	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345373	B. WING		C 03/07/2024	
NAME OF PF	ROVIDER OR SUPPLIER		I STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NRSG & REF	AB CNTR OF SOUTHPORT LLC		FODALE AVENUE ITHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIO	
E 000	Initial Comments		E 000			
F 000	investigation survey v 03/04/24 through 03/0 found in compliance	07/24. The facility was with CFR 483.73 ness. Event ID #34GG11.	F 000			
		complaint investigation d from 03/04/24 through 34GG11.				
	The following compla investigated: NC001 NC00203081, NC002					
F 561 SS=E	13 of the 13 complain in deficiency. Self-Determination CFR(s): 483.10(f)(1)-	nt allegations did not result (3)(8)	F 561		3/29/24	
	promote and facilitate through support of res	right to and the facility must resident self-determination sident choice, including but ts specified in paragraphs (f)				
	activities, schedules (waking times), health					
		ident has a right to make s of his or her life in the cant to the resident.				

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

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/05/2 FORM APPRO OMB NO. 0938-0
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345373	B. WING		C 03/07/2024
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C 630 FODALE AVENUE SOUTHPORT, NC 28461	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLET THE APPROPRIATE DATE
F 561	Continued From page		F 56	61	
	with members of the	ident has a right to interact community and participate in both inside and outside the			
	religious, and commu interfere with the righ facility. This REQUIREMENT	ident has a right to ctivities, including social, inity activities that do not ts of other residents in the ⁻ is not met as evidenced			
	resident and staff inte administer medication	ns, record review, and erviews the facility failed to ns on time as prescribed by 1 residents reviewed.		The statements made on t correction are not an admis not constitute an agreemen alleged deficiencies. To ren compliance with all federal	ssion to and do It with the nain in and state
	Findings included:			regulations the facility has t take the actions set forth in correction. The plan of corr	this plan of
	10/02/20. Diagnoses schizophrenia, anxiet disturbance, and con Data Set quarterly as	y, dementia with behavioral stipation. The Minimum sessment dated 02/09/24 was cognitively intact and		constitutes the facility's alle compliance such that all all deficiencies cited have bee corrected by the dates indic F561 the facility failed to ac medications on time as pre physician for 1 of 1 residen (Resident #7) 1. Corrective action for re	egation of eged in or will be cated. dminister scribed by the t reviewed.
	03/04/24 at 1:00 PM. did not receive her m times the nursing star 10:00 PM to administ due at 8:00 PM. Res the nursing staff she 8:00 PM so she could	ducted with Resident #7 on Resident #7 reported she edications on time and at ff would wake her up after ter her medications that were ident #7 stated she had told wanted her medications at d go to bed and not be #7 stated she had received		affected by the alleged defi On 3/7/2024 Resident #7 w for any adverse events rela medication administration. denied any adverse effects physical changes noted. O Director of Nursing notified director of late administration medications for the followin	cient practice : /as assessed ited to late Resident and no on 3/7/2024 the the medical on of

Facility ID: 923382

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	OF DEFICIENCIES	MEDICAID SERVICES			CONSTRUCTION	(X3) DATE	D. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	• •			· · ·	PLETED
							С
		345373	B. WING			03/	07/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NRSG & REI	AB CNTR OF SOUTHPORT LLC					
				SC	OUTHPORT, NC 28461		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 561	Continued From page	e 2	F 56	61			
		ions as late as 2:00 in the	1.00	<u> </u>	Senna Plus, Risperidone, and Klonopi	n	
		7 stated she did not have			that were all scheduled to be given at		
	any increased anxiety	y, delayed bowel movements rs as a result of receiving the			PM. No new orders received.		
		added, she wanted them			2. Corrective action for residents wit		
	when they were sche				the potential to be affected by the alleg deficient practice.	ged	
		ans' orders revealed an					
		3/20 for Senna Plus 8.6-50			All residents have the potential to be		
		2 tablets one time a day for			affected by the alleged deficient practi	ce.	
	-	r written on 10/14/21 for osychotic) tablet 0.5 mg give			On 3/25/2024 the Director of Nursing		
		, and an order written on			completed a 72 hour look back audit for	h	
		(an antianxiety) 0.5 mg give			late medication administration for both		
	one tablet two times a				day and night shift. This completed or		
					3/25/2024. Results included: there we		
	Review of the Medica	ation Administration Record			29 of 87 residents identified with late		
		vealed the medications			medication administration beyond the		
		done, and Klonopin) were all			timeframe of 1 hour prior to scheduled		
	scheduled to be giver	n at 8:00 PM.			dose and 1 hour post the scheduled d		
	Deview of the Medice	tion Administration Audit			of medication. On 3/25/2024 the Direct		
		ation Administration Audit I through February 29, 2024,			of nursing implemented corrective acti plan to include: Interview of staff to	on	
		redication, the antipsychotic			determine reason for late administratio	n	
		antianxiety medication were			1:1 Education with each identified nurs		
		an 8:00 PM. The audit report			or medication aide on time manageme		
		ed time which was 8:00 PM			and best practice for passing medicati		
	and the administratio	n time. The following			on the unit to include completion of too	bl	
	included the dates the				for improvement form filled out and sig	jned	
		the actual administration			by the identified staff, assessment on		
	time:				residents to ensure no adverse effect, Notification to the medical provider.	and	
	02/01/24 medications	administered at 11:41 PM			realization to the medical provider.		
	by Medication Aide (N				On 3/14/2024 the Director of Nursing		
		administered at 10:30 PM			audit, the medication administration		
	by MA #1				orders to determine if any unnecessar	у	
		administered at 10:04 PM			orders present on the medication		
	by MA #1				administration record that may be		
	02/06/24 medications	administered at 10:04 PM			contributing factor to achievement of		

Event ID: 34GG11

Facility ID: 923382

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/05/2024 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		ISTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345373	B. WING _				C 107/2024
	NAME OF PROVIDER OR SUPPLIER			630 F	ET ADDRESS, CITY, STATE, ZIP CODE DDALE AVENUE ITHPORT, NC 28461	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 561	by MA #5 02/09/24 medications by MA #1 02/13/24 medications by MA #1 02/14/24 medications by MA #5 02/15/24 medications Nurse #4 02/17/24 medications by MA #1 02/20/24 medications by MA #1 02/22/24 medications by MA #1 02/22/24 medications by MA #1 02/22/24 medications by MA #1	e 3 a administered at 10:15 PM a administered at 12:30 AM a administered at 12:30 AM a administered at 10:40 PM a administered at 12:56 AM a administered at 12:56 AM by a administered at 1:46 AM by a administered at 10:27 PM a administered at 10:27 PM a administered at 10:50 PM a administered at 10:58 PM a administered at 10:32 PM a administered at 10:32 PM	F 5	tir cc in fru ac m C re 3. pr pr O e q N Li m	mely medication administration. The completed on 3/22/2024. The results cluded there were several non- medication orders types that would be om placement on the treatment diministration record verses the medication administration order. orrective action was completed to emove any unnecessary orders. Measures /Systemic changes to revent reoccurrence of alleged defice ractice: m 3/21/24 the Nurse Consultant ducated the Director of Nursing and ursing unit managers on daily Qual fe (Monday – Friday) review of medication administration audit for re- f late medication administration. ducated to review during daily clinic	s enefit cient ity of eview	
	for March 2024 revea Plus, Risperidone, an scheduled to be given Review of the Medica Report for March 1 th revealed the bowel m			w st in ca ev et O R	ith immediate follow up with the nur aff for 1:1 education and tool for aprovement, interviews to determine ause, notification to medical provide valuation of residents for any adver ffects. n 3/18/2024, the DON and the egistered Nurse Unit Manager bega ducation of all full time, part time, as	rsing e root er and se an	
	administered later tha indicated the schedul and the administratio included the dates the	an 8:00 PM. The audit report ed time which was 8:00 PM n time. The following		ne R P ai	eeded (PRN) licensed nurses, egistered Nurses (RN) and License ractical Nurses (LPN) and Medicati des to include Agency staff on F56 letermination related to late medica dministration.	ed on 1 Self	

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DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES			PRINTED: 04/05/202 FORM APPROVE
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345373	B. WING		C 03/07/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
				630 FODALE AVENUE	
LIBERTY	COMMONS NRSG & REP	HAB CNTR OF SOUTHPORT LLC		SOUTHPORT, NC 28461	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 561	Continued From page	e 4	F 561		
	03/03/24 medications by MA #1 03/04/24 medications by MA #1 An interview was com phone on 03/06/24 at she worked on the 50 resided and the 300 H AM. She stated she she was late adminis Resident #7. MA #1 she would fall behind her nurse to help her behind because she nurse. MA #1 stated 8:00 PM and the nurs give the medications after the medications the times she gave th later than the prescrift stated she did not red to her that she wante PM. An interview was com phone on 03/07/24 at her routine when she through the progress her medication pass a stated she started on #7 resided and would 10:30 PM. MA #5 sta the medications were #7 on 02/01, 02/07 at Resident #7 had expl	a administered at 10:20 PM a administered at 10:15 PM aducted with MA #1 via t 3:15 PM. MA#1 revealed 00 hall where Resident #7 hall from 7:00 PM to 7:00 could not remember why tering the medications to added, things happen and b. She stated she did not ask when she was getting did not want to bother the the medication time was sing staff had the flexibility to one hour before or one hour were due. MA #1 confirmed the medications were much bed allowable time. MA #1 call Resident #7 expressing ad her medications at 8:00 adducted with MA #5 via t 3:00 PM. MA #5 reported a came on shift was to read notes and she would start about 8:00 - 8:30 PM. She the 500 hall were Resident d usually finish about 10:00 - ated she did not know why a passed so late to Resident ind 02/14/24. MA #5 stated ressed to her to that she ons before she went to bed		 This in-service was incorporated in new employee facility orientation for above-mentioned employees and provided to agency staff working in facility. This will be reviewed by the Quality Assurance process to verify the change has been sustained. Any staff who does not receive sc in-service training will not be allow work until training has been comp 3/25/2024. Monitoring Procedure to ensure the plan of correction is effective as specific deficiency cited remains of and/or in compliance with regulator requirements. The DON or Designee will monitor compliance utilizing the F561 Self Determination Quality Assurance weekly x 3 weeks then monthly x amonths or until resolved. The direct Nursing and nurse management to review Medication Administration Areports for late medications daily for provement of nursing standards Compliance will be monitored and ongoing auditing program reviewed weekly QA Meeting is attended by Administrator, Director of Nursing, Coordinator, Therapy Manager, H Information Manager, and the Die Manager. 	for the also in the also is a second

Facility ID: 923382

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		345373	B. WING		C 03/07/2024
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CO	
LIBERTY	COMMONS NRSG & REI	HAB CNTR OF SOUTHPORT LLC		FODALE AVENUE UTHPORT, NC 28461	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF (CORRECTION (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETI HE APPROPRIATE DATE
F 561	Continued From page	e 5	F 561		
	reach out to the nurs	e on those nights to let her d on passing medications			
		empted with Nurse #4 via t 11:00 AM. There was no			
	03/07/24 at 12:10 PM	ducted with the Physician on 1. The Physician stated she			
	medications when the	sing staff to administer the ey were due or within the cation was due or the hour			
F 636 SS=B	Nursing (DON) on 03 DON reported she fe needed to work on the that the medication p decreased when the audit and discontinue several residents to o pass time and unnec DON stated the medi to start on the 500 ha hall. She stated ther between the two halls should have been ab medications at the pr than an hour after the Comprehensive Asse	escribed time or no later e prescribed time. essments & Timing	F 636		3/29/24
	§483.20 Resident As The facility must con- a comprehensive, ac reproducible assessr	duct initially and periodically curate, standardized			

Facility ID: 923382

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED D NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC B. WING 03/07/202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 630 FODALE AVENUE SOUTHPORT, NC 28461 51000000000000000000000000000000000000		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
345373 B. WING 03/07/202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 630 FODALE AVENUE LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC 630 FODALE AVENUE SOUTHPORT, NC 28461 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4)	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC 630 FODALE AVENUE SOUTHPORT, NC 28461 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4)			345373	B. WING _			C 03/07/2024	
LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC SOUTHPORT, NC 28461 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4)	NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	LIBERTY	COMMONS NRSG & REF	IAB CNTR OF SOUTHPORT LLC					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPI	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		(X5) COMPLETION DATE
F 636 Continued From page 6 functional capacity. F 636 §483.20(b) (Comprehensive Assessments §483.20(b) (Comprehensive Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (I) Identification and demographic information (II) Cognitive patterns. (IV) Oromunication. (V) Vision. (V) Vision. (V) Oromunication. (V) Vision. (V) Subcase diagnosis and health conditions. (X) Destage diagnosis and health conditions. (X) Destage diagnosis and health conditions. (X) Dental and nutritional status. (XII) Decumentation of summary information regarding the additional assessment procedures. (XV) Declarge planning. (XVI) Documentation of participation in assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. 	F 636	functional capacity. §483.20(b) Comprehe §483.20(b)(1) Reside A facility must make a assessment of a resid goals, life history and resident assessment by CMS. The assess the following: (i) Identification and d (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (v) Vision. (vi) Mood and behavid (vii) Psychological we (viii) Physical function (ix) Continence. (x) Disease diagnosis (xi) Dental and nutritid (xii) Skin Conditions. (xii) Activity pursuit. (xiv) Medications. (xv) Special treatmen (xvi) Discharge plann (xvii) Documentation regarding the addition on the care areas trig the Minimum Data Set (xviii) Documentation assessment. The assinclude direct observation with the resident, as with the resident the the there is there is the there is there is	ensive Assessments ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ment must include at least lemographic information e. or patterns. ell-being. ning and structural problems. and health conditions. onal status. ts and procedures. ing. of summary information nal assessment performed gered by the completion of et (MDS). of participation in sessment process must ation and communication well as communication with used direct care staff	F 6	336			

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 04/05/202 MAPPROVE <u>0. 0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345373	B. WING		C 03/07/2024	
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP COD	Ε	
LIBERTY	COMMONS NRSG & REP	HAB CNTR OF SOUTHPORT LLC		630 FODALE AVENUE SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 636	chapter, a facility mus assessment of a resid timeframes specified through (iii) of this se- prescribed in §413.34 apply to CAHs. (i) Within 14 calendar excluding readmissio significant change in mental condition. (Fo "readmission" means following a temporary or therapeutic leave.) (iii)Not less than once This REQUIREMENT by: Based on record rev facility failed to comp assessments within th timeframe for 2 of 2 r comprehensive Minin assessments (Reside #291). Findings included: 1. Resident #290 w 2/16/24. Resident #2 Data Set (MDS) date progress as of 3/7/24 An interview was con on 3/07/24 at 2:41 PM the workload had incu discharging and retur difficulty keeping up v Nurse stated she was	d in §413.343(b) of this st conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) ction. The timeframes 43(b) of this chapter do not r days after admission, ons in which there is no the resident's physical or or purposes of this section, a return to the facility y absence for hospitalization of every 12 months. T is not met as evidenced iew and staff interview the lete comprehensive he 14-day required esidents reviewed for num Data Set (MDS) ent #290 and Resident	F 63	 F636 – Comprehensive Asse Timing Corrective Action Minimum Data Set assessme affected residents that were in not being completed within th 14-day timeframe was compli- follows: Resident #290 was admit facility on 2/16/2024. Admissist data set assessment with Asse Reference Date of 2/23/2024 completed on 3/7/2024. Resident #291 was admit facility on 2/1/2024. Admissist data set assessment with Asse Reference Date of 2/8/2024 w completed on 2/21/2024. Corrective action for resident potential to be affected by the deficient practice. 	ent for dentified as e required eted as itted to the sessment was itted to the on Minimum sessment vas s with the	

Facility ID: 923382

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/ FORM APP OMB NO. 093	ROVI
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	ΞY
		345373	B. WING		C 03/07/20	24
NAME OF PF	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
	COMMONS NRSG & REI	HAB CNTR OF SOUTHPORT LLC		630 FODALE AVENUE SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COM	(X5) IPLETIC DATE
F 636	Nurse stated she was An interview with the 3:10 PM revealed sh assessments be com 2. Resident #291 w 2/1/24. Resident #29 Minimum Data Set as on 2/21/24. An interview was cor on 3/07/24 at 2:41 Pf the workload had inc discharging and return difficulty keeping up w Nurse stated she was completed assessme Nurse stated she was An interview with the 3:10 PM revealed sh	e 8 ents late recently. MDS is trying to get caught up. Administrator on 3/07/24 at e expected that MDS ipleted in a timely manner. vas admitted to the facility on 01's 2/21/24 admission issessment was completed inducted with the MDS Nurse M. The MDS Nurse stated reased with a lot of residents rning and she had more with the workload. The MDS is aware of the timelines for 0S assessments and had ents late recently. MDS is trying to get caught up. Administrator on 3/07/24 at e expected that MDS inpleted in a timely manner.	F 63	 All residents have the potential to affected by the alleged deficient p A 100 % review of all current resid with a comprehensive assessment has been completed and submitter last 30 days will be audited to revia assessments were completed in the days timeframes. This audit will be completed by the regional Minimu set consultant no later than 3/21/2 Effective 3/25/2024, the facilite Minimum data set coordinator will the Minimum Data Set (MDS) in p list in PCC Software daily (Mondar through Friday) and inform the interdisciplinary team members of residents with assessment referent dates (ARD) for that date as well a residents with in progress assessing that are due for completion (Minim data set assessment Z0500 date) date. This has been added to the stand up meeting process. Regional Minimum data set consultant will audit the current Mi data set assessments in progress comprehensive assessments (in procomprehensive assessments (in procomprehensive assessments (in procomprehensive assessments with due date of 3/26/2024 or earlier) to 26, 2024 	ractice. dents it that it that ew that he 14 e m data 2024 ty review rogress y it he nce as any ments num on that daily inimum list for are due et item March set nimum omplete gress Z0500	
				Systemic Changes		

Facility ID: 923382

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					OMB NO. 0938-03		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
					с		
		345373	B. WING		03/07/2024		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	·		
LIBERTY	COMMONS NRSG & RE	HAB CNTR OF SOUTHPORT LLC		630 FODALE AVENUE			
			SOUTHPORT, NC 28461				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETIO		
F 636	Continued From pag	e 9	F 63	6			
				By 2/26/2024 the Administrator	r		
				By 3/26/2024, the Administrator o designee will complete an in-serv			
				training with the facility Minimum			
				Coordinator that includes the imp	ortance		
				of ensuring that each resident rec			
				comprehensive assessment acco	•		
				the rules stated in Chapter 2 of th			
				(resident assessment instrument)	Manual.		
				The monitoring procedure to ensu			
				the plan of correction is effective a			
				specific deficiency cited remains of			
				and/or in compliance with the reg requirements.	ulatory		
				The Director of Nursing or design	ee will		
				begin auditing the facility's compli			
				with comprehensive Minimum Da			
				assessments completion time frame	mes as		
				stated in Chapter 2 of the RAI (re-			
				assessment instrument) Manual u	0		
				quality assurance survey tool enti "Comprehensive Assessments an			
				Audit Tool" to ensure that the plan			
				correction is effective and that spe			
				deficiency cited remains corrected			
				compliance with the regulatory			
				requirements.			
				This audit will be completed on 5			
				residents' completed assessment			
				audit and will be done weekly x 4 and then monthly x 2 months or u			
				substantial compliance is achieve			
				maintained. Reports will be prese			
				the weekly Quality Assurance cor	nmittee		
				by the Director of Nursing to ensu			
				corrective action for trends or ong			
	1		1	concerns is initiated as appropriat			

Event ID: 34GG11

Facility ID: 923382

If continuation sheet Page 10 of 38

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/05/20 FORM APPROVI OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345373	B. WING		03/07/2024
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•
IBERTY	COMMONS NRSG & REF	AB CNTR OF SOUTHPORT LLC		30 FODALE AVENUE OUTHPORT, NC 28461	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETIC
F 636			F 636	weekly Quality Assurance Meeting is attended by the Administrator, Directo Nursing, Minimum Data Set Coordinat Unit Manager, Support Nurse, Therap 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 Nursi Date of Compliance: 3/29/2024	or, y,
F 685 SS=D	CFR(s): 483.25(a)(1)(§483.25(a) Vision and To ensure that reside and assistive devices hearing abilities, the f assist the resident- §483.25(a)(1) In maki §483.25(a)(2) By arra and from the office of the treatment of vision the office of a profess		F 685		3/29/24
	This REQUIREMENT by: Based on record revi resident, staff and phy failed to obtain an app specialist for treatmen of 1 residents (Reside Findings included:	w, observation, and ysician interviews, the facility pointment with a retinol nt of visual impairment for 1 ent #9) reviewed for vision.		The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all feder and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of correcti constitutes the facility's allegation of	al Iken

Event ID: 34GG11

Facility ID: 923382

If continuation sheet Page 11 of 38

			()(0)	E CONCEPTION	OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
				С	
		345373	B. WING		03/07/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BERTY	COMMONS NRSG & RE	HAB CNTR OF SOUTHPORT LLC		630 FODALE AVENUE SOUTHPORT, NC 28461	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 685	Continued From pag	e 11	F 68	5	
	with a diagnosis which syndrome.	ch included dry eye		compliance such that all alleged deficiencies cited have been or wil corrected by the dates indicated.	
	revealed a 10/17/23	#9's electronic health record vision consult which 9 had gradual blurry vision		F685 the facility failed to obtain an appointment with a retinol speciali treatment of visual impairment for	st for
	with the left eye grea care indicated Reside to a retinol specialist	ter than the right. The plan of ent #9 was to have a referral for treatment with an		resident (Resident #9) reviewed for 1. Corrective action for resident(affected by the alleged deficient pr	or vision. (s)
		heduled within 2-3 weeks.		On 3/6/2024 the Director of Nursin	
	revealed a 10/17/23	#9's electronic health record optometry order form o a retinol specialist was		notified the primary care provider of missed referral retinol specialist. (received by Nurse Practitioner to s	Orders
	macular degeneratio vision loss.	on of left eye advanced n, a disease that causes		the appointment. On 3/6/24 the appointment was scheduled for 4/4 12:40 PM. The resident and RP w notified of the appointment.	
	had adequate vision,	ssessment revealed resident corrective lenses were not		2. Corrective action for residents the potential to be affected by the	
	used, and was cogni	tively intact.		deficient practice.	
	revealed resident sitt	lent #9 on 3/4/24 at 3:25 PM ing on the side of the bed s, glasses on and her call		Beginning on 3/6/2024 the Directo Nurses (DON) began auditing 100 the notes from the in-house optom consultant for the last 6 months. T	% of netry Fhis
		nducted with Resident #9 on Resident #9 stated she		audit consisted of reviewing the op notes to ensure that all orders and recommendations were carried ou entirety. Any residents whose ord	l t in its
	appointment was sup scheduled months ag			were not carried out in its entirety, have updated orders to reflect req This audit was completed as of 03	will uired.
	unable to see. Resid	-		3. Measures /Systemic changes prevent reoccurrence of alleged de	to
		#9's progress notes as of		practice: Beginning on 3/18/2024, the Direc	

Facility ID: 923382

If continuation sheet Page 12 of 38

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NC	0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION		LETED
		345373	B. WING			C 07/2024
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZI		
LIBERTY	COMMONS NRSG & REI	HAB CNTR OF SOUTHPORT LLC		630 FODALE AVENUE SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 685	Continued From page	e 12	F 68	35		
	3/5/24 revealed no ev with the retinol special completed. Review of Resident # 3/5/24 revealed no eve evaluated by the retin Interview on 3/6/24 a Transporter/Appointn was in the position si Transporter/Appointn was responsible for si the resident after she nurses. The Transport stated she scheduled informed the resident time. The Transport stated she thought sh Practitioner said she to be seen by the visi facility. The Transpo stated the vision clini- per year. The Transpo	vidence that the appointment alist was scheduled or 49's consult notes as of vidence that the resident was nol specialist. t 12:10 PM with the nent Scheduler revealed she nce September 2023. The nent Scheduler stated she scheduling appointments for e received a referral from the orter/Appointment Scheduler I the appointments and t and family of the date and er/Appointment Scheduler he recalled the Nurse was waiting for the resident ion clinic that visits the rter/Appointment Scheduler c only visits the facility once porter/Appointment c only visits the facility once		Nursing and the Registe manager began educatio part time, as needed (PF nurses, Registered Nurs Licensed Practical Nurse agency staff on F685 to treatment/Devices to Ma Hearing/Vision. Educatio ensure that residents red treatment and assistive of maintain vision and hear facility must if necessary resident in making appoi arrangement of transport the office of a practitioned the treatment of vision of impairment. This in-service was incom new employee facility of above-mentioned emplo provided to agency staff facility. This will be revie Quality Assurance proced the change has been sus Any staff who does not m in-service training will no	on of all full time, RN) licensed es (RN) and es (LPN) including include intain on included to ceive proper devices to ring abilities, the r, assist the intments and tation to and from er specializing in r hearing rporated in the ientation for the yees and also working in the exect by the ts to verify that stained.	
	of Nursing (DON) rev received the report fr appointment in Octob Resident #9's medica had not provided the			 work until training has be 3/25/2024. 4. Monitoring Procedure the plan of correction is a specific deficiency cited and/or in compliance with requirements. 	re to ensure that effective and that remains corrected	
	Resident #9's optome or the recommendation	ade aware of the results of etry appointment in October on for the referral to a retinol stated she was not aware of		The Director of Nursing of monitor compliance utiliz Quality Assurance Tool v then monthly x 2 months	ring the F685 veekly x 3 weeks	

Facility ID: 923382

If continuation sheet Page 13 of 38

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			MPLETED
		345373	B. WING		0	C 3/07/2024
NAME OF P	ROVIDER OR SUPPLIER	•	5	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NRSG & REF	HAB CNTR OF SOUTHPORT LLC		30 FODALE AVENUE SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	the results of the app referral. The DON st made today with the 12:40 PM. Interview on 3/7/24 a physician revealed st the appointment with been scheduled as on The physician stated harm by not obtaining retinol specialist soor process error. Drug Regimen is Free CFR(s): 483.45(d)(1) §483.45(d) Unnecess Each resident's drug unnecessary drugs. drug when used- §483.45(d)(1) In exce duplicate drug therap §483.45(d)(2) For exc §483.45(d)(3) Withou use; or §483.45(d)(5) In the p	ointment in October or the ated an appointment was retinol specialist for 4/9/24 at t 10:50 AM with the ne was just made aware that the retinal specialist had not rdered on the consult report. it would not cause resident g the appointment with the ner, but it was a system e from Unnecessary Drugs -(6) sary Drugs-General. regimen must be free from An unnecessary drug is any essive dose (including y); or cessive duration; or at adequate monitoring; or at adequate indications for its presence of adverse indicate the dose should be	F 685	Audits will include review of all consultations post visit reports to all recommendations and referra This will include auditing 6 resid- various days and shifts to ensur- corrective action is initiated as appropriate. Compliance will be and the ongoing auditing progra reviewed at the weekly Quality A Meeting. The weekly QA Meetin attended by the Administrator, D Nursing, MDS Coordinator, The Manager, Health Information Ma and the Dietary Manager. Date of Compliance: 3/29/24	als made. ents on e monitored m Assurance g is Director of rapy	3/29/24

Facility ID: 923382

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		& MEDICAID SERVICES			
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		245272	B. WING		С
		345373			03/07/2024
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
IBERTY	COMMONS NRSG & R	EHAB CNTR OF SOUTHPORT LLC		630 FODALE AVENUE	
				SOUTHPORT, NC 28461	
(X4) ID			ID	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	
F 757	Continued From pa	ge 14	F 75	7	
		combinations of the reasons			
		ns (d)(1) through (5) of this			
	section.	NT is not met as evidenced			
	by:	I IS NOT THE AS EVIDENCED			
	-	tions, record review, staff, and		The statements made on this plan	of
 		s the facility failed to clarify a		correction are not an admission to	
		rescribed for hypotension (low		not constitute an agreement with the	
		include hold parameters if the		alleged deficiencies.	
		sure was greater than 120		To remain in compliance with all fe	deral
		s of mercury). This resulted in		and state regulations the facility ha	is taken
	,	nt #61) receiving 59 additional		or will take the actions set forth in t	
		ation. There was no significant		plan of correction. The plan of corr	
		iving the medication. This		constitutes the facility's allegation	t
	medication adminis	residents reviewed for		compliance such that all alleged	lha
				deficiencies cited have been or wil corrected by the dates indicated.	i be
	Findings included.			F757 the facility failed to clarify a	
	i mango moladoa.			medication order prescribed for	
	Resident #61 was a	admitted to the facility on		hypotension (low blood pressure) t	0
		noses included in part;		include hold parameters if the syst	
	hypertensive chron	ic kidney disease with end		blood pressure was greater than 1	20
	stage renal disease	e, dependence on dialysis, and		mm/hg (millimeters of mercury). The	
	hypotension.			resulted in a resident (Resident #6	
	A			receiving 59 additional doses of the	
		dated 05/03/23 for Resident		medication. There was no significa	
		drine 10 milligrams (prescribed		outcome from receiving the medica Corrective action for resident(s) af	
		n which works by constricting ausing increased blood		by the alleged deficient practice:	
		ablet by mouth three times a		For resident #61, on 3/14/2024 the	facility
		n. Hold if systolic blood		notified the medical provider to rec	-
	pressure is greater	•		clarification order for Midodrine. O	
		-		3/14/24 new order entered for Mide	odrine
		cation Administration Record		to be administered without parame	ters.
		t #61 from 05/03/23 through			
		Midodrine was administered as		1. Corrective action for residents	
	prescribed.			the potential to be affected by the a	alleged
			1	deficient practice.	

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		MEDICAID SERVICES			OMB NO. 0938-
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345373	B. WING		C 03/07/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LIBERTY	COMMONS NRSG & REF	IAB CNTR OF SOUTHPORT LLC		630 FODALE AVENUE SOUTHPORT, NC 28461	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLE
F 757	Continued From page	e 15	F 757	,	
F / 3/	10/27/23 for Resident oral tablets 10 mg (m mouth three times a c systolic blood pressur mm/hg. There was n Review of the Medica (MAR) for Resident # revealed Midodrine of tablet by mouth three if systolic blood press mm/hg. There was n on the MAR. Further review of the Record (MAR) for Re 2023 revealed Midod administered to Resid blood pressure readir 11/01/23 a blood press revealed 142/76. 11/02/23 a blood press revealed 142/76. 11/03/23 a blood press revealed 142/84. 11/03/23 a blood press revealed 170/65. 11/03/23 a blood press revealed 176/89. 11/03/23 a blood press revealed 176/89. 11/07/23 a blood press revealed 176/89. 11/07/23 a blood press revealed 133/72. 11/07/23 a blood press revealed 133/72.	t #61 revealed Midodrine illigrams). Give 1 tablet by day for hypotension if re is greater than 120 o hold parameter. Ation Administration Record 61 dated November 2023 ral tablets 10 mgs. Give 1 times a day for hypotension oure is greater than 120 o hold parameter included Medication Administration sident #61 dated November rine 10 mg was signed as dent #61 for the following ngs:	F /5/	parameters have the potential to b affected by this alleged deficient p On 3/14/2024 the Director of Nurse nursing team began auditing all medications with parameters to en- that orders did not require clarifica This was completed on 3/14/2024. 3/14/2024 the Director of Nurses a nursing team completed corrective for those residents including notific medical provider for any clarificatio orders and initiation of those order 2. Measures /Systemic changes prevent reoccurrence of alleged de practice: On 3/18/2024 the Director of Nurse Registered Nurse Manager began education of all Full Time, Part Tim needed nurses, medication aides to include agency on Unnecessary Drugs-General. Each resident's dr regimen must be free from unnece drugs. An unnecessary drug is any when used in excessive dose (incl duplicate drug therapy); or for exce duration; or Without adequate mor or Without adequate indications fo use; or in the presence of adverse consequences which indicate the of should be reduced or discontinued This information has been integrat the standard orientation training an required in-service refresher cours all staff identified above and will be reviewed by the Quality Assurance process to verify that the change h been sustained. Any of the above nursing staff who	ractice. es and sure tion. . On and a action cation to on of s. to efficient es and ne, as to ug essary y drug uding essive nitoring; r its dose t. ed into nd in the ses for e ans

Facility ID: 923382

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		MEDICAID SERVICES					<u>). 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY PLETED
		345373	B. WING				C / 07/2024
	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	03	/0//2024
					30 FODALE AVENUE		
LIBERTY	COMMONS NRSG & REF	HAB CNTR OF SOUTHPORT LLC			OUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 757	Continued From page	2 16	F 7	57			
1 757		5 10		57	will not be allowed to work until training	~	
	revealed 122/58.	ssure recorded at 09:00 PM			will not be allowed to work until training has been completed by 3/25/2024.	J	
	revealed 130/79.			3. Monitoring Procedure to ensure the	nat		
		ssure recorded at 02:00 PM			the plan of correction is effective and t		
	revealed 172/95.				specific deficiency cited remains corre		
	11/13/23 a blood pres	ssure recorded at 06:00 AM			and/or in compliance with regulatory		
	revealed 152/97.				requirements.		
		ssure recorded at 02:00 PM			The Director of Nurses or designee wil	I	
	revealed 139/66.	sure recorded at 02:00 PM			monitor compliance utilizing the F757 Quality Assurance Tool for compliance		
	revealed 167/105.	ssure recorded at 02:00 PM			with the Drug Regimen Review Proces		
		ssure recorded at 02:00 PM			related to clarification of orders as part		
	revealed 152/78.			the Daily Clinical Review Process wee			
	11/22/23 a blood pres			x 3 weeks then monthly x 2 months or			
	revealed 144/72.				until resolved. Reports will be presente	ed	
		ssure recorded at 04:00 PM			to the weekly Quality Assurance committee by the Director of Nurses to		
	revealed 148/78. 11/22/23 a blood pres			ensure corrective action is initiated as)		
	revealed 148/78.				appropriate. Compliance will be monitor	ored	
		ssure recorded at 04:00 PM			and the ongoing auditing program		
	revealed 128/70.				reviewed at the weekly Quality Assura	nce	
	11/27/23 a blood pres	ssure recorded at 06:00 AM			Meeting. The weekly QA Meeting is		
	revealed 147/84.				attended by the Administrator, Director	r of	
		ssure recorded at 04:00 PM			Nursing, MDS Coordinator, Therapy		
	revealed 129/78.	ssure recorded at 09:00 PM			Manager, Health Information Manager and the Dietary Manager.	,	
	revealed 132/86.				and the bletary manager.		
		ssure recorded at 06:00 AM			Date of Compliance: 3/29/24		
	Review of the Medica	ation Administration Record					
		61 dated December 2023					
	revealed Midodrine 1						
	administered to Reside blood pressure readire	dent #61 for the following ngs:					
	revealed 141/76.	ssure recorded at 04:00 PM					
	12/04/23 a blood pres	ssure recorded at 09:00 PM					1

Facility ID: 923382

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 04/05/2024 ORM APPROVED 3 NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345373	B. WING				C 03/07/2024
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP COD)E	
LIBERTY	COMMONS NRSG & REF	AB CNTR OF SOUTHPORT LLC			FODALE AVENUE UTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 757	revealed 141/76. 12/06/23 a blood press revealed 128/98. 12/08/23 a blood press revealed 132/64. 12/08/23 a blood press revealed 130/68. 12/11/23 a blood press revealed 142/60. 12/13/23 a blood press revealed 127/79. 12/13/23 a blood press revealed 127/79. 12/15/23 a blood press revealed 130/70. 12/20/23 a blood press revealed 122/64. 12/20/23 a blood press revealed 122/64. 12/27/23 a blood press revealed 122/64. 12/27/23 a blood press revealed 126/79. Review of the Medicas (MAR) for Resident # revealed Midodrine 11 administered to Resid blood pressure readir 01/01/24 a blood press revealed 167/87. 01/03/24 a blood press revealed 136/72. 01/08/24 a blood press revealed 136/72. 01/08/24 a blood press revealed 136/72.	asure recorded at 06:00 AM asure recorded at 04:00 PM asure recorded at 06:00 AM asure recorded at 04:00 PM asure recorded at 04:00 PM asure recorded at 06:00 AM asure recorded at 09:00 PM asure recorded at 06:00 AM asure recorded at 06:00 AM asure recorded at 06:00 AM asure recorded at 04:00 PM asure recorded at 04:00 PM	F 7	57			

Facility ID: 923382

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	-	ID HUMAN SERVICES MEDICAID SERVICES					NTED: 04/05/2024 FORM APPROVED B NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		DNSTRUCTION) DATE SURVEY COMPLETED
		345373	B. WING _				C 03/07/2024
NAME OF P	ROVIDER OR SUPPLIER	I		STRI	EET ADDRESS, CITY, STATE, ZIP COD	E.	
LIBERTY	COMMONS NRSG & REH	AB CNTR OF SOUTHPORT LLC			FODALE AVENUE JTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 757	revealed 131/74. 01/12/24 a blood pres revealed 140/85. 01/15/24 a blood pres revealed 165/84. 01/15/24 a blood pres revealed 165/84. 01/17/24 a blood pres revealed 165/84. 01/19/24 a blood pres revealed 123/68. 01/24/24 a blood pres revealed 134/73. 01/29/24 a blood pres revealed 148/89. 01/29/24 a blood pres revealed 148/89. 01/29/24 a blood pres revealed 148/89. Review of the Medica (MAR) for Resident # revealed Midodrine 1 administered to Resid blood pressure readir 02/02/24 a blood pres revealed 141/82. 02/02/24 a blood pres revealed 141/77. 02/18/24 a blood pres revealed 140/80. 02/21/24 a blood pres revealed 140/80. 02/21/24 a blood pres revealed 140/80. 02/21/24 a blood pres revealed 146/68. 02/23/24 a blood pres revealed 146/68.	assure recorded at 09:00 PM assure recorded at 04:00 PM assure recorded at 04:00 PM assure recorded at 09:00 PM assure recorded at 09:00 PM assure recorded at 06:00 AM assure recorded at 06:00 AM assure recorded at 06:00 AM assure recorded at 04:00 PM assure recorded at 09:00 PM assure recorded at 09:00 PM ation Administration Record 61 dated February 2024 0 mg was signed as dent #61 for the following	F7	57			

Facility ID: 923382

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345373	B. WING				C 07/2024
NAME OF P	ROVIDER OR SUPPLIER		ł	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NRSG & REF	IAB CNTR OF SOUTHPORT LLC			30 FODALE AVENUE OUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 757	(MAR) for Resident # revealed Midodrine 11 administered to Resid blood pressure readir 03/01/24 a blood press revealed 146/87. The Minimum Data S dated 01/31/24 reveal cognitively intact. She During an interview w 03/06/24 at 2:30 PM s aware of what times of low blood pressure w stated dialysis treatm she didn't feel well mo was not certain if rece wasn't needed had ar During a phone interv PM Medication Aide # provided care to Resi knew Midodrine was pressure. She stated medication if her bloo but couldn't indicate v was held. She stated medicated if it was was given, then she g	tion Administration Record 61 dated March 2024 0 mg was signed as lent #61 for the following ngs: ssure recorded at 4:00 PM et quarterly assessment led Resident #61 was e received Hemodialysis. With Resident #61 on she indicated she was not or dates the medication for as administered to her. She ents took a lot out of her and ost days. She indicated she eiving the Midodrine when it my affect at all on her. With work of the stated she prescribed for low blood she thought she held the d pressure was over 120 what dates the medication she could have held the documented she gave it. a signed that the medication gave the medication in error.	F	757			
	Registered Nurse Su	n 03/07/24 at 09:46 AM the pervisor stated Resident rine should have been					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM A	04/05/2024 APPROVED 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SU COMPLE C	
		345373	B. WING		_		7/2024
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
LIBERTY	COMMONS NRSG & REH	IAB CNTR OF SOUTHPORT LLC		30 FODALE AVENUE SOUTHPORT, NC 2846	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	-	(X5) COMPLETION DATE
F 757	discharge summary of Resident #61 received medication times varia schedule. She stated the order entry followi readmission she belie order and was not the She could not determ order. She stated the been clarified and hol but that was not done During a phone interv PM Medication Aide # provided care to Resi thought she held the r indicated if the medica when it wasn't needed During a phone interv Medication Aide #8 st Resident #61 when he 120 (mm/hg). She ind order was written on t Attempts were made the investigation. Nur- and was on duty durin Midodrine was admin There was no response Attempts were made a investigation. The Me during the dates and the states and the states and the medication Aides #5 a	ranscribed from the hospital n 10/27/23. She stated d dialysis and her ed according to her dialysis although her name was on ng Resident #61's eved she only revised the e staff that entered the order. ine who entered the initial Midodrine should have d parameters put in place iew on 03/07/24 at 12:00 42 stated she routinely dent #61. She stated she medication at times. She ation was administered d then it was done in error. iew on 03/07/24 12:13 PM ated she gave Midodrine to er blood pressure was over licated that was how the he MAR. to contact Nurse #1 during se #1 was an agency nurse ng the dates and times the istered to Resident #61. se.	F 757				

Facility ID: 923382

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		ID HUMAN SERVICES			PRINTED: 04/05/202 FORM APPROVE
TATEMENT C	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		345373	B. WING		C 03/07/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
		HAB CNTR OF SOUTHPORT LLC		630 FODALE AVENUE	
				SOUTHPORT, NC 28461	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 757	Continued From page	e 21	F 75	7	
		ho was on duty during the			
		Aidodrine was administered			
	to Resident #61 was phone number was a	no longer employed and no vailable.			
	During an interview o	n 03/07/24 at 10:18 AM the was made aware of the			
N c g n b	•	norning. She wrote a new			
	order with hold paran	neters for blood pressures			
	greater than 160/90.				
		eeded if Resident #61's elevated. She stated the			
	order should have be				
	parameters accurate	She stated Resident #61			
	-	vhen it wasn't needed would			
	have no significant ef been no change in he	fect on her and there had er condition.			
	During an interview o	n 03/07/24 at 12:24 PM the			
		ated medications were			
	reviewed in their mor				
		t aware that hold parameters			
		the order for Resident #61. was corrected today. She			
		ld have been clarified on			
	readmission and adm				
F 760 SS=E		f Significant Med Errors	F 760		3/29/24
	The facility must ensu				
		nts are free of any significant			
	medication errors.	is not met as evidenced			
		is not met as evidenced			
	by:			The statements made on this plan of	
	by: Based on observatio	n, record review, staff,		The statements made on this plan of correction are not an admission to and	1 do
	by: Based on observatio Nurse Practitioner, ai			-	1 do

Event ID: 34GG11

Facility ID: 923382

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<u>CENTER</u>	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	IO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
						С
		345373	B. WING		0	3/07/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NRSG & RE	HAB CNTR OF SOUTHPORT LLC		630 FODALE AVENUE SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 760	Continued From page	e 22	F 76	0		
	reading was greater to per deciliter). This responses to the per deciliter of the per deciliter. This responses to the per deciliter of	04/24. There was no This occurred for 1 of 3 or medication administration. mitted to the facility on ses including Diabetes		To remain in compliance with a and state regulations the facilit or will take the actions set forth plan of correction. The plan of constitutes the facility's allegat compliance such that all allege deficiencies cited have been of corrected by the dates indicate F760 the facility failed to follow physicians order and provide s insulin at bedtime to a resident #18) when the blood glucose re greater than 200 mg/dl (milligra deciliter). This resulted in the re	y has taken n in this correction ion of d r will be d. the liding scale (Resident eading was ams per esident not	
	#18 had diabetes with The goal of care was diabetes in order to n complications. Interve administer sliding sca The Minimum Data S 02/02/24 revealed Re	/23/23 revealed Resident In the risk for complications. to adequately manage her inimize the risk for entions included in part; to ale insulin as ordered. et annual assessment dated esident #18 was cognitively imited assistance with		receiving a total of 74 units of i 01/12/24 through 03/04/24. 1. A corrective action for the re involved On 3/7/2024 the Director of Nu notified Nurse Practitioner for o order related to the Insulin slidi On 3/7/2024 the Nurse Practiti changed the order to blood sug with sliding scale insulin three	esident rsing clarification ing scale. oner gar checks	
	A physicians order da #18 revealed Novolog per milliliter: Inject as	 e meals for diabetes for gs as follows: 0 units; 2 units; 4 units; 6 units; 8 units; 		 before meals. Nurse practition no significant outcome. 2. Corrective action for residen potential to be affected by the deficient practice. All residents who are receiving scale Insulin are at potential ris affected by deficient practice. Beginning on 3/14/24, the Dire Nursing / support nurses audite current physician orders for slic insulin to ensure no required correlated to schedule dosing of in process was completed on 3/1 	ts with the alleged Sliding sk of being ctor of ed all ding scale arification nsulin. This	

Facility ID: 923382

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM): 04/05/202 / APPROVE). 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION		LETED
		345373	B. WING			C 07/2024
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
				630 FODALE AVENUE		
LIBERTY	COMMONS NRSG & REF	HAB CNTR OF SOUTHPORT LLC		SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 760	Continued From page	a 23	F 76	:0		
1 100		5.20	170		the Divertex of	
	notify the physician.			Beginning on 3/18/2024		
	A progress note data	d 01/11/24 documented by		Nursing will begin educa part time, as needed, Re	-	
		r revealed in part; plan to		Licensed Practical Nurse	-	
		8's blood sugars which have		including agency on the		
		ately. Adding sliding scale		F760 Residents are Free	÷ .	
		s a day in addition to her		Medication error.	ororginnoant	
	Lantus (long-acting in	-		What is a Medicatio	n Error?	
	Lantao (long doting i	iounity.		Types of medication		
	A physicians order da	ated 01/12/24 revealed blood		How to Avoid Medic		
		e meals and at bedtime for		administration. The 6 ri	•	
	•	sliding scale instructions.		Clarification of uncle	ear orders helps	
				prevent Significant Medi	cation Errors.	
		ation Administration Record				
		18 dated January 2024				
	revealed Novolog slic			The DON will ensure that	-	
		led before meals. Novolog		above identified staff wh		
		vas not administered at		complete the in-service t		
		or blood glucose greater than		will not be allowed to wo		
	200 mg/dl for the follo	owing:		training is completed. Th		
	04/40/04 -+ 40:00 DM			be incorporated into the	new employee	
		I the blood glucose reading		facility orientation.		
	was 305 mg/dl no ins	1 the blood glucose reading		4. Monitoring Procedure	to ensure that	
	was 253 mg/dl no ins			the plan of correction is e		
	-	the blood glucose reading		specific deficiency cited		
	was 234 mg/dl no ins			and/or in compliance wit		
	-	the blood glucose reading		requirements.	in regulatory	
	was 259 mg/dl no ins			The Director of Nursing	will monitor	
				completion of ongoing a		
	Review of the Medica	ation Administration Record		weekly for 3 weeks and		
		18 dated February 2024		months or until resolved.	-	
	revealed Novolog slic	-		review of sliding scale in		
		led before meals. Novolog		ensure physician orders		
		/as not administered at		indicated. Any negative		
	-	or blood glucose greater than		immediately be addresse		
	200 mg/dl for the follo			with the facility QA nurse		
	- 0	5		interventions or additiona		
	02/02/24 at 10:42 DM	I the blood glucose reading		Reports will be presente	•	

Facility ID: 923382

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	S FOR MEDICARE &					<u>VO. 0938-039</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY MPLETED
		345373	B. WING		C	C 3/07/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
LIBERTY	COMMONS NRSG & REF	HAB CNTR OF SOUTHPORT LLC		630 FODALE AVENUE SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 760	was 248 mg/dl no ins 02/04/24 at 10:11 PM was 235 mg/dl no ins 02/06/24 at 10:11 PM was 215 mg/dl no ins 02/07/24 at 09:18 PM was 348 mg/dl no ins 02/08/24 at 08:34 PM was 274 mg/dl no ins 02/11/24 at 09:29 PM was 203 mg/dl no ins 02/12/24 at 09:20 PM was 204 mg/dl no ins 02/13/24 at 10:48 PM was 341 mg/dl no ins 02/15/24 at 08:56 PM was 253 mg/dl no ins 02/19/24 at 10:18 PM was 204 mg/dl no ins 02/19/24 at 10:41 PM was 204 mg/dl no ins 02/20/24 at 10:41 PM was 204 mg/dl no ins	ulin administered. I the blood glucose reading ulin administered.	F 76	Quality Assurance committee Administrator to ensure corre- initiated as appropriate. Com- be monitored and ongoing au program reviewed at the wee Assurance Meeting. The wee Assurance Meeting is attende Administrator, Director of Nur Coordinator, Therapy, Health Manager, and the Dietary Ma Completion date: 3/29/2024	ctive action bliance will diting kly Quality kly Quality ed by the sing, MDS Information	
	was 225 mg/dl no ins 02/26/24 at 09:55 PM was 284 mg/dl no ins Review of the Medica (MAR) for Resident # revealed Novolog slic administered as need sliding scale insulin w bedtime as needed fo 200 mg/dl for the follo	ulin administered. I the blood glucose reading ulin administered. Ation Administration Record 18 dated March 2024 ling scale insulin was led before meals. Novolog vas not administered at or blood glucose greater than owing:				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/05/2024 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345373	B. WING			_		C 107/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
LIBERTY	COMMONS NRSG & REH	IAB CNTR OF SOUTHPORT LLC			30 FODALE AVENUE OUTHPORT, NC 2846	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	PM Medication Aide # shift from 7:00 PM thr		F	760				
	checked Resident #18 during her shift, which morning. She stated F orders for sliding scale she only received insu She indicated Resider scale insulin to cover	B's blood sugars two times a were at bedtime and in the Resident #18 did not have e coverage at bedtime and ulin coverage before meals. nt #18 was only given sliding her blood sugars when she prinngs. She stated she was						
	bedtime and indicated electronic medical rec was to be administere she was not clear on administered at bedtin Medication Aide she v	scale insulin was ordered at d there was no space on the cord to document that insulin ed at bedtime. She indicated the order if insulin was to be me. She stated as a would not administer the ort it to the charge nurse						
	nurse would administe Resident #18 was not	insulin was ordered and the er it. She reported that symptomatic at bedtime levels were over 200 mg/dl.						
	PM Medication Aide # shift from 7:00 PM thr provided care to Resid checked blood sugars for Resident #18 whice the morning. She stat have orders for sliding She stated she would readings to the nurse scheduled and the nu	iew on 03/07/24 at 12:00 t2 stated she worked night ough 7:00 AM and routinely dent #18. She stated she is two times during her shift th were at bedtime and in ed Resident #18 did not g scale coverage at bedtime. have reported blood sugar in charge if insulin was rse would administer the was ordered at bedtime.						

Facility ID: 923382

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	-	ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 04/05/2024 FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		3) DATE SURVEY COMPLETED
		345373	B. WING			C 03/07/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	FE, ZIP CODE	
LIBERTY	COMMONS NRSG & REH	HAB CNTR OF SOUTHPORT LLC		630 FODALE AVENUE SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 760	She indicated she wa Resident #18 was sup bedtime. Attempts were made the investigation. Nur and was on duty durin sliding scale insulin w Resident #18. There Attempts were made the investigation. Nur the dates and times th not administered to R no longer employed b response. Attempts were made Medication Aides #3, investigation. The Med during the dates and insulin was not admir There was no respon During an interview o Physician indicated s #18 was not getting s bedtime. She reporte wrote the order for sli bedtime. She stated s prescribe nighttime in risk of hypoglycemia. be any significant out receiving insulin at be best that she didn't ge	to contact Nurse #1 during se #1 was an agency nurse ing the dates and times the vas not administered to was no response. to contact Nurse #2 during se #2 was on duty during he sliding scale insulin was tesident #18. Nurse #2 was by the facility. There was no to contact agency #4, and #5 during the edication Aides were on duty times the sliding scale instered to Resident #18. se. n 03/07/24 at 10:18 AM the he was not aware Resident diding scale coverage at d the Nurse Practitioner	F 760			

Facility ID: 923382

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		ID HUMAN SERVICES MEDICAID SERVICES		FORM APPRO OMB NO. 0938-0			
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		345373	B. WING				07/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
LIBERTY	COMMONS NRSG & REF	IAB CNTR OF SOUTHPORT LLC			30 FODALE AVENUE OUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	insulin order after a fe February 2024, but st the order. She stated #18 wasn't getting slid for the bedtime blood some of the blood sug than 200 mg/dl becau hypoglycemia. She st the order today and o with sliding scale insu- meals. During an interview o Registered Nurse Sug sliding scale was orde 01/11/24, then on 01/ for blood sugar check bedtime and to see sl coverage. She indicat occurred when the or meals and at bedtime for Novolog sliding sc have been discontinu scale four times a day bedtime should have not how it was entere likely the cause of the insulin order not being During an interview o Director of Nursing st reviewed daily in the indicated she was not not being followed for her expectation was f physicians orders and	e the bedtime sliding scale aw weeks which would be in the overlooked discontinuing it was fine that Resident ding scale insulin coverage sugar checks even though gar readings were greater use of the risk of ated she planned to change rder blood sugar checks din three times a day before an 03/07/24 at 11: 15 AM the bervisor stated that Novolog ered before meals on 12/24 an order was entered as before meals and at iding scale instructions for ted what should have der for blood sugars before awas added the entire order ale before meals should ed and Novolog sliding y before meals and at been entered and that was d. She indicated this was a bedtime sliding scale g followed. n 03/07/24 at 12:24 PM the ated medications were morning meetings. She t aware of the insulin order resident #18. She stated	F	760			

Facility ID: 923382

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	-	D HUMAN SERVICES MEDICAID SERVICES	-				APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMP	LETED
		345373	B. WING				RM APPROVED NO. 0938-0391 TE SURVEY MPLETED C 3/07/2024 3/29/24
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NRSG & REH	IAB CNTR OF SOUTHPORT LLC			0 FODALE AVENUE DUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION
F 761 SS=D	Label/Store Drugs an CFR(s): 483.45(g)(h)(§483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the e applicable. §483.45(h) Storage of §483.45(h)(1) In accor Federal laws, the faci biologicals in locked of temperature controls, personnel to have accor §483.45(h)(2) The face locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 and abuse, except when t package drug distribut quantity stored is min be readily detected. This REQUIREMENT by: Based on observation interviews the facility date on two insulin per	d Biologicals (1)(2) of Drugs and Biologicals used in the facility must be with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals rdance with State and lity must store all drugs and compartments under proper and permit only authorized	F 7	761	DEFICIENCY)		
		rved on 1 of 3 medication ation cart) reviewed for			To remain in compliance with all 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		

Event ID: 34GG11

Facility ID: 923382

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						NO. 0938-03
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		NSTRUCTION	· · ·	OATE SURVEY
	345373	B. WING				C 03/07/2024
						03/07/2024
COMMONS NRSG & REI	HAB CNTR OF SOUTHPORT LLC					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL) BE	(X5) COMPLETIO DATE
Continued From page	a 29	E 76	1			
		F 70		oficiancias sited have been ar will b		
	Created to distant 20 days			•		
and oppining.					lon	
Review of the manufa	acturer's instructions for					
Brimonidine eye drop	os revealed to discard 4			· · · ·		
weeks after opening.			0	bserved on 1 of 3 medication carts	(300	
				,		
	os revealed to discard 6			.,		
weeks after opening.						
An abaam atian of the	200 hall madiation cant an)	
					no	
	-			-	-	
	•					
	-				the	
			p	otential to be affected by the allege	d	
opened dates labeled	d on the bottles.		d	eficient practice.		
				-		
-						
					e of	
				,		
•						
	•					
not administered eith	er of the eye drops and had				all	
not checked the bottl	es for opened dates.			•	d	
				-		
					ere	
-	-					
					ns of	
	CORRECTION ROVIDER OR SUPPLIER COMMONS NRSG & REL SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page Review of the manufa Lantus insulin pens r after opening. Review of the manufa Brimonidine eye drop weeks after opening. Review of the manufa Latanoprost eye drop weeks after opening. An observation of the 03/04/24 at 11:30 AM revealed two Lantus medication cart that w dates labeled on the Brimonidine eye drop Latanoprost eye drop opened dates labeled During an interview of Nurse #3 stated she pens were not dated administer one of the resident it was presc stated she was new fu used to procedures. Lantus insulin pen wa failed to check for an administering the ins not administered eith not checked the bottl During an interview of Director of Nursing si drops should be labe	CORRECTION IDENTIFICATION NUMBER: SOUMMANY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 Review of the manufacturer's instructions for Lantus insulin pens revealed to discard 28 days after opening. Review of the manufacturer's instructions for Brimonidine eye drops revealed to discard 6 weeks after opening. An observation of the 300-hall medication cart on 03/04/24 at 11:30 AM along with Nurse #3 revealed two Lantus insulin pens stored on the medication cart that were in use with no opened dates labeled on the insulin pens. A bottle of Brimonidine eye drops and a bottle of Latanoprost eye drops were opened with no opened dates labeled on the bottles. During an interview on 03/04/24 at 11:35 AM Nurse #3 stated she was not aware the insulin pens were not dated and indicated she did administer one of the two insulin pens to the resident it was prescribed for earlier today. She stated she was new to the facility and still getting used to procedures. She acknow	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345373 B. WING	CORRECTION IDENTIFICATION NUMBER: A BUILDING 345373 B. WING COVIDER OR SUPPLIER STREE COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC SOU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 29 F 761 Review of the manufacturer's instructions for Lantus insulin pens revealed to discard 28 days after opening. F Review of the manufacturer's instructions for Brimonidine eye drops revealed to discard 4 S weeks after opening. O An observation of the 300-hall medication cart on 03/04/24 at 11:30 AM along with Nurse #3 revealed two Lantus insulin pens stored on the medication cart that were in use with no opened dates labeled on the insulin pens. A bottle of Brimonidine eye drops and a bottle of Latanoprost eye drops and a bottle of During an interview on 03/04/24 at 11:35 AM Nurse #3 stated she was not aware the insulin pens were not dated and indicated she did administer one of the two insulin pens to the resident it was prescribed for earlier today. She stated she was new to the facility and still getting used to procedures. She acknowledged the Lantus insulin pen was not dated and stated she failed to check for an opened dates. O During an interview on 03/07/24 at 12:24 PM the Director of Nursing stated insulin pens and eye drops should be labeled with opened dates. The prescript the insulin pens and eye drops should be labeled with openened dates.	CORRECTION IDENTIFICATION NUMBER: A BUILDING 345373 B. WING COVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 50 FODALE AVENUE SOUTHPORT, NC 28461 COMMONS NRSG & REHAB CNTR OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTING (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 29 F 761 deficiencies cited have been or will L corrected by the dates indicated F 761 the facility failed to record an opened date on two insulin pens two opened bottles of eye drops that shortned expiration dates. This was observed on 1 of 3 medication carts hall medication cart) reviewed for medication storage A nobservation of the 300-hall medication cart on 03/04/24 at 11:30 AM along with Nurse #3 dates labeled on the insulin pens stored on the medication cart that were in use with no opened dates labeled on the insulin pens stored on the medication cart that were in use with no opened dates labeled on the insulin pens were not dated and indicated she did administering the insulin, pens to the resident it was prescribed for earlier today. She stated she was not aware the insulin pens were not dated and indicated she did administering the insulin. She indicated she had not administering the insulin. She indicated she had and indicated with was prescribed for earlier today. She addeuse addressed at time discovery. On 3/5/2024 the pharmacist audited medication carts to ensure no expire medication carts to ensure no expire medication carts to ensure no expire medication carts to ensure	CORRECTION IDENTIFICATION NUMBER A BUILDING C 345373 b. WING STREET ADDRESS, CITY, STRE, ZIP CODE State TADDRESS, CITY, STRE, ZIP CODE COMIDER OR SUPPLER SUMMARY STREMENT OF DEFICIENCIES RECOMPORTED RECEIVED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION; D PREFIX PERCULATORY OR LSC IDENTIFYING INFORMATION; D Continued From page 29 F 761 deficiencies cited have been or will be corrected by the dates indicated Brimonidine eye drops revealed to discard 28 days after opening. F 761 deficiencies cited have been or will be corrected by the dates indicated Brimonidine eye drops revealed to discard 4 weeks after opening. F 761 deficiencies cited have been or will be corrected by the dates indicated Brimonidine eye drops revealed to discard 4 weeks after opening. F 761 deficiencies cited have been or will be corrected by the dates indicated Brimonidine eye drops revealed to discard 4 weeks after opening. F 761 deficiencies cited have been or will be corrected by the alleged deficient practice: On 3/4/204 Nurse #3 discarded two Latanoprost eye drops revealed to discard 6 weeks after opening. F 761 deficiencies cited have been or will be corrected by the alleged deficient practice: On 3/4/2024 Nurse #3 discarded two Latanoprost eye drops mere opened with no opened dates labeled on the insulin pens at bottle of Latanoprost eye drops. C. Or 3/2/2024 Hu pharmacist audited all medication carts to ensure that all eyeu deficient practice.

Facility ID: 923382

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 04/05/2024 RM APPROVED NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		ATE SURVEY MPLETED
		345373	B. WING				C 03/07/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NRSG & REH	HAB CNTR OF SOUTHPORT LLC			80 FODALE AVENUE OUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	Continued From page insulin. She stated ec	e 30 ducation would be provided.	F	761	 Measures /Systemic changes to prevent reoccurrence of alleged defici- practice: On 3/18/2024 the Director of Nurses a Register Nurse Manager began educa of all Full Time, Part Time, as needed nurses, medication aides and agency nurses on facility policy related to medication safety that included safely securing and storing medications, labo of the date on opened insulin pens an checking expiration dates on medicati to assure no expired medications are administered. This information has been integrated if the standard orientation training and if required in-service refresher courses all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above nursing staff who do not receive scheduled in-service trainin will not be allowed to work until trainin has been completed by 3/25/2024. The monitoring procedure to ensure that the plan of correction is effective that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Quality assurance audits will be completed by the Director of Nurses of designee for F761 Adequate Label/St Drugs and Biologicals to assess that a medications are safely and appropriat stored, that all medications are dated labeled when opened. Audits will be completed weekly x 3 and monthly x 2 until resolved for compliance with this 	and ation eling d ons into n the for es ing g e and he or ore all rely and 2 or	

Event ID: 34GG11

Facility ID: 923382

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMF	D. 0938-039 SURVEY PLETED
		345373	B. WING _			C / 07/2024	
	ROVIDER OR SUPPLIER	HAB CNTR OF SOUTHPORT LLC		63	REET ADDRESS, CITY, STATE, ZIP CODE 0 FODALE AVENUE DUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	monitoring. A facility must establis policies and procedur collections systems, a adverse event monito procedures must inclu following: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representativ information will be us	ent Activities (e)(g)(2)(i)(ii) feedback, data systems and sh and implement written res for feedback, data and monitoring, including bring. The policies and ude, at a minimum, the maintenance of effective d use of feedback and input other staff, residents, and ves, including how such ed to identify problems that ume, or problem-prone, and	F 7		process. 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 t weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director Nursing, Activity Director, Dietary Manager, Therapy Manager, Minimum Data Set Coordinator, Health Information Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 3/29/24	he e of	3/29/24

Facility ID: 923382

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				PRINTED: FORM A OMB NO. (PPROVED
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SU COMPLE ⁻	
		345373	B. WING		_	03/07	/2024
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
LIBERTY	COMMONS NRSG & REH	AB CNTR OF SOUTHPORT LLC		30 FODALE AVENUE OUTHPORT, NC 2846	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	- 1	(X5) COMPLETION DATE
F 867	systems to identify, cc information from all de not limited to the facilit §483.70(e) and include will be used to develop indicators. §483.75(c)(3) Facility and evaluation of perf including the methodo development, monitor §483.75(c)(4) Facility including the methods systematically identify analyze and use data adverse events in the facility will use the dat prevent adverse events \$483.75(d) Program s systemic action. §483.75(d)(1) The fac aimed at performance implementing those a and track performance implement policies ad (i) How they will use a determine underlying impacting larger syste (ii) How they will deve will be designed to eff	maintenance of effective pllect, and use data and epartments, including but ty assessment required at ling how such information p and monitor performance development, monitoring, formance indicators, plogy and frequency for such ing, and evaluation. adverse event monitoring, by which the facility will r, report, track, investigate, and information relating to facility, including how the ta to develop activities to ts. systematic analysis and fility must take actions e improvement and, after ctions, measure its success, e to ensure that lized and sustained. fility will develop and dressing: a systematic approach to causes of problems	F 867				

Facility ID: 923382

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						FORM APPROVED //B NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED C
	NO.PLANOF CORRECTION IDENTIFICATION NUMBER: A BUILDING 345373 B. WING STREETADDRESS, CITY, STATE, 2IP CODE SOF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: STREETADDRESS, CITY, STATE, 2IP CODE SOF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: STREETADDRESS, CITY, STATE, 2IP CODE SOF CORRECTION OF SOUTHPORT LLC PROVIDER OR SUPPLIER IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: OPALIA OF CORRECTION STOTES PREFIX REGULTION OF SOUTHPORT LLC PREFIX REGULTION OF CORRECTION STOLES PREFIX REGULTION OF SOUTHPORT LLC PREFIX REGULTION OF SOUTHPORT NO. PREFIX REGULTION OF SOUTHPORT NO. PREFIX REGULTION OF SOUTHPORT LLC PREFIX PREFIX REGULTION OF CORRECTION STOLES PREFIX </td <td></td> <td>03/07/2024</td>		03/07/2024			
		AB CNTR OF SOUTHPORT LLC		630 FODALE AVENUE		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
F 867	safety problems; and (iii) How the facility wi of its performance im- ensure that improvem §483.75(e) Program a §483.75(e)(1) The fac performance improve high-risk, high-volume consider the incidenc of problems in those a outcomes, resident sa resident choice, and o §483.75(e)(2) Perform activities must track m resident events, analy implement preventive that include feedback facility. §483.75(e)(3) As part improvement activitie distinct performance in number and frequence conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project tha problem-prone areas collection and analysi (c) and (d) of this sec	ill monitor the effectiveness provement activities to hents are sustained. activities. cility must set priorities for its ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. nance improvement nedical errors and adverse yze their causes, and actions and mechanisms and learning throughout the cof their performance s, the facility must conduct improvement projects. The ey of improvement projects lity must reflect the scope facility's services and as reflected in the facility at §483.70(e). must include at least t focuses on high risk or identified through the data is described in paragraphs	F 8	67		

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		ND HUMAN SERVICES MEDICAID SERVICES				RM APPROVE 10. 0938-039
TATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345373	B. WING			C 3/07/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		3/07/2024
	NOVIDER OR SOLT EIER					
LIBERTY	COMMONS NRSG & RE	HAB CNTR OF SOUTHPORT LLC		630 FODALE AVENUE SOUTHPORT, NC 28461		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLETION
F 867	Continued From pag	10.34	F 86	27		
1 007			FOC			
		uality assessment and				
		e reports to the facility's				
		lesignated person(s)				
		erning body regarding its				
		mplementation of the QAPI				
		der paragraphs (a) through				
	(e) of this section. T	ne committee must:				
	(ii) Develop and imp	lement appropriate plans of				
	action to correct ider	ntified quality deficiencies;				
	(iii) Regularly review	and analyze data, including				
	data collected under	the QAPI program and data				
		egimen reviews, and act on				
	available data to ma	ke improvements.				
	This REQUIREMEN	T is not met as evidenced				
	by:					
		ons, record review and staff		The statements made on the		
		/'s Quality Assurance and		correction are not an admis		
		vement (QAPI) committee		not constitute an agreement	t with the	
		plemented procedures and		alleged deficiencies.		
		tions that the committee put		· · · · ·		
		the recertification and		To remain in compliance wit		
		7/30/21 and the recertification		and state regulations the fac	-	
		y of 11/21/22. This was for vas originally cited in July		or will take the actions set for		
	-	significant medication errors		plan of correction. The plan constitutes the facility's alle		
		cies originally cited in		compliance such that all alle		
		medication storage and		deficiencies cited have beer	-	
		ations. These deficiencies		corrected by the dates indic		
		ecited on the current				
		of 03/07/24. The continued		F867		
		ederal surveys of record				
	-	ne facility's inability to sustain		1. Corrective action for re-	sident(s)	
	an effective Quality			affected by the alleged defic	· · ·	
				The Quality Assurance and	Performance	
	Findings included:			Improvement (QAPI) comm	ittee failed to	
				maintain implemented proce	edures and	
	This tag is cross refe	erenced to:		monitor the interventions the	at the	
				committee put into place fol	lowing the	
RM CMS-256	7(02-99) Previous Versions Ot	osolete Event ID: 34GG	11	Facility ID: 923382	If continuation sh	oot Page 35 of

	S FOR MEDICARE &				OMB NO.	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SI COMPLE	
		345373	B. WING		C	/2024
AME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/07	/2024
		AB CNTR OF SOUTHPORT LLC		330 FODALE AVENUE SOUTHPORT, NC 28461		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 867	Continued From page	e 35	F 867			
	F757: Based on obse staff, and Physician in clarify a medication of hypotension (low block parameters if the syst greater than 120 mm/ This resulted in a resi receiving 59 additional There was no signific the medication. This of reviewed for medication During the recertificat 11/21/22 the facility a a resident that was no An interview was con Administrator on 03/0 Administrator stated s needed to be more for	ervations, record review, neterviews the facility failed to rder prescribed for od pressure) to include hold tolic blood pressure was (hg (millimeters of mercury). ident (Resident #61) al doses of the medication. ant outcome from receiving occurred for 1 of 3 residents on administration. tion and complaint survey of dministered a medication to ot medically justified. ducted with the 17/24 at 3:30 PM. The she believed the QA process ocused on clarifying orders dications daily for accuracy		recertification and complaint survey 7/30/21 and the recertification and complaint survey of 11/21/22. This is one deficiency that was originally ci July 2021 in the area of significant medication errors and for two defici originally cited in November 2022 for medication storage and unnecessal medications. These deficiencies we subsequently recited on the current recertification survey of 03/07/24. T continued failure during three federa surveys of record shows a pattern of facility's inability to sustain an effect Quality Assurance Program. 2. Corrective action for residents of the potential to be affected by the a deficient practice: Corrective action has been taken for identified concerns in the areas of: Label/Store Drugs and Biologicals.	was for ted in encies or ry re he al of the tive with lleged	
	F760: Based on obse Nurse Practitioner, ar facility failed to follow provide sliding scale i resident (Resident #1 reading was greater t per deciliter). This res receiving a total of 74 01/12/24 through 03/0 significant outcome. T residents reviewed fo During the recertificat 07/30/21, the facility f	ervation, record review, staff, and Physician interviews the the physicians order and insulin at bedtime to a 8) when the blood glucose han 200 mg/dl (milligrams sulted in the resident not units of insulin from 04/24. There was no This occurred for 1 of 3 r medication administration.		Corrective action has been taken for identified concerns in the area of: F Residents free of Significant medica errors. Corrective action has been taken for identified concerns in the area of: F Drug regimen free from unnecessar drugs. Corrective action has been taken for identified concerns in the areas of: I The Quality Assurance Performance Improvement (QAPI) committee hel meeting on March 19, 2024 to revie deficiencies from the recertification	760 ation r the 757 Y r the F867 e d a w the	

Facility ID: 923382

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DEPARTI CENTER	FOF	PRINTED: 04/05/2024 FORM APPROVED OMB NO. 0938-0391					
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345373		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAT	(X3) DATE SURVEY COMPLETED	
		B. WING		C 03/07/2024			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODI			
				630 FODALE AVENUE SOUTHPORT, NC 28461			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
F 867	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 36 An interview was conducted with the Administrator on 03/07/24 at 3:30 PM. The Administrator stated she believed the QA process needed to be more focused on clarifying orders and reviewing all medications daily for accuracy and following the parameters. F761: Based on observations, record review, and staff interviews the facility failed to record an opened date on two insulin pens and on two opened bottles of eye drops that had shortened expiration dates. This was observed on 1 of 3 medication carts (300 hall medication cart) reviewed for medication storage. During a recertification and complaint survey of 11/21/22 the facility failed to: accurately label and record an opened date on a bottle of tuberculin solution and a bottle of Influenza vaccine; accurately record an opened date on a bottle of eye drops and insulin pens; dispose of expired bottles of nitroglycerin, insulin pens, and bottle of nasal spray; lock and secure a medication cart in an unattended resident care area; and to securely store medication on a medication cart. An interview was conducted with the Administrator revealed the facility including the pharmacist and the Director Nursing believed that the problems with medication storage were		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR		clinical ility Assurance functioning te purpose entifying deficiencies. es to prevent ent practice: tor e QAPI e ses, or, Therapy Manager, the QAPI f the ng any recting ted in the ion for the		
	related to the inconsi and 500 halls. The A	stency of the staff on the 300 dministrator stated two new be consistent floor nurses		This will be reviewed by the Q Assurance process to verify th change has been sustained. Any staff who does not receive in-service training will not be a work until training has been co 3/25/2024.	nat the e scheduled allowed to		

Event ID: 34GG11

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				PRINTED: 04/05/2024 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345373	B. WING		C 03/07/2024	
NAME OF PROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP CODE		
			630 FODALE AVENUE		
LIBERTY COMMONS NRSG & REI	HAB CNTR OF SOUTHPORT LLC		SOUTHPORT, NC 28461		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 867 Continued From page	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		 4. Monitoring Procedure to ensit the plan of correction is effective specific deficiency cited remains of and/or in compliance with regulat requirements. The Administrator or designee will compliance utilizing the F867 Quat Assurance Tool weekly x 4 weeks monthly x 6 months. The tool will facility identified concerns that ne addressed by the QA Committee. Reports will be presented to the w Quality Assurance committee by the Director of Nurses to ensure corre- action is initiated as appropriate. Compliance will be monitored and ongoing auditing program reviews weekly Quality Assurance Meetin indefinitely or until no longer deer necessary for compliance with the laundry process. The weekly QA is attended by the Administrator, of Nursing, MDS Coordinator, The Manager, Health Information Mar and the Dietary Manager. Date of Compliance: 3/29/24 	and that corrected ory II monitor ality s then monitor ed to be veekly the ective d the ed at the g, med e missing Meeting Director erapy	

Facility ID: 923382

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