STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nursing & Rehabilitation Center of Johnston County	**2315 Highway 242 North , Benson, North Carolina, 27504**

(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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/17/2025 through 11/20/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1DB4D1-H1.	E0000		12/19/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/17/2025 through 11/20/2025. Event #1DB4D1-H1. The following intakes were investigated: 871915, 871918, 2659163, 2570564 and 2672558. 13 of the 13 allegations did not result in deficiency.	F0000		12/19/2025
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response.	F0565	Corrective action for resident(s) affected by the alleged deficient practice: An additional resident council meeting was held on 12/03/2025. Minutes were taken by the DON. Council concerns/or grievances were addressed by the Administrator along with the appropriate department manager on 12/16 /2025 and resolution was communicated back to Resident Council on 12/16/2025. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning with the 12/16/2025 resident council meeting, Resident Council concerns/or grievances will be reviewed by the Administrator and applicable department manager for timely resolution and follow-up utilizing the Resident Council Communication tool. Resident with a BIMS of 13-15 and did not attend the council meeting will be interviewed for any noted concerns. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/05/2025, the Administrator educated the facility	12/19/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0565 SS = E	Continued from page 1 (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interviews with residents and staff, the facility failed to resolve repeat concerns and/or to communicate the facility's efforts to address concerns voiced during organized resident group meetings (Resident Council and Dietary Council) related to call-light response times, housekeeping services, and dietary services during 6 of 6 monthly meetings (May 2025, June 2025, July 2025, August 2025, September 2025, and October 2025). The findings included: Resident Council Meeting Minutes dated 5/28/2025 included concerns related to housekeeping services, ice, water, snacks, call light strings needing to be fixed, and a resident being told that there was no gauze in the facility. The minutes indicated that Dietary had been marked off the agenda and no dietary concerns were included in the Resident Council minutes. The Resident Council Communication Form attached to the 5/28/2025 meeting minutes indicated the concerns about strings on call lights and a lack of gauze in the building were the only issues addressed. There was no documentation showing that dietary concern or housekeeping concerns were addressed or resolved. Resident Council Meeting Minutes dated 6/30/2025 identified concerns related to call-light response times and room cleaning. The Resident Council Communication Form attached to the 6/30/2025 meeting minutes indicated that Administrator spoke with staff and encouraged them to answer call lights promptly and administrator stated several new housekeeping staff had been hired and were orienting.	F0565	Continued from page 1 department heads on the following: F565 requirements The Administrator educated department managers on the utilization of the Resident Council Communication tool and requirement for timely follow-up for all Resident Council concerns on 12/16 /2025. Going forward, Administrator or Director of Nurses will continue to assign responsibility for resolving concerns/or grievances from the Resident Council the morning after the meetings occur. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all department managers and will be reviewed by the Quality Assurance Committee to verify that the change has been sustained. Any managers who do not receive the scheduled in-service training on 12/19/2025 will not be allowed to work until training has been completed. The newly hired Activity Director will also receive 1:1 education upon orientation. The new Activity Director's start date is 1/5/26. 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 will monitor compliance utilizing the F0565 Quality Assurance Tool monthly x 3 months or until resolved. The tool will monitor that Resident Council concerns/or grievances are addressed and that follow-up is documented and provided to the Resident Council by the next scheduled council meeting. Reports will be presented to the monthly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Date of Compliance: 12.19.2025	

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F0565 SS = E	Continued from page 2 Resident Council Meeting Minutes dated 7/31/2025 showed repeat concerns related to call-light response times and room cleaning noted in June. The Resident Council Communication Form attached to the 7/31/2025 revealed there was no documented evidence of facility response or resolution to the repeat concerns related to call-light response times and room cleaning. Resident Council Meeting Minutes dated 8/27/2025 showed repeat concerns related to call-light response times and room cleaning. The Resident Council Communication Form attached to the 8/27/2025 meeting minutes indicated staff received routine customer service education, management would continue to monitor call lights and the Environmental Services Supervisor was to meet with housekeeping staff. Resident Council Meeting Minutes dated 9/30/2025 again included repeat concerns regarding call-light response times and room cleaning. The Resident Council Communication Form attached to the 9/30/2025 meeting minutes indicated call lights response time being monitored by camera. Resident Council Meeting Minutes dated 10/30/2025 documented resident concerns regarding menu choices, call bell response times and rooms cleaning. The Resident Council Communication Form attached to the 10/30/2025 meeting minutes stated to continue to monitor call lights via camera and a housekeeping meeting was to be held by the Environmental Services Supervisor. On 11/18/2025 at 2:30 PM interviews with Resident #18, Resident #5, Resident #37, Resident #49, Resident #61, Resident #91 and Resident #6 revealed that dietary issues, call light concerns and housekeeping concerns were ongoing and remained unresolved. Residents stated they had been expressing these same concerns for months with no resolution. Residents stated they were no longer able to voice food concerns during Resident Council because a separate Dietary Council had been created. Residents stated that they had many complaints about food and were told by the Activities Director to tell the Dietary Manager, but the residents did not feel as if he (the Dietary Manager) was approachable.	F0565		

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F0565 SS = E	Continued from page 3 The residents indicated that whenever they attempted to bring up food concerns to the Dietary Manager, he would shrug them off or dismiss their concerns. The residents could not recall the date of the last Dietary Council meeting or if the Dietary Manager attended. They stated whenever the Dietary Manager did attend, he sat quietly rolling his eyes to the point they would be hesitant to voice any concerns. The residents reported that the Dietary Manager did not attend any Resident Council meetings but if they brought up a food complaint they would be told by Activities Director to wait and discuss it at Dietary Council meeting. Residents reported they did not receive updates regarding any actions taken or resolutions for concerns voiced during the Resident Council or Dietary Council meetings. An interview conducted with the Activities Director on 11/18/2025 at 4:50 PM revealed she documented Resident Council minutes, took the concerns from the minutes to the Administrator, and the Administrator completed the Resident Council Communication Forms. The Activities Director stated she did not bring resolved or pending issues back to the next Resident Council meetings, she just verbally communicated the resolution to the resident that voiced the complaint. She verified that residents did voice repeat concerns about housekeeping and call light response times at the Resident Council meetings. The Activities Director stated she started Dietary Council meetings in May 2025 so that the Resident Council meetings were not taken over with dietary concerns. She indicated that Dietary Council meetings normally took place a few days before the Resident Council meetings, but she could not remember any dates of the Dietary Council meetings. The Activities Director explained that she did not keep formal minutes from Dietary Council meetings and could not locate the notes she kept in a notebook. The Activities Director further explained she did not submit grievances/concerns voiced during the meetings to the Administrator because the Dietary Manager attended the Dietary Council meetings. She reported she could not recall all of the concerns discussed at Dietary Council meetings, but she did recall concerns about food quality. She stated that she did not believe that residents were told that they could not bring up dietary concerns at Resident Council meetings. She added that the residents were encouraged to come to the Dietary Council meetings. The Activities Director stated that she marked “Dietary” off of the agenda at Resident Council meetings because those issues were already discussed at the Dietary Council meetings. An interview with the Dietary Manager on 11/18/2025 at 4:43 PM revealed he attended the Dietary Council	F0565		

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F0565 SS = E	Continued from page 4 meetings when he was able to do so. He stated that he could not recall the last Dietary Council meeting he attended but he was not receiving any complaints about the food. He reported the only food complaint he recalled receiving was about tuna casserole and he took it off the menu. The Dietary Manager stated that to his knowledge, no documentation or grievances were completed from the Dietary Council meetings. The Dietary Manager stated that he did not attend any Resident Council meetings. He indicated he was not receiving any grievances or complaints about food or dietary services from the Resident Council meetings. In an interview with the Administrator at 11/18/2025 at 4:00 PM she stated that a separate Dietary Council had been created in May 2025 because Resident Council meetings were “taken over with food complaints.” The Administrator stated that no meeting minutes were kept for Dietary Council meetings. The Administrator stated she expected the Activities Director to inform Resident Council members of resolutions for concerns discussed during Resident Council meetings. She revealed that she did not know how or if this occurred. The Administrator stated she addressed some concerns verbally with residents but did not document the follow-up. She reported that she felt she addressed all the issues from Resident Council meetings and she only did a grievance if she felt it was necessary. She indicated that it tended to be the same residents coming to the Resident Council meeting and some of them were difficult to appease. She stated that she felt the call light issue was an isolated issue rather than a facility issue as it was the same resident over and over voicing the concern. The Administrator acknowledged that she was aware that some of the residents found the Dietary Manager difficult to approach and stated that he (the Dietary Manager) could be passionate about his menu. The Administrator further stated that she would step in and handle any dietary issues that were not being addressed, but she was not aware that residents were not happy about the menu or the food being served. An additional interview was conducted with the Administrator on 11/19/2025 at 10:58 am. The Administrator stated residents could still bring food concerns to Resident Council, but she did not know what concerns were addressed in Dietary Council meetings. The Administrator was not aware that residents felt they could only bring food concerns up at the Dietary Council meetings.	F0565		
F0628 SS = B	Discharge Process	F0628	F628	12/19/2025

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F0628 SS = B	Continued from page 5 CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F0628	Continued from page 5 Corrective action for resident(s) affected by the alleged deficient practice: On 11/19 /25, the Social Service Director provided written documentation for the reason for discharge to the Ombudsman for resident #103. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 12/ 01 /25, the Administrator completed audit for the month of November 2025 to ensure written documentation for discharges was provided to the Ombudsman. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/ 10 /25, the Administrator provided education to the Social Service Director and case manager on written notification to be provided to the Ombudsman for residents who discharge. The Ombudsman prefers monthly notification via email and any discharges against medical advice (AMA) the Ombudsman will be notified at the time of discharge. 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 audit all Discharges and transfers for notification of the Ombudsman for compliance. The Administrator will be copied on all communication to the Ombudsman. This monitoring will be complete monthly times 3 months and on-going to ensure compliance. Reports will be presented to the monthly Quality Assurance committee by the Social Worker, Case Manager or designee to ensure sustainability of compliance. This validation will be noted by attaching a return receipt email from the Ombudsman to the communication. Additional interventions will be implemented as determined necessary by the committee. Date of Compliance: 12/19/2025	

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F0628 SS = B	Continued from page 6 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care	F0628		

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F0628 SS = B	Continued from page 7 Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F0628		

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F0628 SS = B	Continued from page 8 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff and Ombudsman interviews, the facility failed to send a copy of the notice of transfer to the Long-Term Care (LTC) Ombudsman for 1 of 2 residents transferred to the hospital (Resident #103). The findings included: Resident #103 was admitted on 8/18/2025. A review of a progress note dated 8/23/2025 indicated	F0628		

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F0628 SS = B	Continued from page 9 Resident #103 was transferred to the hospital. Resident #103 did not return to the facility. An interview on 11/19/2025 at 11:20 am with the Social Services Director revealed the social services department notified the Ombudsman via email about discharges/transfers. The Social Services Director could not see in facility records that the Ombudsman was notified of the August discharges or transfers or any transfers regarding Resident #103. An interview with the LTC Ombudsman for facility on 11/19/2025 at 12:00 pm revealed the Ombudsman did not receive notification of any discharges/transfers for August from the facility. The Ombudsman further stated they did not receive any information regarding Resident #103's transfer or discharge. On 11/19/2025 at 2:00 pm an interview with the Administrator revealed her expectation was for staff to make certain that the Ombudsman received discharges/transfers monthly the way the Ombudsman had requested to receive the notices. The Administrator acknowledged the facility did not send the email for August but could show documentation for September and October. The Administrator did not know why the email was not sent to the Ombudsman in August.	F0628		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification.	F0641	F641 Accuracy of Assessments For resident # 12 a corrective action was obtained on 11/20/25 by modifying and submitting to CMS a correction to the Minimum Data Set MDS) assessment for assessment reference date (ARD) of 9/19/2025 coding of question GG0120D Mobility Devices to accurately reflect the use of a limb prosthesis. MDS was transmitted and accepted in the state database on 11/20/25 in batch #2937. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents who use a limb prosthesis have the potential to be affected by the alleged deficient practice. Audit Results: 100% audit was completed for residents who use a limb prosthesis. Audit was completed by Clinical Reimbursement consultant on 12/11/25. 0 of 2 residents reviewed were found with deficient practice. Systemic Changes	12/19/2025

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(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
F0641 SS = D	Continued from page 10 §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code a Minimum Data Set Assessment for prosthetics for 1 of 24 residents reviewed for accuracy of assessments (Resident #12). The findings included: Resident #12 was admitted to the facility on 12/23/21 with diagnoses which included bilateral below the knee amputations and hemiplegia (paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebral infarction. Review of Resident #12's care plan with a revision date of 6/4/25 revealed a focus for bilateral below the knee amputations and the use of bilateral prosthetic legs. Review of Resident #12's quarterly Minimum Data Assessment (MDS) dated 9/19/25 revealed he was not coded for limb prothesis. During an interview with the MDS Coordinator on 11/19/25 at 4:42 pm, she stated the MDS should have indicated Resident #12 had bilateral below the knee prosthetics and this had been an error. She verified that the Minimum Data Set Assessment was inaccurate and MDS should have been coded correctly. During an interview with the Administrator on 8/7/25 at 2:00 pm, she stated the MDS assessments should have been coded accurately for Resident #12's bilateral below the knee prosthetics.	F0641	Continued from page 10 On 12/11/2025, the Clinical Reimbursement Consultant completed an in-service training for the facility Minimum Data Set (MDS) nurse(s) that included the importance of thoroughly reviewing the medical record and accurately coding use of limb prosthesis. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will review Minimum Data Set Assessments for 5 residents for accuracy of coding of MDS section GG utilizing the Accurate Coding of MDS Audit Tool. This audit will be done weekly x 3 weeks and then monthly x 2 months. Reports will be presented to the monthly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. Date of Compliance: 12/19/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345519**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/20/2025**
NAME OF PROVIDER OR SUPPLIER **Liberty Commons Nursing & Rehabilitation Center of Johnston County**		STREET ADDRESS, CITY, STATE, ZIP CODE **2315 Highway 242 North , Benson, North Carolina, 27504**	

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F0641 SS = D F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §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	F0641 F0655	F655 Baseline Care Plan Corrective action for affected resident: Resident # 54: Specific deficiency for this resident was corrected by the care plan being updated for the use of oxygen by the minimum data set nurse on 11/20/25. Corrective action for residents with the potential to be affected by the alleged deficient practice: A 100% audit of all residents who admitted to facility between 12/9/25 and 12/11/25 was completed to determine if oxygen was included on the baseline care plan within 24 hours if applicable. Audit was completed by Regional Clinical Reimbursement Consultant on 12/11/25. The results of this audit were: 0 of 0 residents were identified as not having oxygen on baseline care plan if applicable. Systemic Changes On 12/11/2025, the Clinical Reimbursement Consultant completed an in-service training for the facility Minimum Data Set (MDS) nurse(s) that included the importance of thoroughly reviewing MD orders and nursing documentation in PCC. The MDS nurse will also observe the resident. if applicable according to the baseline care plan regulations per CMS. 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, Administrator or designee will review 5 newly admitted residents to validate whether or not oxygen is included on the baseline care plan if applicable using the Quality Assurance Tool titled “Baseline Care Plan.” This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the monthly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. Date of Compliance: 12/19/25	12/19/2025

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F0655 SS = D	Continued from page 12 dietary instructions. (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 include the use of supplemental oxygen on the baseline care plan for 1 of 2 residents reviewed for baseline care plans (Resident #54). Findings included: A review of Resident #54's hospital's discharge summary dated 11/10/2025 did not indicate the use of oxygen while Resident #54 was in the hospital. Resident #54 was admitted to the facility on 11/10/2025. Diagnoses included atherosclerotic heart disease and chronic idiopathic (unknown cause) venous hypertension with ulcers to both lower legs. Nursing documentation dated 11/10/2025 at 8:58pm by Nurse #2 recorded Resident #54 was receiving oxygen by nasal cannula oxygen. Resident # 54's baseline care plan dated 11/12/2025 included focus areas for pressure ulcers and non-pressure ulcer wound care, use of pain medications and anti-anxiety medications and the use of a peripheral inserted central catheter (PICC) for administration of intravenous antibiotics. The use of oxygen was not included as a focus area on Resident #54's baseline care plan. In an interview with MDS (Minimum Data Set) Nurse #1 on 11/20/2025 at 11:08am, she stated the MDS Coordinator would have started Resident #54's baseline care plan on admission. She stated on 11/16/2025, she completed Resident #54's MDS assessment for the use of oxygen and should have updated the baseline care plan for the use of oxygen at that time. In an interview with MDS Coordinator on 11/20/2025 at 11:14am, she explained she was not aware that Resident #54 had been receiving oxygen since admission to the facility. She explained the reason there was no focus area for the use of oxygen on Resident #54's baseline care plan was because there was no physician order on	F0655		

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F0655 SS = D	Continued from page 13 Resident #54's EMR when admitted to the facility. The MDS Coordinator further stated Resident #54's baseline care plan should have been updated after assessed by MDS Nurse #1 for the use on oxygen on 11/16/2025. In an interview with the Administrator on 11/20/2025 at 12:54pm, she stated Resident #54's admission orders were discussed the following morning in the clinical morning meeting. She explained Resident #54's discharge orders from the hospital did not include an order for oxygen therapy that led the MDS Coordinator not to include a focus for oxygen therapy on Resident #54's baseline care plan. She stated the individualized person-centered baseline care plan should be accurate and updated as needed.	F0655		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly smoking assessments for 1 of 1 resident reviewed for smoking (Resident #23). The findings included: Review of the facility's smoking policy dated 2/2025 revealed a smoking assessment must be completed upon admission, quarterly, and upon changes in the resident's condition. Resident #23 was admitted to the facility on 10/20/08 with diagnoses which included hypertension, muscle weakness, dementia, and blindness in one eye. Review of Resident #23's annual Minimum Data Set (MDS)	F0689	F689 1. Corrective action for resident(s) affected by the alleged deficient practice: On 11/13/25 an updated smoking assessment was completed on resident #23 by the ADON. On 11/13/25, Resident #23 had smoking assessment completed. Smoking assessments have been scheduled to be updated in PCC quarterly per facility policy. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 11/18 /25, the Director of Nurses completed a 100% audit of current residents to identify that smoking assessments were completed per facility policy. No other residents were identified as being smokers. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 11/18/25, the Nurse Consultant re- educated the Director of Nursing and nursing administrative staff on the facility policy and requirements for completion of smoking assessments. The Director of Nursing/designee educated the nursing staff during staff meetings on 12/8/25 thru 12/11/25. Any nurse who did not attend the training will be removed from the schedule until educated. This education will be integrated into the nurse's "new hire" orientation. 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.	12/19/2025

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F0689 SS = D	Continued from page 14 dated 11/18/24 revealed the resident was coded for tobacco use. Review of Resident #23's quarterly MDS dated 8/17/25 revealed the resident was moderately cognitively impaired and needed assistance for most activities of daily living (ADL). The MDS indicated Resident #23's mobility device was a wheelchair. Resident #23 was coded for tobacco use. Review of Resident #23's smoking assessments revealed smoking assessments were completed on 2/28/25 and 11/13/25. Review of Resident #23's care plan dated 11/17/25 revealed the resident was a supervised smoker. The goal was for Resident #23's smoking related injuries to be minimized with intervention through next review. Interventions included smoking assessment to be completed quarterly per facility policy. Resident #23 was observed smoking on 11/19/25 at 9:18 am. Resident #23 was supervised while smoking and no concerns or issues were noted. An interview was conducted with Team Leader #1, who was a nurse, on 11/18/25 at 2:30 pm and she revealed smoking assessments were expected to be completed quarterly by the Team Leaders and/or the Assistant Director of Nursing (ADON). Team Leader #1 indicated nurses were notified by the computer what assessments were pending and needed to be completed during their shift, and they were expected to do so. Team Leader #1 indicated she was not aware Resident #23's smoking assessments had not been completed quarterly. During an interview with the Assistant Director of Nursing (ADON) on 11/20/25 at 12:30 pm, she revealed Resident #23 was the only smoker in the facility. The ADON indicated the computer system notified staff when a resident's assessment needed to be completed. The ADON explained that the Team Leaders were responsible for completing the smoking assessments quarterly; however, other members of the management staff could complete the smoking assessments if the Team Leaders were busy. The ADON further indicated she completed Resident # 23's smoking assessment on 11/13/25. The ADON stated she was not aware that Resident #23 had	F0689	Continued from page 14 The DON or designee will monitor compliance utilizing F689 Quality Assurance Tool monthly for 6 months. Monitoring tools completed by the DON or designee will monitor identified smokers and scheduled smoking assessments due by electronic medical record dashboard daily in clinical meeting. Reports will be presented to the monthly Quality Assurance committee by the DON for 6 months to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. 5. Date of Compliance: 12/19/25	

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F0689 SS = D	Continued from page 15 missing smoking assessments. The Administrator was interviewed on 11/20/2025 12:16 pm and indicated her expectations were that the smoking assessments should be completely quarterly as stated in the smoking policy.	F0689		
F0694 SS = D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff and Physician interviews, the facility failed to perform a weekly dressing change to a resident's peripherally inserted central catheter (PICC), a long, thin tube inserted through a vein in your arm and passed through the larger veins near your heart to deliver medication and/or treatment, as ordered for 1 of 1 resident sampled for receiving antibiotics intravenously (inside the vein) through a PICC line (Resident #54). Findings included: Resident #54 was admitted to the facility on 11/10/2024 and diagnoses included chronic idiopathic (cause unknown) venous hypertension with ulcers to both lower legs. A review of the hospital's discharge summary dated 11/10/2025 included an order to flush the PICC line with heparin 10 units per milliliter every 12 hours. There were no orders for PICC dressing change. Physician orders dated 11/10/2025 included an order to change PICC line dressing with sterile procedure weekly and as needed, measure the length of the exposed catheter to check for migration every day shift every Friday for line care. An incomplete in process admission Minimum Data Set (MDS) assessment indicated Resident #54 was moderately cognitively impaired, was receiving intravenous antibiotics and had an intravenous access.	F0694	F694 1. Corrective action for resident(s) affected by the alleged deficient practice: On 11/ 19 /25, Resident #54 had PICC line dressing change completed by Nurse #1 with the assist of the Staff Development Nurse using enhanced barrier precautions and sterile technique. Site without sign and symptoms of infection. On 11/19/25, resident #54 EMAR updated to reflect correct PICC line dressing change by the medication nurse. On 11/19 /25, Nurse #1 was provided 1:1 education for PICC line dressing changes and Process by SDC. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 11/24/25, the DON and/or designee began auditing all current residents with orders for PICC line to ensure orders to change dressings per policy were noted and dressing changes were completed per policy. Results included: one resident with PICC Line and had been changed per policy. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/08 /2025 the DON and SDC began in servicing of all licensed nurses (full time, part time, and prn including agency nurses) on PICC Line dressing change and documentation requirements in accordance with professional standards of practice. This education will be integrated into the "new hire" nurse orientation. 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 DON or designee will monitor 2 residents for compliance with PICC line dressing changes and documentation is being completed per policy. The 0694	12/19/2025

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F0694 SS = D	Continued from page 16 Resident #54's baseline care plan dated 11/12/2025 included a focus for intravenous medications via PICC with risk for complications such as infection and infiltration. Interventions included performing dressing change to site per protocol and inspecting the site for redness, inflammation, bruising or change in location and reporting to MD if noted. There was no nursing documentation that Resident #54's PICC dressing had been changed since admission. A review of the November 2025 Medication Administration Record (MAR) recorded Nurse #1 documented NA (not applicable) on Friday, 11/14/2025, for changing the PICC dressing. On 11/17/2025 at 12:43pm, Resident #54's transparent PICC dressing was observed dated 11/10/2025. The PICC site was observed with no redness, swelling or drainage underneath the transparent dressing. In an interview with Nurse #1 on 11/18/2025 at 5:54pm, she stated she did not change the PICC dressing as ordered on 11/14/2025 because she knew the PICC dressing was to be changed every 7 days and the 14th was only 4 days from the date on the PICC dressing. She explained she discussed the PICC dressing with someone (unable to recall who) on 11/14/25 and was told to record NA since the dressing was not due to be changed. Nurse #1 stated the team leaders enter admission orders into the electronic medical record (EMR) and she did not recall informing or discussing with the team leaders changing the PICC dressing order to reflect 7 days from 11/10/2025. She explained the November MAR was not prompting a PICC dressing change for 11/17/2025 and she did not work on 11/17/2025 when the PICC dressing should have been changed. On 11/19/2025 at 11:45am, Resident #54's transparent PICC dressing was observed dated 11/10/2025. The site was observed with no swelling, redness or drainage under the transparent dressing. In an interview with Nurse #1 on 11/19/2025 at 11:50 am, she stated she didn't know who was responsible for changing the PICC dressing. She stated she reported to Team Leader #1 on 11/18/2025 the PICC dressing had not been changed 11/14/2025 and the Team Leader reported the wound nurse was to change the PICC dressing. Nurse #1 stated she would add changing the PICC dressing to her list to complete on 11/19/2025 if not changed by the wound nurse, who was responsible for changing the PICC dressing.	F0694	Continued from page 16 Quality Assurance monitoring tool will be utilized weekly x 3 weeks then monthly x 2 months. Results of the monitoring of PICC line dressing changes and documentation will be reported by the DON or designee at the monthly Quality Assurance committee meeting times 3 months to ensure compliance. 5. Date of Compliance: 12.19.2025	

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F0694 SS = D	Continued from page 17 In an interview with Team Leader #1 on 11/19/2025 at 11:54am, she stated she wasn't aware who entered the PICC dressing to be changed on 11/14/2025 because the policy stated to change PICC dressing every 7 days. In a follow up interview with Team Leader #1 on 11/19/2025 at 12:24 pm, she stated Nurse #1 should have changed the PICC dressing on 11/14/2025 as ordered and clarified that the assigned nurses to Resident #54 were responsible to change the PICC dressing, not the wound nurse. On 11/19/2025 at 3:34pm, Nurse #1, assisted by the Staff Development Coordinator (SDC) Nurse, was observed using enhanced barrier precautions and sterile technique to change Resident #54's PICC dressing. The PICC insertion site was without redness, swelling or drainage. Resident #54 voiced no complaints of tenderness at the PICC site. The PICC catheter was measured at 13 centimeters and the site as cleansed, secured and dressed using a new transparent dressing. In an interview with the Assistant Director of Nursing on 11/20/2025 at 11:24am, she stated she entered the order for Resident #54's PICC dressing on 11/10/25 and chose Fridays as the day to change the PICC dressing weekly starting on 11/14/2025. She explained the MAR was set to trigger Nurse #1 to change the PICC dressing on 11/14/202, and Nurse #1 should have changed the PICC dressing on 11/14/2025. The ADON explained there was nothing wrong with changing a PICC dressing before the 7-day period. On 11/20/2025 at 10:33am in an interview with the Director of Nursing, she stated Nurse #1 did not inform her on 11/18/2025 that Resident #54's PICC line dressing had not been changed. She explained the PICC dressing should have been ordered to be changed in the first 24 hours to assess and document the site and scheduled every 7-day dressing change from that date. She explained there was an order to change the PICC dressing on 11/14/2025 and Nurse #1 should have changed Resident #54's PICC dressing on 11/14/2025 as ordered. On 11/20/2025 at 12:38 pm in a phone interview with Physician #1, he explained he was unable to observe the PICC site directly due to the net dressing covering the transparent PICC dressing when he visited Resident #54 on 11/19/2025 and observed no signs of infection in the area of the PICC dressing. He stated the PICC dressing should have been changed per the facility's policy in the 7-day period. He explained there were no clinical concerns or harm to Resident #54 because the PICC dressing was not changed due to no reports or	F0694		

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F0694 SS = D	Continued from page 18 observation of sign of infection to the PICC site. In an interview with the Administrator on 11/19/2025 at 2:03 pm, she stated Resident #54's PICC dressing was to be changed by the assigned nurse. On 11/20/2025 at 12:53pm in an interview with Administrator, she stated Nurse #1 should have followed physician order and facility's policy to change Resident #54's PICC dressing.	F0694		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and resident and staff interviews, the facility (a) failed to obtain a physician order for the use of oxygen and (b) failed to place signage outside the resident's door indicating the use of oxygen for 1 of 2 residents reviewed for oxygen use (Resident #54). Findings included: (a) Resident #54 was admitted to the facility on 11/10/2024 and diagnoses included atherosclerotic heart disease. A review of the hospital discharge orders dated 11/10/2025 did not include orders for oxygen therapy for Resident #54. A review of the physician progress notes included no record of Resident#54 receiving oxygen. In an interview with Nurse #1 on 11/18/2025 at 4:50pm, she stated the assigned team leader on 11/10/2025 was responsible for entering the oxygen order. In a follow-up interview with Nurse #1 on 11/20/2025 at 7:50 am, she stated she was the nurse assigned to Resident #54 on 11/10/2025 and was unable to recall	F0695	Corrective action for resident(s) affected by the alleged deficient practice: For Resident #54, on 11/18/25 an order was obtained from the physician for the use of oxygen at 2L per minute via Nasal cannula by Nurse #1. On 11/18/25 oxygen signage was placed outside of resident #54's room. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 11/18/25, the Director of nurses and/or Assistant Director of Nurses completed an audit of all current residents receiving Oxygen Therapy to ensure that all residents receiving supplemental oxygen had a physician order in place for use of supplemental oxygen. The results included: No concerns were identified. On 12/05/2025, the Director of Nurses/ Assistant Director of Nurses audited all resident receiving ordered supplemental oxygen for the presence of oxygen signage outside of each resident's room. The results included: No concerns were identified. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/08/25, the Director of Nurses/ Staff Development Nurse began education to all full time, part time, and PRN CNAs, med-aides, nurses (including agency) and central supply on the following: All residents who require the use of supplemental oxygen must have an active physician order in place.	12/19/2025

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F0695 SS = D	Continued from page 19 receiving report from the hospital that Resident #54 was receiving oxygen or that Resident #54 was wearing oxygen when arriving to the facility. Nursing documentation dated 11/10/2025 at 8:58pm by Nurse #2 recorded Resident #54 was receiving oxygen by nasal cannula oxygen and oxygen saturation was recorded at 91 percent (normal range 95-100%). There was no nursing documentation of the amount of oxygen Resident #54 was receiving. In a phone interview with Nurse #2 on 11/20/2025 at 9:10am, she stated she thought Resident #54's room was already set up for oxygen on 11/10/2025 before she started her shift at 7:00pm and could not recall if oxygen in use signage was placed outside the door. She explained she usually checked for oxygen therapy orders and didn't know why she did not check for Resident #54. There was further nursing documentation on 11/14/2025 at 11:36pm, 11/5/2025 at 11:58pm and 11/17/2025 at 12:18 am by Nurse #5 that Resident #54 was receiving oxygen via nasal cannula. There was no nursing documentation of the amount of oxygen Resident #54 was receiving. An attempt to interview Nurse #5 was unsuccessful. MDS (Minimum Data Set) Nurse #1 documented on 11/16/2025 that Resident #54 was receiving oxygen via nasal cannula. There was no documentation of the amount of oxygen Resident #54 was receiving. In an interview with MDS Nurse #1 on 11/20/2025 at 11:08am, she stated on 11/16/2025 Resident #54's MDS assessment for the use of oxygen was completed and Resident #54's MDS assessment was coded for the use of oxygen. She explained data for Resident #54's MDS assessment continued to be completed and was currently incomplete. She explained she was not aware there was no order for oxygen therapy in the EMR (Electronic Medical Record). She stated residents receiving oxygen therapy should have an order in the EMR. Nursing documentation on 11/17/2025 at 8:17pm by Nurse #4 documented Resident #54 was receiving oxygen via nasal cannula. There was no nursing documentation of the amount of oxygen Resident #54 was receiving. In a phone interview with Nurse #4 on 11/20/2025 at 8:52am, she stated she thought she had prompted the oxygen orders in the EMR for Resident #54's oxygen therapy when assigned to Resident #54 on 11/17/2025. She explained when there was no order for Resident	F0695	Continued from page 19 All residents who have ordered supplemental oxygen must a have oxygen signs in place outside of their room indicating that oxygen is in use. This information has been integrated into the "new hire" nurse orientation 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 who give residents care in the facility. 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 F695 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor that residents receiving oxygen have a physician order in place and have oxygen signage posted outside of their room. Reports will be presented to the monthly 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 monthly Quality Assurance Meeting. Date of Compliance: 12/19/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025

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F0695 SS = D	Continued from page 20 #54’s oxygen therapy, nursing staff should have told the team leader or entered an order. She stated she did not know why there was no order for oxygen in Resident #54’s EMR. She stated it was an oversight by herself and the nursing staff. There was no documentation of oxygen use on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) from 11/10/2025 to 11/18/2025. On 11/17/2025 at 12:43pm, Resident #54 was observed receiving oxygen therapy at two liters per minute via nasal cannula. On 11/17/2025 at 12:44pm in an interview with Resident #54, she stated she started using oxygen while in the hospital and had been receiving oxygen since her admission to the facility. In an interview on 11/18/2025 at 5:22pm with Team Leader #2, she stated nursing staff were responsible to obtain an order for oxygen when oxygen was in use and place signage indicating no smoking, oxygen in use outside the door. She explained the central supply personnel would set up the concentrator and place the sign on the door when an oxygen order was included in the discharge orders. She stated the team leaders reviewed the admission orders and entered the orders into the EMR when residents were admitted before 5:00pm and the assigned nurse was responsible after 5:00pm. Team Leader #2 stated she did not know exactly what time Resident#54 arrived at the facility on 11/10/2025 and she did not know why there was no order for oxygen therapy for Resident #54 on the EMR. In an interview with Team Leader #1 on 11/19/2025 at 11:54am, she explained there was no order on Resident #54’s chart prior to the evening hours of 11/18/2025 when she showed Nurse #1 how to activate the orders for oxygen therapy for Resident #54 who was receiving oxygen. She stated Resident #54 had been receiving oxygen therapy since admission and should have had an order. Team Leader #1 stated she was not working on 11/10/2025 when Resident #54 was admitted to the facility. A physician order transcribed on 11/18/2025 at 5:01pm by Nurse #1 included oxygen via nasal cannula at 2 liters per minute. (b) There was nursing documentation that Resident #54 was receiving oxygen on the following dates:	F0695		

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F0695 SS = D	Continued from page 21 * On 11/10/2025 at 8:58pm Nurse #2 recorded Resident #54 was receiving oxygen by nasal cannula oxygen. * On 11/14/2025 at 11:36pm, 11/5/2025 at 11:58pm and 11/17/2025 at 12:18 am Nurse #5 recorded that Resident #54 was receiving oxygen via nasal cannula. * On 11/16/2025, MDS Nurse #1 documented on 11/16/2025 that Resident #54 was receiving oxygen via nasal cannula. * On 11/17/2025 at 8:17pm, Nurse #4 documented Resident #54 was receiving oxygen via nasal cannula. In a phone interview with Nurse #2 on 11/20/2025 at 9:10am, she stated she thought Resident #54's room was already set up for oxygen on 11/10/2025 before she started her shift at 7:00pm and could not recall if oxygen in use signage was placed outside the door. She explained she usually checked that signage was posted outside the door for residents receiving oxygen therapy and didn't know why she did not check for Resident #54. An attempt to interview Nurse #5 was unsuccessful. In an interview with MDS Nurse #1 on 11/20/2025 at 11:08am, she stated on 11/16/2025 Resident #54's MDS assessment for the use of oxygen was completed and Resident #54's MDS assessment was coded for the use of oxygen. She explained she was not aware there was no signage for oxygen use outside Resident #54's door. She stated residents receiving oxygen therapy should have signage outside the resident's door indicating oxygen was in use. In a phone interview with Nurse #4 on 11/20/2025 at 8:52am, she stated there should be signage outside Resident #54's door for oxygen in use. She stated she did not know why there was no oxygen in use sign outside Resident #54's door and it was an oversight by herself and the nursing staff. On 11/17/2025 at 12:43pm, Resident #54 was observed receiving oxygen therapy at two liters per minute via nasal cannula. There was no oxygen in use signage observed outside Resident #54's door that indicated Resident #54 was using oxygen. On 11/17/2025 at 12:44pm in an interview with Resident #54, she stated she started using oxygen while in the hospital and had been receiving oxygen since her admission to the facility on 11/10/2025. On 11/17/2025 at 12:43pm, Resident #54 was observed	F0695		

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F0695 SS = D	Continued from page 22 receiving oxygen therapy at two liters per minute via nasal cannula and there was no signage outside Resident #54's door indicating oxygen was in use. On 11/17/2025 at 12:44pm in an interview with Resident #54, she stated she started using oxygen while in the hospital and had been receiving oxygen since her admission to the facility. There was no documentation of oxygen use on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) from 11/10/2025 to 11/18/2025. In an interview with Nurse #1 on 11/18/2025 at 4:50pm, she stated the assigned team leader on 11/10/2025 was responsible for putting the oxygen use signage on Resident #54's door. In a follow-up interview with Nurse #1 on 11/20/2025 at 7:50 am, she stated she was the nurse assigned to Resident #54 on 11/10/2025 and was unable to recall receiving report from the hospital that Resident #54 was receiving oxygen or that Resident #54 was wearing oxygen when arriving to the facility. In an interview on 11/18/2025 at 5:22pm with Team Leader #2, she stated nursing staff were responsible to place signage indicating no smoking, oxygen in use outside the door. She explained the central supply personnel would set up the concentrator and place the sign on the door when an oxygen order was included in the discharge orders. She stated the team leaders placed the oxygen use sign on the door when residents were admitted before 5:00pm and nursing staff were responsible after 5:00pm. Team Leader #2 stated she did not know exactly what time Resident#54 arrived at the facility on 11/10/2025 and she did not know why there was no signage of oxygen in use outside Resident #54's door. On 11/20/2025 at 10:33am in an interview with the Director of Nursing, she stated nursing staff needed to ensure there was an order on Resident #54's EMR for oxygen therapy and signage indicating oxygen was in use was posted outside Resident #54's door. She explained that the assigned team leaders or the admission nurse (Nurse #1) would have been responsible for clarifying with the physician and entering oxygen orders and ensuring an oxygen in use sign was posted outside Resident #54's door. She further stated all licensed nurses could enter orders into the EMR and all nursing staff could post the oxygen in use signage on the door when oxygen therapy was in use. On 11/20/2025 at 12:53pm in an interview with	F0695		

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F0695 SS = D	Continued from page 23 Administrator, she explained new admissions and their admission orders were discussed in clinical morning meetings and because Resident #54's hospital discharge orders did not include oxygen therapy, the interdisciplinary team members were not aware Resident #54 was receiving oxygen and needed an order for oxygen. She further explained the facility had a standing order for oxygen therapy and nursing staff should have transcribed the standing order into the EMR and placed signage oxygen in use outside the door when Resident #54 was admitted using oxygen and continued to use oxygen.	F0695		