manager including batch orders. On 12/22/2022 all residents were in compliance with Indwelling catheter batch	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 30 "strong" enough because she did have chronic UTI ' s and stated she was afraid of becoming septic. She clarified during a second interview on 11/18/22 at 12:55 PM she had originally asked to go to the emergency room for evaluation on 11/13/22 because she felt short of breath, but after being evaluated at the hospital she found out she still had a UTI. In an interview with the Director of Nursing (DON) on 11/18/22 at 10:30 AM she commented it was the responsibility of the floor nurse to contact the physician and report findings when laboratory reports were received. She stated she herself did not follow laboratory results, but it was the responsibility of the floor nurse and the unit Support Nurse to follow the laboratory reports daily and make sure the residents were on the correct antibiotics. She did not review the results of the follow up urinalysis culture and sensitivity report. In an interview with the physician on 11/18/22 at 1:38 PM he stated he was familiar with Resident #66. He reported the nurse had not told him the antibiotic Bactrim DS was documented as resistant on the 10/16/22 laboratory results. He stated had he known he would have ordered a different medication the organism was susceptible to. He commented it had not hurt Resident #66 to receive the antibiotic the organism was resistant to, but it was an unnecessary medication because it wouldn ' t kill the organism. He reported no problems were encountered because of it. He stated he had not seen the follow up urinalysis culture and sensitivity report and it had not been reported to him. He noted had he been aware of the results on the follow up report he would have seen the	F 690	orders. All residents requiring Urinalysis for Culture and Sensitivity have the potential to be affected by this alleged deficient practice. The Director of Nurses and nursing team began auditing the past 14 days of Urine Culture and Sensitivity reports to ensure that an antibiotic order was initiated that was not resistant to the ordered antibiotic. This will be completed by 12/22/2022. The Director of Nurses began competency evaluation of all Certified Nursing Assistants, Medication Aides and agency nursing aides on Catheter Care. Competency evaluation will continue for 100% of newly hired certified nursing assistants to include staff or agency nursing assistants, along with medication aides by the Director of Nurses. As of 1/05/2023 all of the above will be in compliance. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 12/_20_/2022 the nurse managers began educating all full time, part time, and prn nurses and CNA's on the following topics: • How to perform catheter care and perineal care • Foley catheter batch orders • Urine Culture and Sensitivity report	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 31 antibiotic, Bactrim DS, had not been effective and he would have ordered a different medication to treat the infection. In an interview with Nurse #8 on 11/18/22 at 5:41 PM she stated it was the responsibility of the floor nurse to report to the physician any laboratory results that were received. She reported she had taken the order for the antibiotic Bactrim DS for Resident #66 on 10/16/22. She noted she usually sent a copy of the laboratory report via fax to the physician. She could not recall this laboratory report or situation. She could not remember calling the results to the physician or taking the verbal order from the physician that she had handwritten on page one of the report. She did not know if the report had a second page. In an interview with Support Nurse #1 on 11/21/22 at 9:22 AM she stated she reviewed physician orders daily. She reviewed records to ensure labs were collected and sent, reviewed laboratory reports that were received and reviewed physician orders for appropriateness. Typically, the floor nurse would contact the physician and obtain an order. She stated she was not aware of the report results of 10/16/22 because it was a Sunday when the report came in and she only worked Monday through Friday. Support Nurse # 1 added, normally on Mondays she would look at the Order Listing Report to view new orders and would then know to look for a follow up culture and sensitivity. She noted this situation happened a month ago and she could not recall what happened a month ago. In an interview with Nurse #5 on 11/21/22 at 10:27 AM she stated she had been the nurse on duty caring for Resident #66 on 10/26/22 when	F 690	reviews for appropriate medication This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 1/5/2023. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F690 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor to ensure the Foley catheter batch orders are in place, aides able to perform proper perineal care and review of Urine Culture and Sensitivity reports for appropriate medication orders. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance with foley catheter securement. The weekly QA Meeting is attended by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 32	F 690		

the second follow up urinalysis came back. She did not recall calling the results to the physician and had not seen the report until today.

In an interview with Pharmacist #1 on 11/21/22 at 12:12 PM she stated she reviewed the orders for Resident #66 on 10/22/22 and confirmed she had documented: "Antibiotics: Reviewed and following." She commented she had not realized the laboratory report had a second page and missed that the organism was resistant to the medication the resident was receiving, Bactrim DS. She noted had she seen the second page of the report she would have alerted the facility that the resident was receiving the wrong medication.

In an interview with Pharmacist #2 on 11/21/22 at 12:51 PM she stated she reviewed the medications for Resident #66 in November 2022. She noted she normally began her review where the previous pharmacist left off the month prior, but in this instance, she did not review the follow up urinalysis that was reported to the facility after the October review by Pharmacist #1 because she noted Resident #66 had been to the emergency room on 11/13/22 and was prescribed a different antibiotic (Macrobid) than she was on in October.

Review of the hospital report dated 11/13/22 for Resident #66 revealed she was diagnosed with a UTI and prescribed the antibiotic Macrobid 100 MG, one capsule orally every 12 hours for 7 days.

Review of the electronic Medication Administration Record revealed Resident #66 received Macrobid 100 MG by mouth every 12 hours on 11/14/22, 11/15/22, 11/16/22 and one dose on 11/17/22. While the survey was in

Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.

Date of Compliance: 01/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 33	F 690		

process, the facility received the final culture and sensitivity report for the urinalysis collected at the hospital on 11/13/22. The organism was resistant to Macrobid. The resident was started on Imipenem Sodium Solution reconstituted 1 Gram intramuscularly every 24 hours for 3 days on 11/17/22. The laboratory report documented the infection was susceptible to the antibiotic Imipenem.

2. Resident #9 was admitted to the facility on 09/29/21. Diagnoses included Benign Prostate Hypertrophy (enlarged prostate gland BPH).

The Minimum Data Set annual assessment dated 09/28/22 revealed Resident #9 was cognitively intact and was occasionally incontinent of bladder and frequently incontinent of bowel and was coded as receiving hospice services.

2a. A physician note written on 10/28/22 revealed, in part, resident noted with episodic urinary retention. Recent ultrasound showed bladder distention with greater than 1000 milliliters (ml) of retained urine. Hospice Nurse assisted with inserting a catheter with great difficulty. Once the catheter was placed, an immediate return of 200 ml of clear urine followed by steady flow of some blood-tinged urine for a total of 300 ml.

A hospice progress note written on 10/28/22 revealed nurse made a visit with the physician to assist with inserting a catheter for Resident #9. The note indicated a #16 French, 10 milliliter (ml) catheter was inserted using sterile technique.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 34	F 690		

A review of the physician orders revealed there were no physician orders written for an indwelling urinary catheter on 10/28/22.

A review of the Treatment Administration Record (TAR) revealed there were no orders to care or maintain an indwelling urinary catheter.

A review of Resident #9's care plan revealed the last updated plan of care was 10/19/22. There was no care plan in place to include an indwelling urinary catheter.

An observation of Resident #9 on 11/15/22 at 11:45 AM revealed the resident was lying in bed. He was noted to have an indwelling urinary catheter which was hanging lower than the bladder, covered with dignity bag, and secured to his right leg. The catheter was noted to have dark yellow urine with about 400 ml in the urinary bag.

An interview was conducted with Resident #9 on 11/15/22 at 11:45 AM. Resident #9 stated he had a catheter, and he believed the staff cleaned it but could not be sure. Resident #9 stated they usually secured the tubing to his leg.

An interview was conducted with Nurse #1 on 11/17/22 at 2:30 PM. Nurse #1 stated she was aware Resident #9 had an indwelling urinary catheter. Nurse #1 reviewed the physician orders and confirmed there were no orders to indicate the size of the catheter or any orders to maintain and care for the catheter or when the catheter should be changed. Nurse #1 stated she did not know how it got missed for two and half weeks and she would put the orders in the electronic medical record (eMAR) now. Nurse #1 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 35	F 690		

that although the Hospice Nurse and the Physician inserted the catheter on 10/28/22, it would have been the facility nurse that would have been responsible for putting the orders in the eMAR and not the Hospice Nurse. Nurse #1 stated she knew the resident had a catheter but did not know how many millimeters the balloon was filled with. She stated since there were no orders put in the eMAR. Nurse #1 also stated thankfully, she was made aware the orders were not put in because, she added, the catheter was due to be changed in about a week and it may have gotten missed if we did not have the orders put in the eMAR. Nurse #1 stated whenever an order was put into the eMAR it would prompt the staff to initiate "batch" orders to include the type of catheter, the size and balloon amount, an order to change the catheter every 30 days or as needed for occlusion, secure the tubing with a stat lock (device to secure to leg), to do catheter care each shift, to change the urinary bag weekly, and to monitor urine output.
An interview with the Nurse who was assigned to Resident #9 on 10/28/22 was not obtained. Nurse no longer worked at facility and there was no working forwarding number.

An interview was conducted with the Director of Nursing (DON) on 11/18/22 at 3:10 PM. The DON stated she would have expected her nursing staff to put all the orders pertaining to the catheter and the care of the catheter into the eMAR on 10/28/22 so that it could be monitored and managed daily on each shift and to make the nurses aware of when it needed to be changed. The DON added it was important to ensure urinary catheters were being monitored daily to prevent increased chance of urinary tract infections.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 36	F 690		

An interview was attempted with the Physician via phone on 11/21/22 at 2:34 PM. Physician returned call at 5:04 PM on 11/21/22 and left message to return his call. Called physician at 6:02 PM on 11/21/22 and left message for a returned call.

2b. An observation of Nurse Aide (NA) #1 on 11/18/22 at 9:45 AM during catheter care was conducted. NA #1 washed her hands, applied gloves, obtained a wash basin with warm water and soap. She obtained face clothes, personal wipes, and towels, and had Resident #9 check the water for temperature. NA #1 proceeded with Resident #9's catheter care as she unfastened and opened the brief. She was noted to use a single facility provided personal moistened cleansing wipe as she began to cleanse the Resident's penis. She pulled back the foreskin to cleanse the shaft of the penis and then moved upward toward the tip of the penis with the wipe. NA #1 proceeded to use the same cleansing wipe as she cleansed the catheter tubing starting at the tip of the penis down toward the connecting port of the catheter and then discarded the used wipe. NA #1 did not use a separate wash cloth to clean the tip of the penis or a separate wash cloth to cleanse the shaft of the penis or the catheter tubing.
An interview was conducted with NA #1 on 11/18/22 at 10:15 AM. She stated she was a new agency nurse aide and had been working at the facility for a month. She stated she received training at her school on how to perform catheter care and she acknowledged she should have used soapy washcloths instead of using a single wipe and she should have washed the resident starting at the tip of the penis and working

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 37 downward to avoid contamination. She stated she had only been a Nurse Aide for a month, and she did not receive any catheter care training by her Agency or the facility when she began working here a month ago. An interview was conducted with the Director of Nursing (DON) on 11/18/22 at 3:10 PM. The DON stated she would have expected the Nurse Aide to follow the procedures of doing catheter care the way she was taught. The DON stated the staff at the facility were not trained to use the cleansing wipes to do catheter care and their policy was to use warm soapy water to cleanse the perineal area and the catheter insertion site. The DON stated she would have expected the Nurse Aide to have had training with the agency she was working for prior to sending them to facilities and she would have expected the facility staff to ensure she was properly trained prior to starting her shift at this facility. The DON added, somehow the facility training "slipped through the cracks."	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition	F 692		1/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 38 demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to obtain a weight upon admission and physician ordered weekly weights on 1 of 2 residents (Resident #82) reviewed for nutrition. Findings included: Resident #82 was originally admitted to the facility on 10/07/22, discharged to the hospital on 10/10/22 and readmitted back to the facility on 10/24/22 with admitting diagnoses included, in part, gastrointestinal bleed, anemia, Parkinson's Disease, and diabetes. A review of the hospital discharge summary dated 10/07/22 revealed Resident #82's weight was 259 lbs. A review of Resident #82's facility weight record revealed on 10/07/22 his weight was 259 lbs. There were no other weights recorded in the log. The Minimum Data Set (MDS) discharge assessment dated 10/10/22 revealed Resident #82's weight was recorded as 259 lbs. A review of the hospital discharge summary dated	F 692	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F692 1. For clinical services, a corrective action was obtained between 11/15/2022 and 11/18/2022. Based on staff interviews, observation, and record review nutrition and hydration maintenance was not maintained for 1 of 2 residents. For Resident #82 the facility failed to obtain an admission weight following admission on 10/24/2022 and properly intervene prior to a significant weight change. For Resident #82 reweights obtained 11/21/2022, 11/22/2022, and 11/30/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 39 10/24/22 did not indicate Resident #82's weight. A review of the MDS entry assessment on 10/24/22 revealed there was no recorded weight. A physician order written on 10/25/22 revealed weekly weights every 7 days for 28 days. The MDS admission assessment dated 10/31/22 revealed Resident #82 was moderately cognitively impaired. Resident #82 was independent with set up with meals and the weight was recorded as 259 lbs. A review of the medical record revealed there was no care plan for nutrition. A review of the Medication Administration Record (MAR) on 11/15/22 revealed weights were due during the evening shift on 10/25, 11/02, 11/08 and 11/15. On 10/25, the MAR indicated a #9 (which meant see nurse's note), on 11/02/22 the MAR indicated a #2 (which meant resident refused), on 11/08/22 no weight was recorded, and the weight on 11/15/22 was recorded as 259 lbs. A review of the nurse's notes on 10/25/22 revealed there was no documentation regarding Resident #82's weight. An interview was conducted with Nurse Aide (NA) #8 on 11/17/22 at 4:40 PM. NA #8 stated she worked on the 700 hall where Resident #82 resided on the evening of 11/15/22, but no one had asked her to get his weight. An interview with Nurse #3 on 11/20/22 at 7:48 PM who worked the evening shift on 11/15/22	F 692	Weight changes discussed with Resident #82 and family. Dietitian Assessment completed 12/1/2022. High Protein supplement orders entered into PCC and provided per family request. Resident #82 discharged 12/3/2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice in-service will be completed with nursing, nursing assistants, and department heads by compliance date of 1/5/2023. On 12/1/2022 an all facility weight and supplement order review completed. On 12/16/2022 December admissions audited to ensure admission weights obtained and orders for weekly weights x 4 in place. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: " Weight Policy " Admission Checklist Procedures " Weight Meeting Procedures This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 40 revealed if a weight was due for a resident it would populate in the MAR so the nurse would know to obtain and document the weight. She stated she does not remember getting a weight on Resident #82 that evening and did not know why 259 lbs. was documented in the MAR. She stated it was an error that she documented that weight. She stated she did not recall asking NA #8 to get a weight for the resident. Nurse #3 stated she would need to be more careful in the future because it was confusing since the weight obtained on 11/17/22 was 205 lbs. and that showed a great weight loss. Nurse #3 stated she did not know why she did not obtain the weight as ordered, and added, it must not have populated for her to get a weight. An observation of Resident #82 on 11/15/22 at 12:20 PM revealed the resident was lying in bed and sleeping. The lunch tray had been provided and was at the resident's bedside. A nutritional supplement was noted to be on the tray. An interview with a family member on 11/15/22 at 12:20 PM revealed Resident #82 had lost a lot of weight in the last couple of months, and he had not been eating well, but was willing to try many different foods they brought in. The family member stated the weight loss was mostly from his hospital stay and she had not seen a great weight loss since he was admitted to the facility. She stated he enjoyed milk shakes which they brought in a couple of times a day for him. The family member stated Resident #82 had not been weighed since he came to the facility, and she was curious what his weight was. On 11/17/22 at 2:10 PM the family member stated she had requested Resident #82 be weighed on	F 692	4. Quality Assurance monitoring procedure. The DON or designee will monitor weights weekly x 4 weeks and then monthly x 3 months using the Weight Review QA Audit tool. Weight change reviews will include insuring weights are obtained per policy and significant weight changes are addressed properly and timely to maintain nutrition and hydration status. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 41	F 692		

the scale as they were passing by it with the Wound Treatment Nurse. The family member reported the weight was 208 lbs.

On 11/17/22 at 4:30 PM a reweigh was requested on the scale, but the resident refused because he was tired and already in bed. A weight was instead obtained on the mechanical lift and was noted to be 205 lbs.

An interview was conducted with Nurse #2 on 11/18/22 at 2:09 PM. Nurse #2 reported the resident was not eating much but he would drink his milk shakes the family brought in. She stated she was surprised to see the weight difference from 259 lbs. to 205 lbs. She stated the 259 lb. weight was recorded in the weight log on 10/07/22 and she did not see a new admission weight on 10/24/22 so she questioned how much he actually lost between 10/24/22 and 11/17/22. Nurse #2 stated she notified the physician regarding the new weight and an order was obtained to give nutritional supplements with meals. Nurse #2 stated there should have been an admission weight on 10/24/22 and the weekly weights should have been obtained as ordered on 10/25/22.

An interview was attempted with the Registered Dietician (RD) on 11/18/22 and 11/21/22 via phone. The RD did not return the phone calls.

An interview was conducted with the Director of Nursing (DON) on 11/18/22 at 3:15 PM. The DON stated the nurses should have obtained an admission weight upon entry because that was the facility protocol. The DON added if weekly weights were ordered, the nurses should have been getting the weights. She stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 42 questioned the accuracy of the 259 lb. weight obtained on 11/15/22 since that was the admitting weight on 10/07/22 and he was hospitalized for 2 weeks and definitely needed that readmission weight. The weight that was obtained on 11/18/22 of 205 lbs. is a 54 lb. discrepancy and she was not sure of the accuracy. The DON stated if an admission weight as well as weekly weights were getting done they would have a more accurate weight.	F 692		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides.	F 726		1/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 43 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interviews, the facility failed to provide an agency Nurse Aide (NA #1) with education and to verify their competency to deliver catheter care for 1 of 3 residents (Resident #9) observed for catheter care. Findings included: Resident #9 was admitted to the facility on 09/29/21. Diagnoses included Benign Prostate Hypertrophy (enlarged prostate gland BPH). The Minimum Data Set annual assessment dated 09/28/22 revealed Resident #9 was cognitively intact and was occasionally incontinent of bladder and frequently incontinent of bowel. A hospice progress note written on 10/28/22 revealed nurse made a visit with the physician to assist with inserting a catheter for Resident #9. The note indicated a #16 French, 10 milliliter (ml) catheter was inserted using sterile technique. An observation of Resident #9 on 11/15/22 at 11:45 AM revealed the resident was lying in bed. He was noted to have an indwelling urinary catheter which was hanging lower than the bladder, covered with dignity bag, and secured to his right leg. The catheter was noted to have dark yellow urine with about 400 ml in the urinary bag.	F 726	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F726 The facility failed to provide an agency Nurse Aide (NA #1) with education and to verify their competency to deliver catheter care for Resident #9. Corrective action for resident(s) affected by the alleged deficient practice: Resident #9 received appropriate catheter care by Nurse aide #1 after Nurse aide #1 was re-trained and observed by the Nurse Consultant on 11/ 18 /2022. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents that have a catheter are at risk to be affected by this practice. The Director of Nurses began competency evaluation of all Certified Nursing Assistants, Medication Aides and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 44 An interview was conducted with Resident #9 on 11/15/22 at 11:45 AM. Resident #9 stated he had a catheter, and he believed the staff cleaned it but could not be sure. Resident #9 stated they usually secured the tubing to his leg. An observation of Nurse Aide (NA) #1 on 11/18/22 at 9:45 AM during catheter care was conducted. NA #1 washed her hands, applied gloves, obtained a wash basin with warm water and soap. She obtained wash clothes, personal wipes, and towels, and had Resident #9 check the water for temperature. NA #1 proceeded with Resident #9's catheter care as she unfastened and opened the brief. She was noted to use a single facility provided personal moistened cleansing wipe as she began to cleanse the Resident's penis. She pulled back the foreskin to cleanse the shaft of the penis and then moved upward toward the tip of the penis with the wipe. NA #1 proceeded to use the same cleansing wipe as she cleansed the catheter tubing starting at the tip of the penis down toward the connecting port of the catheter and then discarded the used wipe. NA #1 did not use a separate wash cloth to clean the tip of the penis or a separate wash cloth to cleanse the shaft of the penis or the catheter tubing. An interview was conducted with NA #1 on 11/18/22 at 10:15 AM. She stated she was a new agency nurse aide and had been working at the facility for a month. She stated she received training at her school on how to perform catheter care and she acknowledged she should have used soapy washcloths instead of using a single wipe and she should have washed the resident starting at the tip of the penis and working downward to avoid contamination. She stated she had only been a Nurse Aide for a month, and	F 726	agency nursing aides on Catheter Care. Competency evaluation will continue for 100% of newly hired certified nursing assistants to include staff or agency nursing assistants, along with medication aides by the Director of Nurses. As of 1 / 05 /2023 all of the above will be in compliance. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/20/2022, the Director of Nurse and Nurse Consultant began education of all full time, part time, PRN nurses, certified nursing assistants, med aides and agency on the following: This in-service included the following topics: " How to perform catheter care " When to perform catheter care On 12/ 16 /2022 the Nurse Consultant educated the DON/Registered Nurse Supervisors on the orientation process and competency evaluation for Catheter Care for Certified Nursing Assistants, Medication Aides and Agency nursing assistants. The Director of Nursing will ensure that any nurse who has not received this training by 1/05/2023 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 45 she did not receive any catheter care training by her Agency or the facility when she began working here a month ago. An interview was conducted with the Director of Nursing (DON) on 11/18/22 at 3:10 PM. The DON stated she would have expected the Nurse Aide to follow the procedures of doing catheter care the way she was taught. The DON stated the staff at the facility were not trained to use the cleansing wipes to do catheter care and their policy was to use warm soapy water to cleanse the perineal area and the catheter insertion site. The DON stated she would have expected the Nurse Aide to have had training with the agency she was working for prior to sending them to facilities and she would have expected the Support Nurses to make sure the agency NA was properly trained prior to starting her shift at this facility. The DON provided an Agency Nurse Aide Orientation outline that should have been used for NA #1's orientation. The outline had a signature line for the Agency Nurse Aide and date and a signature line for the Nurse providing training and date. The DON added, somehow the facility training "slipped through the cracks." The DON was not able to provide any documentation from the facility that NA #1 had received orientation or training prior to starting at this facility.	F 726	process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training or competency evaluation by 01/05/2023 will not be allowed to work until the training has been completed. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F726 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. The Director of Nursing/designee will monitor compliance with competency evaluation for Catheter Care for all certified nursing assistants and medication aides (staff/agency) as part of facility orientation and observation of 3 CNA/Med Aides/Agency catheter care skills. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 46	F 726	Date of Compliance: 01/05/2023	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in	F 756		1/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 47 the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, physician interview and Consultant Pharmacist #1 interview, the Consultant Pharmacist failed to identify that a resident (Resident #66) was prescribed and administered an antibiotic that was resistant to the organism based on laboratory test results for 1 of 4 residents reviewed for urinary tract infections. Findings included: Resident #66 was admitted to the facility on 08/05/21. She had diagnoses that included a urinary tract infection (UTI) and a neurogenic bladder. A quarterly Minimum Data Set (MDS) assessment dated 11/01/22 documented Resident #66 had intact cognition. She had an indwelling urinary catheter. Review of the physician orders revealed Resident #66 was ordered the antibiotic medication Bactrim DS (Sulfamethox/Trimethoprim) tablet 800-160 MG (Milligrams) every 12 hours for a UTI for 7 days on 10/16/22. Review of a final laboratory report dated 10/16/22 for a urine culture and sensitivity documented Resident #66 had a urinary infection of >100,000 Escherichia coli, an organism that was resistant to the antibiotic Bactrim DS. This information was documented on page 2 of the laboratory report.	F 756	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F756 Drug Regimen Review, Report Irregular The Consultant Pharmacist failed to identify that a resident (Resident #66) was prescribed and administered an antibiotic that was resistant to the organism based on laboratory test results. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 11/17/2022 facility received Culture and Sensitivity report for Resident #66 with provider notification and review. New order for Ertapenem received and initiated. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents requiring Urinalysis for Culture and Sensitivity have the potential to be affected by this alleged deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 48 Review of the electronic Medication Administration Record (eMAR) for Resident #66 documented she was administered the antibiotic Bactrim DS 800-160 MG every 12 hours for 7 days (14 doses) between 10/16/22 and 10/23/22. In an interview with the physician on 11/18/22 at 1:38 PM he stated he was familiar with Resident #66. He reported the nurse had not told him the antibiotic Bactrim DS was documented as resistant on the 10/16/22 laboratory results. He stated had he known he would have ordered a different medication the organism was susceptible too. He commented it had not hurt Resident #66 to receive the antibiotic the organism was resistant to, but it was an unnecessary medication because it wouldn ' t kill the organism. In an interview with Consultant Pharmacist #1 on 11/21/22 at 12:12 PM she stated she reviewed the orders for Resident #66 on 10/22/22 and confirmed she had documented: "Antibiotics: Reviewed and following." She commented she had not realized the laboratory report had a second page and missed that the organism was resistant to the medication the resident was receiving, Bactrim DS. She noted had she seen the second page of the report she would have alerted the facility that the resident was receiving the wrong medication.	F 756	The Director of Nurses and nursing team began auditing the past 14 days of Urine Culture and Sensitivity reports to ensure that an antibiotic order was initiated that was not resistant to the ordered antibiotic. This will be completed by 12/22/2022. The Director of Nurses and nursing team completed corrective action for those residents including notification to medical provider for clarification of orders and initiation of those orders. On 12/22/2022 all residents were in compliance with appropriate medication management. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: The Pharmacist Manager will educate the Pharmacy Consultant on reviewing all culture and sensitivity reports to ensure appropriate antibiotics are ordered for treatment. This will be completed by 1/5/2023. Beginning on 12/20/2022 the Nurse Consultant educated the Director of Nurses and nursing team on the following topics: " Urine Culture and Sensitivity report reviews to ensure that they have been addressed by the physician and appropriate orders received and implemented timely. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 49	F 756	process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training by 1/5/2023 will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F756 Quality Assurance Tool for compliance with the Drug Regimen Review Process related to Urine and Culture Sensitivity Reports weekly x 2 weeks then monthly x 3 month or until resolved. The Director of Nursing will monitor 5 Urine Culture and Sensitivity Reports to ensure an appropriate antibiotic is ordered with follow through of physician review and that all orders received are initiated. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 01/05/2023	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs	F 757		1/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 50 CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, physician interview, staff interviews, and pharmacist interview, the facility administered a medication to a resident that was not medically justified for 1 of 5 residents reviewed for unnecessary medications, Resident #66. Findings included: Resident #66 was admitted to the facility on 08/05/21. She had diagnoses that included a urinary tract infection and a neurogenic bladder.	F 757	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F757	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 51 A quarterly Minimum Data Set (MDS) assessment dated 11/01/22 documented Resident #66 had intact cognition. She had an indwelling urinary catheter. Review of the physician orders for October 2022 revealed Resident #66 was ordered the antibiotic medication Bactrim DS (Sulfamethox/Trimethoprim) tablet 800-160 MG (Milligrams) every 12 hours for a UTI for 7 days on 10/16/22. Review of the electronic Medication Administration Record (eMAR) for Resident #66 for October 2022 documented she was administered the antibiotic Bactrim DS 800-160 MG every 12 hours for 7 days (14 doses) between 10/16/22 and 10/23/22. Review of a final laboratory report dated 10/16/22 for a urine culture and sensitivity documented Resident #66 had a urinary infection of >100,000 Escherichia coli, an organism that was resistant to the antibiotic Bactrim DS. This information was documented on page 2 of the laboratory report. On page 1 of the laboratory report Nurse #8 hand wrote a verbal order from the physician to administer Bactrim DS twice daily for seven days then recheck another urinalysis. In an interview with the Director of Nursing (DON) on 11/18/22 at 10:30 AM she commented it was the responsibility of the floor nurse to contact the physician and report findings when laboratory reports were received. She stated she herself did not follow laboratory results, but it was the responsibility of the floor nurse and the unit Support Nurse to follow the laboratory reports daily and make sure the residents were on the	F 757	The facility administered a medication to a resident that was not medically justified, Resident #66. 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident#66 had Culture and Sensitivity report reviewed by provider on 11/17/22 with new order for Ertapenem initiated. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents requiring Urinalysis for Culture and Sensitivity have the potential to be affected by this alleged deficient practice. The Director of Nurses and nursing team began auditing the past 14 days of Urine Culture and Sensitivity reports to ensure that an antibiotic order was initiated that was not resistant to the ordered antibiotic. This will be completed by 12/22/2022. The Director of Nurses and nursing team completed corrective action for those residents including notification to medical provider for clarification of orders and initiation of those orders. On 12/22/2022 all residents were in compliance with physician notification and concerns. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 12/20/2022 the Nurse Consultant educated the Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 52 correct antibiotics. In an interview with the physician on 11/18/22 at 1:38 PM he stated he was familiar with Resident #66. He reported the nurse had not told him the antibiotic Bactrim DS was documented as resistant on the 10/16/22 laboratory results. He stated had he known he would have ordered a different medication the organism was susceptible to. He commented it had not hurt Resident #66 to receive the antibiotic the organism was resistant to, but it was an unnecessary medication because it wouldn ' t kill the organism. He reported thankfully no problems were encountered because of it. In an interview with Nurse #8 on 11/18/22 at 5:41 PM she stated it was the responsibility of the floor nurse to report to the physician any laboratory results that were received. She reported she had taken the order for the antibiotic Bactrim DS for Resident #66 on 10/16/22. She noted she usually sent a copy of the laboratory report via fax to the physician. She could not recall this laboratory report or situation. She could not remember calling the results to the physician or taking the verbal order from the physician that she had handwritten on page one of the report. She did not know if the report had a second page. In an interview with Support Nurse #1 on 11/21/22 at 9:22 AM she stated she reviewed physician orders daily. She reviewed records to ensure labs were collected and sent, reviewed laboratory reports that were received and reviewed physician orders for appropriateness. Typically, the floor nurse would contact the physician and obtain an order. She stated she was not aware of the report results of 10/16/22 because it was a	F 757	Nurses, Assistant Director of Nurses and nursing team on the following topics: " Urine Culture and Sensitivity report review to ensure that they have been addressed by the physician and appropriate orders received and implemented timely to avoid unnecessary drug administration as part of the Daily Clinical Process. " Timely notification of the physician of Urine for Culture and Sensitivity and sensitivity/resistance results. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training by 1/5/2023 will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F757 Quality Assurance Tool for compliance with the Drug Regimen Review Process related to Urine and Culture Sensitivity Reports as part of the Daily Clinical Review Process weekly x 2 weeks then monthly x 3 month or until resolved. The Director of Nursing will monitor 5 Urine Culture and Sensitivity Reports to ensure an appropriate antibiotic is ordered with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 53 Sunday when the report came in and she only worked Monday through Friday. Normally on Mondays she would look at the Order Listing Report to view new orders and would then know to look for a follow up culture and sensitivity. She noted this situation happened a month ago and she could not recall what happened a month ago. In an interview with Pharmacist #1 on 11/21/22 at 12:12 PM she stated she reviewed the orders for Resident #66 on 10/22/22 and confirmed she had documented: "Antibiotics: Reviewed and following." She commented she had not realized the laboratory report had a second page and missed that the organism was resistant to the medication the resident was receiving, Bactrim DS. She noted had she seen the second page of the report she would have alerted the facility that the resident was on the wrong medication.	F 757	follow through of physician review and that all orders received are initiated to avoid unnecessary drug administration. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 01/05/2023	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		1/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 54 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, the facility failed to: accurately label and record an opened date for a bottle of tuberculin solution in the Station #1 medication room refrigerator and a bottle of Influenza vaccine in the 400 hall medication room. The facility failed to accurately record an opened dated for a bottle of eye drops, dispose of 2 expired bottles of nitroglycerin and an expired insulin pen on the 300 hall medication cart. The facility failed to dispose of an expired bottle of nasal spray, discard an expired Insulin pen, and accurately record an opened date for 2 Insulin pens on the 100/200 hall medication cart. The facility failed to lock and secure a medication cart (100/200 hall medication cart) in an unattended resident care area for 1 of 5 medication carts observed. The facility also failed to securely store medication on a medication cart for 2 of 5 (300 hall and 500 hall) carts observed. Findings included: 1.Observation on 11/15/22 at 4:15 PM of Nurses Station #1 medication room refrigerator revealed: 1 bottle of Tuberculin Solution labeled as opened on 8/22/22. Manufacturer's instructions indicated	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 The facility failed to date/label an open bottle of Tubersol and Influenza vaccine and open bottle of eye drops. The facility failed to dispose of expired medication to include 2 nitroglycerin, nasal spray, and 2 insulin pens. The facility failed to lock and secure a medication cart and to securely store medication on a medication cart. 1. The undated/labeled medications were removed from the cart on 11/ 15 /2022 and 11/16/2022 by Director of Nursing and appropriately disposed of. The unsecured medication carts were locked by the Director of Nursing on 11/ 16 /2022. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 55 tuberculin solution was to be discarded 30 days after opened. 2. Observation on 11/15/22 at 4:20 PM of the 300 Hall Medication Cart revealed the following: Resident #30: bottle of Timolol 0.5% eye drops observed as opened with no opened date noted on bottle. Resident #47: bottle of nitroglycerin 0.4 mg. dispense date 10/14/21. Expiration Date on label 10/13/22. Resident #27: bottle of nitroglycerin 0.4 mg. dispense date on label 3/11/21. Expiration Date on label listed as 3/10/22. An opened Insulin Glargine Pen labeled with the name of a resident no longer in the facility with no opened date indicated. Interview on 11/15/22 at 4:30 PM with Nurse Aide (NA)#4 who was also a medication aide working on 300 Hall medication cart revealed that expired medications were to be discarded and medication for a discharged resident should be discarded. 3.Observation on 11/16/22 at 1:13 PM of 100/200 Hall medication cart with Nurse #4 in attendance revealed the following: Resident #60 Fluticasone nasal spray bottle with opened date recorded as 7/19/22 Resident #25's Lantus Pen labelled with an opened date of 10/10/22. Label stated expired 28 days after opening. Resident #11 with 2 Tresiba Flex Pens with the seals broken and opened date not recorded on either of the pens. The label indicated the medication expired 56 days/8 weeks after opening.	F 761	unsecured medication was discarded by Nurse #4 on 11/16 /2022. No resident was identified to be affected. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. The Director of Nurses / Register Nurse Supervisor□s began audits of all medication carts and the medication storage rooms to assure no other undated or expired medications were found. This will be completed by 12/22/2022. The Director of Nurses / Register Nurse Supervisor□s began audit of all medication carts to assure that all medications were appropriately stored and that each medication cart was appropriately locked. This will be completed by 12/22/2022. 3. Systemic changes. All nurses, medication aides and agency nurses/med aides will be re-educated by the Director of Nurses on the facility medication storage, dating policy and disposition of medications for discharged residents. This will be completed by 1/5/2023. The pharmacist consultant was notified of the survey findings on 12/ 16 /2022 and will perform monthly audits of the medication carts and medication room to assist the facility in discarding, monitoring dating of medications that are opened and securing of medications and assuring that all medication carts are appropriately locked.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 56 Interview on 11/16/22 at 1:20 PM with Nurse #4 revealed she didn't know why the pens weren't dated when opened. Nurse #4 stated she only worked PRN or as needed and did not know who was supposed to be checking the medication cart for expired medications. Interview on 11/16/22 at 1:25 PM with the Director of Nursing (DON) revealed that the insulin pens should be discarded when expired and that medications were to be accurately labelled and dated. 4. Observation on 11/16/22 at 1:45 PM revealed 100/200 hall med cart was observed unlocked and not under direct supervision in a common area at the nurses station for approximately 15 minutes as multiple staff members and residents were observed walking past the cart. After approximately 15 minutes the DON came up to the medication cart and observed that it was unlocked. The DON stated that it should not be left unlocked. Nurse #4 who was assigned to the 100/200 hall medication cart returned to the cart. Nurse #4 stated she had gone to take care of something with a resident and the cart should not have been left unlocked. 5. Observation on 11/16/22 at 4:17 PM revealed a cup with crushed medications in liquid was left on top of the 100/200 hall medication cart unattended in an area where residents could access it while Nurse #4 went into a resident's room to perform a blood sugar check. The medication cart was not within direct observation of Nurse #4. Nurse #4 stated the medication was for a resident on another hall and it needed to be dissolved. The nurse further stated that it probably should	F 761	4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will audit medication refrigerators and medication carts on all halls weekly for 2 weeks and then monthly for 3 months or until resolved for compliance with dating of applicable medications after medications are opened, expired medication disposition, medication being secured and all medication carts being locked. The Pharmacist Consultant will submit a monthly report to the Director of Nursing. The Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, Minimum Data Set Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director, Medical Director and the Director of Social Services. Date of Compliance: 01/05/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 57	F 761		

not have been left unattended on top of the medication cart.

6. Observation on 11/16/22 at 4:30 PM of the 400 Hall medication prep room refrigerator revealed: 1 vial of Influenza vaccine solution with the cap removed from the vial with no opened date on the label.

7. Observation on 11/16/22 at 5:05 PM revealed Resident #43 entered her room, removed a bottle of Tums antacid tablets from the bedside table, removed 2 tablets from the bottle and ingested them.

Resident #43 was admitted to the facility on 8/12/22 with medical diagnoses which included in part dementia and gastroesophageal reflux disorder. Record review revealed resident had not been assessed as appropriate for self-administration.

Interview on 11/16/22 at 5:11 PM with Nurse #5 revealed Resident #43 was not alert and oriented and not able to self-administer medications. Nurse #5 further stated Resident #43 did not have an order for Tums and should not be taking them without an order. Nurse #5 stated that if a resident wanted to self-administer medication, they were to be assessed for this and if appropriate the doctor was informed and an order obtained.

8. Resident #47 was noted with a physician order dated 1/11/22 for self-administration of Fluticasone Propionate Suspension 50 micrograms/actuation. 1 spray in each nostril one time a day for allergies. unsupervised self-administration Shake before use. Blow nose

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 58	F 761		

before use.

Initial Self Administration assessment was completed on 1/19/22 and resident was determined to be able to self-administer. Self-administration assessment was updated on 10/13/22 and resident was approved as able to self-administer medications.

Resident #47's care plan revealed a Self-administration focus dated 1/19/22.

Interview with Resident #47 on 11/17/22 at 2:00 PM regarding self-administration of nasal spray revealed resident had nasal spray on the table that she used once per day as needed. Observation revealed a bottle of nasal spray on the bedside table labelled Nasonex (memetasone furoate nasal spray 50 micrograms) label read 2 sprays into both nostrils once per day. Written on the bottle was a date 3/20/22. Also observed on the bedside table were 2 bottles of Pain Relief Cream 4 % Lidocaine topical analgesic. Resident #47 stated she used the pain relief cream every night for arthritis of her hands and shoulder.

Interview was conducted on 11/17/22 at 2:15 pm with Nurse Aide #4 who was also the Med Aide on the 300 hall. NA#4 stated a self-administration evaluation was completed before a resident could self-administer medications. NA #4 stated she thought the medication was to be kept in a locked box, that she was unsure where Resident #47 kept her nasal spray and didn't check with her about when or how often she administered it. NA #4 was unaware that Resident #47 had other medication in her room.

Interview on 11/17/22 at 2:55 PM with DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 59 revealed that her expectation was that medications would not be kept at the bedside. The DON further stated that if a resident was assessed as able to self-administer, she expected a physician order and for medication to be stored in a drawer at the bedside or on the medication cart. The DON added that a physician order was required.	F 761		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced	F 803		1/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 60 by: Based on observations, record review, resident interview and staff interviews, the facility failed to follow the prepared menu for 3 out of 4 meals observed when food items were substituted or omitted, but not noted or updated on the menu in advance time. Findings included: 1. The menu provided titled Fall/Winter 2022-2023 Week 3 revealed the lunch on 11/16/22 was homemade vegetable soup, saltine crackers, grilled cheese sandwich, vegetable sticks, and chilled peaches. A review of a handwritten menu dated 11/16/22 at 9:30 AM which posted at the nurses' station on 11/16/22 revealed a pimento cheese sandwich instead of grilled cheese sandwich. Observation of the lunch meal on 11/16/22 at 12:30 PM revealed a cold pimento cheese sandwich was served instead of grilled cheese sandwich. An interview with Resident #26 on 11/16/22 at 12:30 PM who was described by staff as being alert and oriented revealed the menu that was provided was often different from what was served and added "We never know what we are going to get." An interview was conducted with the Dietary Manager (DM) on 11/17/22 at 11:15 AM. The DM reported she served pimento cheese sandwiches on 11/16 because her flat griddle did not work. She stated she was not able to cook grilled cheese sandwiches for the whole facility, so she	F 803	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F803 1. For dietary services, a corrective action was obtained on 11/16/2022. Based on meal observation and interviews it was noted the facility failed to follow the prepared menu for 3 of 4 meals. On 11/16/2022 pimento cheese sandwich served instead of the grilled cheese per menu and on 11/17/2022 tater tots During an interview with resident #26 on 11/16/2022 the resident stated the meal is often different from the posted menu and we never know what we are going to get. Observation of handwritten menus posted at nursing station on 11/16/2022 and 11/17/2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 12/16/2022, the Dietary Service Director and Nutrition Service Coordinator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 61 substituted with the pimento cheese sandwiches. She stated the flat griddle had been broken for a while and she told the previous Administrator about 2 months ago, but she had not informed the current Administrator. The DM stated she posted the revised menu on the morning of 11/16/22 at the nursing stations and felt that was enough notice to the residents about the revised menu. 2. The menu provided titled Fall/Winter 2022-2023 Week 3 revealed the lunch on 11/17/22 was turkey melt, tater tots, zucchini and tomatoes and sugar cookie. A review of a handwritten menu on 11/17/22 at 9:30 AM posted at the nurses' station on 11/17/22 revealed there were no tater tots written on the menu. Observation of the food service line starting at 11:30 AM on 11/17/22 revealed temperatures were taken on the turkey melt, zucchini and tomatoes and the alternate meal, but there were no tater tots on the food line. During the food service observation, the Cook prepared 10 trays with no tater tots and the Dietary Aide put the trays on the dietary cart for delivery. During this observation on 11/17/22, an interview was conducted with the Cook. The Cook was asked if she was going to be serving a starch and she reported she forgot to make the tater tots. The Cook continued to place food on the trays and did not ask for tater tots to be cooked. An interview with the DM on 11/17/22 at 11:40 AM was conducted. The DM was asked if tater tots were going to be served. The DM looked at the	F 803	completed menu review. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: " Menu Policy " Procedures for menu changes " Menu substitution Procedures Dietary Manager will attend resident council as invited and follow up with any food complaints as identified in regards to menu. Dietary Manager will review menus to assess for menu changes and alert Dietitian if permit changes needed to be reviewed. Menus posted daily at nursing stations, main dining area, and at the time clock daily. Menu changes are legible and posted in a timely manner to inform residents of menus. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director or designee will monitor daily x 2 weeks and then weekly one month using the Menu QA Audit. Monitoring will include reviewing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 62 fall/winter menu and saw that tater tots were supposed to be served. The DM stated she did not know how the tater tots were missed to be served. The DM went to the freezer and brought out hash brown patties and stated we don't have tater tots and began cooking the hashbrowns. The first tray of hash brown patties were cooked by 11:55 AM and brought to the food line. The DM stated we could substitute the tater tots with the hash brown potatoes because they were comparable. The temperature was taken on the hash brown patties and the Dietary Aide removed the 10 trays from the dietary cart. The Cook placed a hash brown patty on the trays. 3. The menu provided titled Fall/Winter 2022-2023 Week 3 revealed the lunch on 11/18/22 was butter crumb tilapia, tartar sauce, macaroni and cheese, cucumber and onion slices salad, hush puppies and yellow cake with chocolate frosting. A review of a handwritten menu on 11/18/22 at 9:00 AM posted at the nurses' station on 11/18/22 revealed there were peas and carrots being served instead of cucumber and onion slices salad and dessert (no named dessert). Observation of the food service line starting at 11:30 AM on 11/18/22 revealed steamed peas and carrots were being served instead of cucumber and onion slices salad and a packaged cookie was served instead of yellow cake with chocolate frosting. During this observation on 11/18/22, the Cook reported, "We did not have any cucumbers, so we are serving peas and carrots." The Cook also stated she was supposed to make a cake this	F 803	meals served vs planned menu. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 63	F 803		

morning and did not because we did not have any frosting, so we are serving a cookie.

An interview was conducted with the DM on 11/18/22 at 11:50 AM. The DM reported, "We were out of cucumbers, so we replaced the menu with peas and carrots." The DM also reported she did not know why the Cook did not make cake and was asked if she had frosting available. The DM stated, "We did not have canned frosting, but the Cook could have used other ingredients we had on hand to make a frosting and should have made the cake." The DM stated she did not always look at the food service line to be sure what was on the menu was being served because she was busy doing other tasks.

A follow up interview was conducted with the DM on 11/18/22 at 2:30 PM. The DM reported sometimes she had to substitute food with a similar food because the food distributer may not have what we need. She stated she was made aware of the fall/winter menu a few weeks before we would begin to use it and she ordered what she would need based on the menu. The DM could not say why she did not have tater tots, cucumbers, or frosting. She stated it had to do with the supply and demand of the food service company.

An interview with the Administrator on 11/21/22 at 4:40 PM revealed she expected the Dietary Manager to follow the planned menu and to place her food order accordingly. The Administrator further stated that her expectation was that the menu was correct and that the residents were informed timely of changes or substitutions to the menu and that being notified hours before the meal was being served was not sufficient amount

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 64 of time to inform the residents. The Administrator added that food was a major component of enjoyment to the residents, and she would be looking into all of these concerns.	F 803		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews the facility failed to honor food preferences for 2 of 29 residents (Resident #24, and #7) reviewed for meal preferences. Findings included. 1.) Resident #24 was admitted to the facility on 12/22/21 with diagnoses to include hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side. A physician order dated 12/29/21 revealed Resident #24 was to receive a low concentrated sweets (LCS) diet, with soft and bite sized texture foods with thin consistency for nutritional needs.	F 806	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F806 1. Corrective action Based on meal observations and interviews between 11/15/2022 and 11/16/2022 the facility failed to obtain food preferences and provide preferred food selections for 2 or 29 residents. Resident	1/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 65 A care plan dated 09/19/22 revealed Resident #24 had a nutritional problem or potential nutritional problem related to receiving a therapeutic and mechanically altered diet and had the potential for fluctuation in weight. The goal of care included to maintain adequate nutritional status as evidenced by maintaining weight within 4 % of baseline with no signs or symptoms of malnutrition and consuming at least 50% of at least three meals daily. Interventions included in part to provide and serve diet as ordered. The Minimum Data Set (MDS) quarterly assessment dated 10/28/22 revealed Resident #24 had mildly impaired cognition. She had no rejection of care and required extensive assistance with activities of daily living. She had impaired range of motion on one side and received a therapeutic diet. A meal observation conducted on 11/16/22 at 6:00 PM revealed Resident #24 sitting up in her wheelchair feeding herself. She was alert and oriented to person, place, and time. She had eaten all of her food on the dinner plate except for a serving of broccoli. When asked by the surveyor why she didn't eat her broccoli when she ate everything else, she stated I don't like broccoli. Resident #24 stated she had received broccoli on her meal tray before even though she didn't like it. Upon review of her meal ticket on the dinner tray it revealed her dislikes were: Broccoli. A phone interview was conducted on 11/21/22 at 4:29 PM with the Dietary Manager. She stated she had new staff in the kitchen who weren't paying attention to the dislikes on the resident's meal slip. She stated she would have to educate	F 806	#24 observed not consuming broccoli at mealtime, resident stated she disliked broccoli and even though broccoli was indicated as a dislike on her tray ticket she had been served it before. Dietitian visited resident #24 on 12/16/22, food preferences obtained and diet liberalized as patient states LCS diet too limited. Resident #7 observed not consuming certain items on her tray stating she was unable to consume certain item based on gastric bypass surgery. Resident #7 states she often receives food items she cannot consumes and relies on family to be in food items. Dietitian visited resident #24 on 12/16/22, food preferences obtained and traycard updated; resident #7 on menu selection program. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. All dietary staff in-serviced 12/12/2022 regarding accuracy of meals served and diet consistency policies. All dietary staff are to have competencies evaluated. All current entries in Traycard will be reviewed for accuracy and modified as needed by 12/16/2022. Menu selection program modified to ensure all residents cognitively appropriate receive menu selections and are assisted as needed with program. All residents will be interviewed to update food preferences by date of compliance of 1/5/2023. 3. Systemic changes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 66 staff on reading the meal cards accurately and stated she would start getting on the food serving line with dietary staff to make sure they were reading the meal cards accurately. She stated after admission and then again periodically she would go over likes and dislikes with residents to determine food preferences. She stated if a resident's food preferences changed in between that time and the resident informed the nurse aide the nurse aide would in turn notify the kitchen to update the resident's food preferences. She stated about a month ago all residents were interviewed to update food preferences on their diet cards. She stated when plating food for meals the dietary aides on the opposite side of the serving line read the dislikes to the person plating the food, she stated it was missed on this incident and stated Resident #24 should not have been served broccoli when it was clearly on the meal ticket that Resident #24 did not like broccoli. During a phone interview conducted on 11/21/22 at 6:30 PM the Director of Nursing (DON) indicated she expected resident food preferences to be honored and stated Resident #24 should not have been served foods from her dislike list. 2.) Resident #7 was admitted to the facility on 12/2/15 with diagnoses which included in part chronic obstructive pulmonary disease, diabetes, and history of bariatric surgery. Review of Resident #7's 10/12/22 quarterly minimum data set (MDS) assessment revealed resident was cognitively intact, was independent with eating and received a therapeutic diet. Resident #7's 10/18/22 care plan contained a nutritional problem or potential nutritional problem	F 806	In-service education was provided to all full time, part time, and as needed staff by the Dietary Services Director. Topics included: ¿ Tray Accuracy Education ¿ Diet Consistency and Accuracy Policies ¿ Meal Selection Program Process This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Traycard to be reviewed and modified on admissions, quarterly, and as needed by Dietary Service Director. Menus to be reviewed daily and modified per diet preferences as needed by Dietary Service Director. 4. Quality Assurance monitoring procedure. The Dietary Services Director will monitor accuracy of completed trays served to residents per Dietary Meal QA Audit weekly x4 and then monthly x 3. Traycard will be audited monthly and test trays completed monthly per policy by the Dietary Service Director. The consultant dietitian will complete quarterly diet orders. Reports will be presented to the weekly Quality Assurance committee by the Dietary Service Director and/or Dietitian. Compliance will be monitored by the Ambassador Program daily and reviewed at the weekly Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 67 related to therapeutic diet and potential for fluctuations in weight. Interventions included to provide and serve the diet as ordered. Interview with Resident #7 on 11/15/22 at 10:49 AM revealed she frequently received foods she was not able to eat. Resident #7 stated she had gastric bypass surgery and she had things she couldn't eat. Resident #7 stated her family members brought in food for her frequently. Interview on 11/16/22 12:50 PM with Resident #7 revealed lunch was not something she was able to eat. Resident #7 was served a cheese sandwich and soup. Resident #7 stated they (the dietary department) knows I can't eat cheese. Then they brought me a crab cake, broccoli, and lima beans. Resident #7 stated she doesn't eat fish. Resident #7 stated she ate what she could of the vegetables and ate some snacks her family members brought in. Review of Resident #7's meal ticket revealed: Regular LCS (low concentrated sweets) diet. Allergies: grapefruit, oranges. Dislikes: cheese, fish, oranges. Interview on 11/18/22 at 12:30 PM with NA #4 revealed residents were asked before each meal which option they wanted and this information was brought to the kitchen. NA #4 stated that sometimes the residents did not receive the meal they wanted or received items they disliked. NA #4 further revealed that if a resident received something they did not like, they went to the kitchen and requested an alternate meal. A meal observation conducted on 11/18/22 at 1:10 PM revealed Resident #7 in bed with head of	F 806	Meeting. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Services Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 68 bed elevated feeding herself a hamburger. Observation of the meal tray revealed the hamburger, a cookie and the beverages were the only items on the meal tray. Review of the menu for lunch indicated macaroni and cheese and peas and carrots were to be served with the hamburger. Resident #7 did not know why she received only a hamburger for lunch with no side items. A phone interview conducted on 11/21/22 at 4:29 PM with the dietary manager revealed she had new staff in the kitchen who were not paying attention to the dislikes on the resident meal tickets. The dietary manager stated she needed to educate the staff about reading the meal tickets. She stated that after admission and periodically afterwards she went over likes and dislikes with residents to determine food preferences. During a phone interview on 11/21/22 at 6:30 PM the Director of Nursing stated she expected food preferences to be honored and residents be served meals according to their preferences.	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		1/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 69 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard leftover food stored ready for use past the use dates and failed to label, date, and seal a leftover food item stored in 1 of 1 walk-in refrigerator. These practices had the potential to affect food served to residents. Findings included: During the initial kitchen tour of the walk-in refrigerator on 11/15/22 at 10:05 AM the following concerns were observed: - a container labeled vanilla pudding with an opened date of 11/04/22 and a use by date by 11/08/22 - a container labeled franks and beans with an opened date of 11/07/22 and use by date by 11/13/22, and - a container labeled apple sauce had no opened date, and a use by date of 11/13/22 - a package of exposed ham which was unwrapped, and the expiration date was illegible. An interview with the Dietary Manager (DM) on 11/15/22 at 10:05 AM revealed she and any dietary staff who opened and stored the food items were responsible for checking the products	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services, a corrective action was obtained on 11/15/2022. During initial walk through of the kitchen, it was noted dietary services had failed to properly date, label, and discard several items out of date in the walk-in fridge: vanilla pudding with open date of 11/4/2022 and use by date of 11/08/2022, container of franks & beans with open date of 11/7/2022 and use by date 11/13/2022, and apple sauce with no opened date and use by date of 11/13/2022. Dietary also failed to properly seal a package of ham with illegible date.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 70 to be sure it was dated when opened and they were responsible for discarding any products by their use by date. She stated she overlooked these products and discarded them at this time. The DM also revealed she and any dietary staff who opened food packages were responsible for checking the products to be sure it was dated when opened and all the items were to be sealed to prevent the items from spoilage. She stated she overlooked seeing the package unsealed with no open date and discarded the item. An interview with the Administrator on 11/18/22 at 4:40 PM revealed she expected the dietary staff to ensure all the items in the kitchen were dated when opened and discarded by the use date and that all items were sealed to prevent spoilage.	F 812	On 11/15/2022 the Dietary Service Director discarded non-labeled/dated and outdated items from walk-in refrigerator. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 12/16/2022 the Dietary Service Director, QA Dietary Manager, and Nutrition Service Coordinator completed a kitchen walk through to ensure all food items were within their dates and dated properly. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: " Storage and dating policies and regulations. " Use By Dates " Inspections on shifts to observe all food are within their dates and tossed if out of date. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Dietary Service Director will complete	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 71	F 812	weekly kitchen inspection audits and the Administrator will complete at least monthly. 4. Quality Assurance monitoring procedure. The Dietary Service Director, Dietitian, or designee will monitor procedures for proper food storage weekly x 3 weeks then monthly x 3 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that all food is labeled, dated, and within proper dates. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility's Quality Assurance and	F 867	The statements made on this plan of correction are not an admission to and do	1/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 72 Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey on 07/30/21 and the recertification survey on 01/09/20. This was for two deficiencies that were originally cited in July 2021 in the areas of infection control and competent nursing staff and for one deficiency originally cited in January 2020 for food procurement, storage, and sanitation and were subsequently recited on the current recertification survey of 11/21/22. The continued failure during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included. This tag is cross referenced to: F880: Based on observations, record review, and staff interviews the facility failed to 1) demonstrate how to clean and disinfect a glucometer device per manufacturers instructions after use for 2 of 2 nurses (Nurse#4 and Nurse#5) observed during medication pass. The facility also failed to perform hand hygiene prior to donning and after removal of gloves when performing a blood glucose check for 1 of 1 nurses (Nurse#4) observed. 2) failed to perform hand hygiene after removing soiled gloves and prior to donning clean gloves during a wound care observation for 1 of 3 residents (Resident #34) reviewed for infection control practices. 3) During the recertification survey and the complaint investigation completed on 07/30/21 the facility failed to implement the Centers for	F 867	not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #34: On 11/17/2022 The Director of Nursing educated the Wound Treatment Nurse on IC practice related to changing gloves between clean and dirty application of dressing and performing hand hygiene before donning, when changing gloves and upon removal of gloves during wound care. For resident #9: On 11/18/2022 the Nurse Consultant educated NA#1 on proper catheter care. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the deficient practice. Beginning on 12/7/2022 the Health Department provided an on-site all staff in-service on hand hygiene and this was completed on the same date. Beginning on 12/_20_/2022, the Director of Nursing provided an in-service for all direct care staff on catheter care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 73 Medicare and Medicaid Services (CMS) guidelines and the facility's COVID-19 program Infection Control Policy to ensure staff were screened upon entering the facility when a staff member was observed entering through a back door upon arriving for her shift and failed to be screened by a trained staff member before entering the resident care area (Nurse Aide#11), and two staff members were observed entering through the back door without screening and walked through the facility to the front entrance to be screened prior to starting their shift (Nurse Aide #4, #5). The facility failed to ensure staff were screened by a nurse or trained staff member prior to entering the facility when a staff member was observed screening herself upon entering the facility through a back door for 4 of 4 staff members observed. These failures occurred during the COVID-19 pandemic. F726: Based on observation, record review, resident and staff interviews the facility failed to provide an agency Nurse Aide (#1) with education and to verify their competency to deliver catheter care for 1 of 3 residents (Resident #9) observed for catheter care. During the recertification survey and the complaint investigation completed on 07/30/21 the facility failed to demonstrate a working knowledge of the IV (intravenous) pump equipment to enable antibiotic IV medications to be administered for 1 of 1 resident reviewed for IV medication administration (Resident #160). F812: Based on observations and staff interviews the facility failed to discard left over food stored ready for use past the use dates and failed to label, date, and seal a leftover food item stored in	F 867	3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 12/16/2022, the Nurse Consultant provided an in-service education to the Administrator and Director of Nursing Service. Topics included: " Preventing repeat survey tags " Quality assurance monitoring for tags F880, F726 and F812 This information has been integrated into the standard orientation training and in the required in-service refresher courses for administrator and Director of Nursing as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who do not receive scheduled in-service training will not be allowed to work until training has been completed effective 1/5/2023 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor completion of ongoing audits for F880, F726 and F812 for 6 months. Any negative findings will immediately be addressed and reviewed with the facility Clinical Nurse Consultant for interventions or additional training. Reports will be presented to the weekly Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 74 1 of 1 walk-in refrigerators. These practices had the potential to affect food served to residents. During the recertification survey on 01/09/20 the facility failed to maintain a sanitary ice machine free from brown debris on the interior of the machine. A phone interview was conducted on 11/21/22 at 6:30 PM with the Administrator along with the Director of Nursing (DON). The Administrator stated the process put in place regarding the screening of staff members during the COVID-19 pandemic was successful. She indicated the QAPI meeting was held monthly, and QA activities and outcomes were on the agenda of every staff meeting. She indicated they prioritized opportunities for improvement and ongoing education and improvements would continue regarding infection control, competency training of staff, and food storage and sanitation.	F 867	Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the Quality Assurance Meeting. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		1/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 75 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 76 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to: 1a) demonstrate how to clean and disinfect a glucometer device per manufacturer's instructions after use for 2 of 2 nurses (Nurse #4 and Nurse #5) observed during medication pass; 1b) perform hand hygiene prior to donning and after removal of gloves when performing a blood glucose check for 1 of 1 nurse (Nurse #4) observed; 2) perform hand hygiene after removing soiled gloves and prior to donning clean gloves during a wound care observation for 1 of 3 residents (Resident #34) reviewed for infection control practices; and 3) dispose soiled linens in a bag during catheter care for 1 of 3 residents (Resident #9) observed for catheters. Findings included: The facility's policy for glucometers updated January 2011 revealed, in part, "anytime the glucometer is visibly soiled and as needed, it will be cleaned and disinfected per Manufacturer's guidelines." The Manufacturer's Guidelines for the	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 880 The facility failed to demonstrate how to clean and disinfect a glucometer device per manufacturer instructions, perform hand hygiene prior to donning and after removal of gloves, when performing a blood glucose check, to remove soiled gloves prior to donning clean gloves for wound care and to dispose of soiled linens appropriately. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 77 antimicrobial wipes revealed "the meter should be cleaned prior to disinfection." The cleaning process included: step 1: wear appropriate protective gear such as disposable gloves, step 2: remove one towelette, step 3: wipe the entire surface of the meter 3 times horizontally and 3 times vertically using 1 towelette to clean blood and other bodily fluids, step 4: discard towelette. The disinfecting process included: step 5: remove one towelette, step 6: wipe the entire surface of the meter 3 times horizontally and 3 times vertically to remove blood borne pathogens and allow exterior to remain wet for the appropriate contact time and then wipe the meter using a dry cloth, step 7: dispose of the used towelette in a trash bin, step 8: allow exteriors to remain wet for the appropriate contact time and then wipe the meter using a dry cloth, step 9: after disinfection, the user's gloves should be removed and thrown away. Wash hands before proceeding to the next patient." 1a. An observation of Nurse #4 was conducted on 11/16/22 at 4:17 PM as she obtained a blood sugar on Resident #69 using the resident's personal glucometer. Nurse #4 was observed as she donned gloves and removed a plastic box labeled with Resident #69's name from the bottom drawer of the medication cart. Nurse # 4 entered Resident #69's room carrying the plastic box which contained a glucometer, an alcohol prep pad, a lancet and a test strip. Nurse #4 obtained Resident #69's blood sugar. The glucometer read error. Nurse #4 with gloved hands went back to the medication cart, retrieved another lancet from a box, returned to the room, and obtained the blood sugar from Resident #69. After the blood sugar was successfully completed, Nurse #4 gathered the supplies,	F 880	On 11/ 18 /2022 the Nurse Consultant educated Na#1 on proper disposal of soiled linen/wipes and the soiled linen/wipes were appropriately disposed of by NA #1. On 11/ 16 /2022 the Nurse Consultant educated Nurse #4 and # 5 on hand hygiene/gloving practice when using the glucometer. Education was provided on when/how to perform the manufacturer instructions on cleansing/disinfection of personal glucometers. Education was provided on use of the approved bleach product for cleansing/disinfecting the glucometers. On 11/ 16 /2022 the glucometer was appropriately cleansed/disinfected by Nurse #4 and #5 with observation by the nurse consultant and each nurse was able to state when the glucometers were to be cleansed/disinfected and what bleach product was to be utilized for this process and both nurses demonstrated appropriate gloving and hand hygiene practices when performing this procedure. On 11/ 16 /2022 the nurse consultant educated Nurse #4 and #5 on hand hygiene practices to include washing of hands prior to and after removal of gloves, during medication pass or when obtaining blood sugars. The nurse consultant observed Nurse #4 and #5 then comply with appropriate hand hygiene and gloving practices. On 11/ 17 /2022 the Director of Nursing educated the Wound Treatment Nurse on IC practice related to changing of gloves between clean and dirty application of dressings and performing hand hygiene	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 78 exited the room, and returned to the medication cart. Nurse #4 removed a bottle of blood glucose test strips from the box and placed it in the top drawer of the medication cart. Nurse #4 disposed of the used lancets, removed her gloves, signed into the laptop computer, and recorded the blood sugar reading. A continuous observation was made as Nurse #4 failed to wash her hands or use hand sanitizer before moving on to the next resident during medication administration pass observation. The personal glucometer was not cleaned or disinfected prior to or following use. An interview was conducted with Nurse #4 at 4:25 PM to discuss the cleaning and disinfectant procedure for the glucometer. Nurse #4 stated she wiped it all over with an alcohol prep pad as needed. Nurse # 4 took the glucometer out of the plastic box on the medication cart and quickly swiped an alcohol prep pad over the surface of the device. She then placed it back in the plastic box and put the box back on the medication cart. When asked when she typically washed or sanitized her hands during a medication pass Nurse #4 stated after removing gloves and between residents. Nurse #4 acknowledged she had not done so. 1b. The medication pass observation continued with Nurse #5 as she was observed exiting a resident room after completing a blood sugar check. An interview conducted with Nurse #5 on 11/16/22 at 4:25 PM revealed she typically cleaned the personal glucometer with an antimicrobial wipe. Nurse #5 had just completed a blood sugar check. Nurse #5 removed a towelette from a cannister of antimicrobial wipes, wiped it once across the surface, placed the glucometer back in a plastic bag, and put it in the	F 880	before donning, when changing gloves and upon removal of gloves during wound care. The wound treatment nurse was then observed by the Director of Nursing on 11/ 17 /2022 with no further concerns identified. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents are at risk to be affected by a failure to follow appropriate hand hygiene/gloving practices when providing medications, when performing procedures such as wound care or blood sugar monitoring. All residents are at risk when disposing of soiled linens/contaminated items or cleansing/disinfecting of glucometers per manufacturer instructions are not followed. The Director of Nurses/ Infection Preventionist began audits on random shifts and days times 3 days for compliance with hand hygiene/gloving practices during med pass/wound care/blood sugar monitoring/ cleaning/disinfecting glucometers/use of approved bleach product for glucometer cleansing /disinfecting and disposing of soiled linens/contaminated items such as wipes. This will be completed by 12/22/2022. 2. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: Root Cause Analysis was completed on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 79 drawer of the medication cart. An interview was conducted with the Director of Nursing (DON) on 11/21/22 at 9:05 AM via phone. The DON stated she expected the nursing staff to clean the personal glucometers with the antimicrobial wipes only and to follow the manufacturer's guide lines on how to clean them appropriately. The DON stated that antimicrobial wipes were provided and available for the staff to use. The DON further stated she expected the nursing staff to complete hand hygiene prior to donning and following removal of gloves. 2. A wound care observation was conducted on 11/17/22 at 10:30 AM with the Wound Treatment Nurse The nurse washed her hands and donned gloves when she entered the residents room. The soiled dressing was removed from the left hip wound. The dressing had a moderate amount of serosanguineous (containing blood and serum) drainage. She removed her soiled gloves and did not wash her hands before donning clean gloves and applying the clean dressing. The nurse cleaned the wound with wound cleanser, applied the treatment and covered with an oil emulsion dressing. She removed her gloves but did not wash her hands before donning clean gloves and removing the soiled dressing from wound site #2 a Stage IV coccyx wound, the dressing had a moderate amount of serosanguineous drainage, she removed the soiled dressing changed her gloves but did not wash her hands before donning clean gloves, packing the wound with gauze, and applying the clean protective dressing to the wound. After completion of the dressing change to the Stage IV coccyx wound, she removed her gloves and washed her hands.	F 880	12/ 20 /2022 with the following staff in attendance: Administrator, Director of Nurses /Infection Control Preventionist, Dietary Manager, House Keeping Manager, Support Nurse and the Nurse Consultant. Root cause analysis was done related to staff members failing to appropriately clean and disinfect a glucometer device per manufacturer instructions utilizing the approved bleach product, perform hand hygiene prior to donning and after removal of gloves as well as when performing a blood glucose check, to remove soiled gloves prior to donning clean gloves for wound care and to dispose of soiled linens /contaminated items appropriately. Upon interview of the staff/agency it was determined that the root cause for failure to follow facility is Lack of knowledge. On 12/ 16 /2022 the Director of Nurses/ICP initiated education for all registered nurses, licensed practical nurses, certified nursing assistants, medication aides and agency on IC practices related to hand hygiene practices, gloving practices, appropriate handling of soiled linens and contaminated items and hand hygiene gloving practices during wound care. All nurses including agency nurses on when and how to clean and disinfect of glucometers and use of the approved bleach product for cleaning/disinfecting glucometers. The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 1/ 05 /2023 will not be allowed to work until	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 80 An interview was conducted with the Wound Treatment Nurse on 11/17/22 at 10:50 AM. She acknowledged that she did not wash her hands after removing the soiled gloves and donning clean gloves during the observation. She stated she thought she did everything right but with the State surveyor and the Federal surveyor in the room with her it made her nervous. She stated she always washed her hands after removing soiled gloves and prior to donning clean gloves and when moving between wound sites when performing wound care. An interview was conducted with the Director of Nursing who was also the Infection Control Preventionist on 11/18/22 at 2:30 PM. She indicated the facility policy required staff to wash hands after removing gloves. She stated the wound nurse should have washed her hands after removing soiled gloves and prior to donning clean gloves during wound care. 3. An observation of Nurse Aide (NA) #1 on 11/18/22 at 9:45 AM during catheter care was conducted. NA #1 washed her hands, applied gloves, and filled a basin with warm water and soap. She obtained wash clothes, personal wipes, and towels. NA #1 proceeded with Resident #9's catheter care. She was noted to use a single facility provided personal moistened cleansing wipe used for catheter care. NA #1 discarded the soiled wipe on the floor. At this time, Resident #9 stated he had a bowel movement. NA #1 cleansed his buttocks with a wash cloth and discarded the soiled wash cloth on the floor. NA #1 repositioned Resident #9 on his back and cleansed the perineal area with a washcloth, rinsed and dried the area with a towel and threw the used towel and washcloth on the	F 880	the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The Director of Nurses/ Infection Control Preventionist/ implemented IC rounds to include monitoring of hand hygiene/gloving practices during med pass and when obtaining blood sugars or using glucometers, observation of hand hygiene/gloving during wound care, appropriate handling of soiled linens and contaminated items as well as appropriate cleansing/disinfection of glucometers. The training will be validated by the Director of Nurses/Infection Control Preventionist with observation audits in resident care areas and resident rooms for compliance with facility policy on the utilization of the above identified IC areas. . 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses/Infection Control Preventionist/designee will observe and monitor at least 5 staff/agency on various shifts to include weekends for staff adherence to infection control compliance with the appropriate hand hygiene and gloving practices, when and how and with what product to disinfect glucometers, handling of soiled linens/contaminated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 81 floor. She then used 3 separate wash cloths to finish the catheter care and discarded the wash cloths on the floor. NA #1 used a towel to dry the area and discarded the towel on the floor. NA #1 removed her gloves, washed her hands, and exited the room stating she was getting a bag. Upon return she reapplied gloves and picked the soiled linens off the floor and placed them in a bag. An interview was conducted with NA #1 on 11/18/22 at 10:15 AM. She stated she was an agency nurse aide and had been working at the facility for a month. NA #1 acknowledged she discarded the soiled linens on the floor and stated she usually brought in trash bags to put the dirty linens in, but she forgot to bring them in the room with her prior to starting her care. An interview was conducted with the Director of Nursing (DON) on 11/18/22 at 3:40 PM. The DON reported she expected her nursing staff to put all soiled linens in a bag, secure the bag and place the bag in the dirty linen bin when finished. The DON added, disposing of soiled linens on the floor was an infection control concern.	F 880	items. Immediate resolution or coaching will be done when required. Monitoring to be done weekly x 2 weeks and monthly x 3 or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing/Infection Control Preventionist, Minimum Data Set Coordinator, Therapy, Health Information Manager and Dietary Manager. A Directed Plan of Correction was completed on 12/22/2022 and alleged compliance will be in place by 1/05/2023. Attestation Statement I attest that I have completed a course in Infection Control. I am an Infection Preventionist having completed a course on Infection Control from NC SPICE. I have provided education on adhering to the hand hygiene and gloving practices, how and when to cleanse/disinfect glucometers, approved bleach product to cleanse /disinfect glucometers with, handling of soiled linens/contaminated items as described in the Plan of Care for F tag 880 between the dates of 12/16/2022 □ 1/05/2023. Topics included: " Hand hygiene and gloving practices during med pass, wound care, when	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 82	F 880	performing. procedures such as obtaining blood sugars or use of glucometers. " Following manufacturers guidelines on when and how to clean/disinfection glucometers. " Use of facility approved bleach product for cleaning/disinfecting glucometers. " Appropriate disposal of soiled linen or contaminated items. Education sessions were completed by each staff member utilizing the above education. Inservice dates and times include: 12/20/2022 X 9:00 am □ 12:00pm 12/22/2022 X 9:00 am □ 12:00pm 12/27/2022 X 9:00 am □ 12:00pm 12/29/2022 X 9:00 am □ 12:00pm As of 1/05/2023, any employee who has not received this education will not be allowed to work until the training has been completed. This includes all staff full time, part time, agency staff, and PRN staff. The in-service will be incorporated into the new employee facility orientation. Printed Name: Emily Weaver Credentials: RN Date: 12/16/2022	
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced	F 908		1/5/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 83 by: Based on observations, record review and staff interviews, the facility failed to make repairs to the flat griddle for greater than 2 months which caused residents to not receive a planned meal since it was inoperable for 1 of 1 flat griddles. This affected all residents who expected grilled items according to the planned menu. Findings included: The menu provided titled Fall/Winter 2022-2023 Week 3 revealed the lunch on 11/16/22 was homemade vegetable soup, saltine crackers, grilled cheese sandwich, vegetable sticks, and chilled peaches. Review of a handwritten lunch menu posted at the nurses' station on 11/16/22 at 9:30 AM revealed a pimento cheese sandwich instead of grilled cheese sandwich. Observation of the lunch meal on 11/16/22 at 12:30 PM revealed a cold sandwich with pimento cheese was served instead of a grilled cheese sandwich. An interview was conducted with the Dietary Manager (DM) on 11/17/22 at 11:15 AM. The DM reported she served pimento cheese sandwiches on 11/16 because her flat griddle did not work. She stated she was not able to cook grilled cheese sandwiches for the whole facility, so she substituted with the pimento cheese sandwiches. She stated the flat griddle had been broken for a while and she told the previous Administrator about 2 months ago, but she had not informed the current Administrator who had been at the facility for about a month.	F 908	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F908 1. The item that failed to be repaired was the griddle in the kitchen. Griddle replacement was ordered on 12/16/22 with installation date set for 1/6/23. 2. An initial audit for kitchen equipment was obtained on Friday, December 16, 2022. Administrator reviewed kitchen equipment with Dietary Manager to ensure equipment was in proper working condition. The audit was completed for all kitchen equipment. Convection oven was noted to heat unevenly at times however remains in safe working condition. Will follow up as needed. 3. Systemic changes In-service education was provided to dietary staff. Topics included:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC	630 FODALE AVENUE SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 84 An interview with the Administrator on 11/21/22 at 4:40 PM revealed that she was not made aware that the flat griddle was broken, and she would make sure to get it addressed. The Administrator added, she would have expected the Dietary Manager to inform her of any equipment that was not operable so that the menu could be served as planned.	F 908	• All broken equipment should be reported to Maintenance Director in a timely manner. • In the event the Maintenance Director is unable to repair an item, this should then be reported to the Administrator. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Maintenance Director or designee will monitor procedures for reporting non-working kitchen equipment weekly for two weeks then monthly for three months using the non-working equipment Quality Assurance monitor. Monitoring will include auditing kitchen equipment to ensure in safe operating condition. Reports will be presented to the Quality Assurance committee by the Administrator or designee to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing. The Quality Assurance (QA) Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, Maintenance Director and the Dietary Manager. Date of Compliance: 1/5/23	