PRINTED: 08/22/2024 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		
		345207	B. WING	B. WING		C 07/26/2024	
	ROVIDER OR SUPPLIER	COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP CODE  1402 PINCKNEY STREET  WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
E 000	Initial Comments		E 00	00			
F 000	investigation survey withrough 7/26/2024. T	ertification and complaint was conducted 7/21/2024 ne facility was found in equirement CFR. 483.73.	F 00	00			
		complaint investigation d from 07/21/2024 through 0 # 4BTK11					
	The following intakes NC00218912, NC002 Intake NC00216407 in jeopardy.  1 of the 5 complaint a deficiency.	1819, and NC00216407. resulted in immediate					
	Immediate Jeopardy	was identified at:					
	(K)	680 at a scope and severity					
	The tag F684 constitu Care.	ited Substandard Quality of					
	was removed on 07/2 An extended survey v	vas conducted.					
F 580 SS=K	Notify of Changes (In CFR(s): 483.10(g)(14	jury/Decline/Room, etc.) )(i)-(iv)(15)	F 58	30		7/27/24	
	consult with the resid	ediately inform the resident; ent's physician; and notify,					
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

Electronically Signed 08/17/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345207	B. WING _			C 07/26/2024	
	ROVIDER OR SUPPLIER  COMMONS N&R CTR O	F COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP COL 1402 PINCKNEY STREET WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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 E APPROPRIATE	(X5) COMPLETION DATE	
F 580	representative(s) who (A) An accident involongesults in injury and high physician intervention (B) A significant charmental, or psychosod deterioration in health status in either life-th clinical complications (C) A need to alter trained to discontinuate treatment due to advocommence a new for (D) A decision to trainesident from the fact §483.15(c)(1)(ii). (ii) When making not (14)(i) of this sectionall pertinent informatics available and proviphysician. (iii) The facility must resident and the	ther authority, the resident en there is- ving the resident which has the potential for requiring h; age in the resident's physical, bial status (that is, a h, mental, or psychosocial reatening conditions or eatment significantly (that is, a en existing form of erse consequences, or to m of treatment); or esfer or discharge the elity as specified in effication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ended upon request to the elaso promptly notify the dent representative, if any, an or roommate assignment entitle(e)(6); or ent rights under Federal or ons as specified in paragraph in the record and periodically mailing and email) and	F 5	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
in its admission agreement on, including the various on the composite distinct the policies that apply to in its different locations is not met as evidenced on an its different locations is not met as evidenced on an its different locations is not met as evidenced on an its different locations is not met as evidenced on an its different locations is not met as evidenced on an its different location on the physician when its clostridium Difficile (C. persistent loose, watery, tool. From 2/9/24 through on the sea abnormal was notified on 2/13/24 of out was not made aware of 2/27/24 when it was attention by the resident's discharge from the facility of the member directly to her on's office where she was and the lab test was positive 2024. This deficient ent #86 at risk for one from C. difficile such as a kdown, and death. The one from C. difficile such as a insulin outside the ter insulin. This deficient residents reviewed for #86 and #59).	F 58	This Plan of Correction is submitted required under State and/or Federal The submission of this Plan of Corrections and the facility or community as to accuracy of the surveyors findings conclusions drawn therefrom.  Submission of this Plan of Correction does not constitute an admission that findings constitute an admission that findings constitute a deficiency or the scope and severity regarding the deficiency cited are correctly applied changes to the facility sor community policies and procedures should be considered subsequent remedial measures as that concept is employed Rule 407 of the Federal Rules of Evidence, corresponding state rules civil procedure and should be inadmissible in any proceeding on the basis. The facility / community submit that it be inadmissible by any third part any civil or criminal action against the facility / community or any employee, agent, officer, director, attorney, or shareholder of the facility / community affiliated entities.  F580: the facility failed to notify the	law.  ction the the or the also t the at the dithe at the dithe at the any dity is ed in at	
	IDENTIFICATION NUMBER:	A. BUILDING  345207  B. WING  COLUMBUS CTY  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)  2 in its admission agreement on, including the various at the composite distinct the policies that apply to n its different locations  is not met as evidenced  aw and interviews with staff, and Physician Assistant to notify the physician when f Clostridium Difficile (C. persistent loose, watery, tool. From 2/9/24 through was notified on 2/13/24 of ut was not made aware of 12/27/24 when it was attention by the resident's discharge from the facility dent was immediately member directly to her n's office where she was and the lab test was positive 2024. This deficient ent #86 at risk for ons from C. difficile such as kdown, and death. The otify the physician when a insulin outside the ter insulin. This deficient residents reviewed for #86 and #59).  egan on 2/15/2024 when notified that Resident #86 a multiple loose and watery B hours. Immediate	A BUILDING  345207  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  1402 PINCKNEY STREET  WHITEVILLE, NC 28472  ID PREFIX TAG CROSS-REFERENCED TO THE APPROPI  DEFICIENCY)  2 In its admission agreement on, including the various the composite distinct the policies that apply to in its different locations is not met as evidenced ever and interviews with staff, and Physician Assistant to notify the physician when Clostridium Difficile (C. Dersistent loose, watery, tool. From 2/9/24 through generienced these abnormal was notified on 2/13/24 of ut was not made aware of 12/27/24 when it was attention by the resident's discharge from the facility dent was immediately or member directly to her n's office where she was attention by the resident's end the lab test was positive 2024. This deficient ent #86 at risk for member directly to her n's office where she was kdown, and death. The biffy the physician when a insulin outside the ter insulin. This deficient residents reviewed for #86 and #59).  egan on 2/15/2024 when notified that Resident #86 en watery is hours. Immediate  345207  SURING  STREET ADDRESS, CITY, STATE, ZIP CODE  1402 PINCKNEY STREET  WHITEVILLE, NC 28472  ID PREFIX TAG  F 580  F 580  This Plan of Correction is submitted required under State and/or Federal II The submission of this Plan of Correction does not constitute an admission on part of the facility or community as to accuracy of the surveyors inclings to conclusions drawn thereform. Submission of this Plan of Correction does not constitute an admission tha findings constitute an admission tha findings constitute and enties or considered subsequent remedial measures as that concept is employed the deficiency cited are correctly applied changes to the facility? Formunity policies and procedure and should be inadmissible in any proceeding on the basis. The facility / community submit is Plan of Correction with the intent that it be inadmissible to any third part of correction with the intent that it be inadmissible to any third part of the facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345207	B. WING _			1	26/2024
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				1	402 PINCKNEY STREET		
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY			VHITEVILLE, NC 28472		
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F 580	Continued From page		F s	580		by	
	facility implemented a Immediate Jeopardy	removal. The facility			included persistent loose, watery, mus and odorous stool. From 2/9/24 throug	h	
	severity of "E" (no ha	iance at a lesser scope and rm with the potential for			2/27/24 the resident experienced these abnormal stools.	<del>)</del>	
		arm that is not Immediate			1.Address how corrective action will be		
		education was completed			accomplished for those residents found	d to	
		ms put in place are effective. ed at scope and severity "D".			have been affected by the deficient practice.		
	Findings included:	ou at ecope and ecotomy 2.			Resident #86 was discharged to home 02/28/2024 and is no longer a resident	of	
	, o				the facility. No further corrective action		
		the following : C. difficile is			could be completed specific to Resider	nt	
		acteria that causes diarrhea			#86		
	and inflammation of the				2 Address how the facility will identif	5.	
		otoms include 3 or more foul s a day lasting longer than 1			<ol><li>Address how the facility will identife other residents having the potential to</li></ol>	-	
	day, and abdominal o				affected by the same deficient practice		
	complications include	· -			All residents are at risk for harm related		
		olon. One in 11 people over			the deficient practice requiring a		
		th a healthcare-associated			comprehensive assessment for signs a	and	
	C. diff infection die wi	thin one month.			symptoms of C. difficile (Clostridium		
	The facility's Physicia	in's Standing Orders			difficile). Signs and symptoms for C. difficile include: watery diarrhea, fever		
		a means for physician or			loss of appetite, nausea, malodorous s		
		rovider to legally convey to a			and abdominal pain/tenderness.		
	nurse, the ability to p	rovide routine medical			On 07/25/2024 the Director of Nursing		
		ident based on subjective			met with all direct care nurses who we		
	, ,	s) revealed the following:			working to initiate an assessment of 10	00%	
		e (antidiarrheal medication) ers) after each diarrhea			of current residents. Beginning on 07/25/2024, the Registered Nurse		
		ction before giving. Notify			Managers and Licensed Practical Supp	oort	
		vement after 8 hours or in			Nurses completed an audit of all		
	the morning if stable.				residents. This audit consisted of an		
					assessment of each resident for the		
		mitted to the facility on			following signs and symptoms: watery		
	02/08/2024.				diarrhea, fever, loss of appetite, nause	a,	
	The medical record in	ndicated Resident #86 was			malodorous stool and abdominal pain/tenderness in the last 7 days.		
	80 years old in Febru				Included in this assessment was a revi	ew	

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NAME OF P	ROVIDER OR SUPPLIER	•	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	<u> </u>	┪	
				1402 PINCKNEY STREET			
LIBERTY	COMMONS N&R CTF	OF COLUMBUS CTY		WHITEVILLE, NC 28472			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION (X5)	ヿ	
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE DATE	1	
F 580	Continued From p	age 4	F 5	580			
	·			of each resident⊡s bowel r	movement		
	Resident #86's bo	wel movement documentation		documentation for the last			
	and medication ac	Iministration record (MAR)		identify symptoms of water			
	revealed the follow	` ,		resident had 3 or more loo			
				stools in 24 hours the MD/	NP/PA will be		
	- 2/9/2024 Nurse /	Aide (NA) #9 documented 1		notified for evaluation of C	. difficile.		
		nd watery stool at 1:49 PM and		If any residents were ident	-		
		nd watery stool at 5:40 PM. No		signs and symptoms of C.			
		ocumented as given for loose		medical record was review	-		
	stools per the MAI	₹.		the MD/NP/PA had been no			
	0/40/0004 NA //0			MD/NP/PA had not been no			
		documented 1 large and		nurse would then make the	e notification to		
		ol at 1:16 PM, 1 large loose it 4:16 PM, and NA #11		the MD/NP/PA. This audit was completed of	on 07/25/2024		
		arge loose and watery stool at		The audit identified that 2			
		dication was documented as		had signs or symptoms of			
	given for loose sto			which are: watery diarrhea			
		•		appetite, nausea, malodoro			
	- 2/11/2024 NA #1	2 documented 1 large loose		abdominal pain/tenderness			
	and mushy stool a	it 12:26 PM, 1 large loose and		07/25/2024, a corrective ad			
	watery stool at 3:1	8 PM, and NA #11 documented		completed for 2 of 80 resid	lents identified		
	1 medium loose a	nd watery stool at 11:39 PM.		as having signs and sympt	oms of C.		
		s documented as given for		difficile when the provider v			
	loose stools per th	ie MAR.		the change in condition an			
	0/40/0004 NIA //4			change in condition were o	carried out by		
		2 documented 1 medium loose		the direct care staff.			
		at 11:30 AM and NA #13					
		all and putty like stool at 7:57 on was documented as given for		2. Address what measur	oo will be put		
	loose stools per th	<del>-</del>		Address what measure into place or systemic char			
	10030 310013 pci ti	ic mar.		ensure that the deficient pr	_		
	A nurse's note wri	tten by Minimum Data Set		recur.			
		or Resident #86 revealed the					
	` '	onversation text messages		On 07/25/2024 the Directo	r of Nursing		
	_	age from the nurse to the		and the Registered Nurse	_		
		ved and uploaded to the		began in servicing all licen	_		
	progress notes in	the electronic medical record)		Registered Nurses (RN) ar			
	from MDS Nurse #	#2 to the Medical Director on		Practical Nurses (LPN) and		- 1	
	2/13/2024 at 11:44	4 AM which read in part,		nursing assistants (CNA) (	full time, part		

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X4) PROVIDER (X4) PROVIDER (X5) PROVIDER (X6) PROVIDER (X6) PROVIDER (X7) PROVID							
			A. BUILDI	NG _		Ι,	_	
		345207	B. WING				C 26/2024	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-	
				14	402 PINCKNEY STREET			
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY		W	/HITEVILLE, NC 28472			
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F 580	0 Continued From page 5 F 580							
		arrhea since admitting and			time, and prn including agency) on sigr	าร		
		ame of medication-bismuth			and symptoms of C. difficile including	.0		
	_	diarrheal medication] on			watery diarrhea, fever, loss of appetite,			
		n order for loperamide			nausea, abdominal pain/tenderness. Ti			
	[antidiarrheal medica	•			above staff were educated on the			
	Thanks." The Medica	l Director responded back			importance of documenting bowel			
	on 2/13/2024 at 11:46	6 AM with an order for			movements including consistency of			
		oride (HCL) 2 milligrams			bowel movements accurately. In addition			
	, ,,	ay as needed for diarrhea.			the CNA□s were educated to report an			
		rs for Resident # 86 revealed			changes in condition including diarrhea	to		
		de hydrochloride (HCL) 2mg			the nurse when noted.			
	-	by mouth three times a day			RN□s and LPN□s were additionally			
	2/13/2024.	iarrhea was ordered on			educated on if a resident has 3 or more			
	2/13/2024.				loose watery stools in 24 hours then no the MD for evaluation of C. difficile, init	-		
	An interview with MD	S Nurse #2 was completed			Enteric Contact Isolation when C. diffic			
		AM. MDS Nurse #2 stated			is known or suspected, when to report			
		call Resident #86 or why she			changes in condition, completing an			
		ent the text message to the			assessment, and notifying the MD/NP/	PA		
		2/13/2024 regarding her			when interventions are not effective.			
	diarrhea. MDS #2 sta	ited that the nurse working			The DON will ensure that all licensed			
	that hall must have to	old her about the diarrhea			nurses, RN□s, LPN□s, and CNA□s (fu	H		
	and that the facility w	as out of the medication			time, part time, and prn including agen	cy)		
	bismuth subsalicylate				who do not complete the in-service			
		Orders. MDS Nurse #2			training by 07/26/2024 will not be allow	ed		
		nt was having diarrhea and			to work until the training is completed.			
		n and it was ineffective, the			This in-service was incorporated into the	e l		
		assessed them for signs and			new employee facility and agency			
		ile. She further stated that none of the staff members			orientation for all licensed nurses and	ort		
	•	nt #86's stools had a foul			certified nursing assistants (full time, patime, and prn including agency.)	ai t		
	T	ould have been a sign that			ano, and printinduality agency.)	ĺ		
	she might have a C.				3. Indicate how the facility plans to	ſ		
	•	ficile was left untreated it			monitor its performance to make sure t	hat		
		eakdown and dehydration.			solutions are sustained.			
		<b>,</b>			The Administrator and/or Director of	ſ		
	On 2/13/2024 NA #13	3 documented 1 large and			Nursing will monitor tag F580 for Chan	ge		
		ol at 6:10 AM, 1 large loose			in condition related to C. Difficile and	-		
	and watery stool 10:5				Notification to medical provider weekly	for		

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TO WILL OF T	TO VIDER OR GOLF ELER			1402 PINCKNEY STREET	,,,,			
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F 580	Continued From pag	e 6	F 5	580				
F 580	documented 1 large 6:44 PM. Loperamid administered by Nurs documented as having A telephone interview #8 on 7/25/2024 at 8 Resident #86's name was not able to recal She indicated if she at HCL to Resident #86's hen the NA or the resident having of the resident having of Resident #86's bowe and MAR revealed the resident having of the resident #86's bowe and watery stool at 1 and watery stool at 1 and watery stool 5:26 documented 1 small 11:34 PM. No medic given for loose stools - 2/15/2024 NA #10 of formed/normal stool loose and mushy stomedication was docustools per the MAR.  On 2/16/24 Nurse #9 physician's order for subsalicylate oral surmg/15 ml; give 15 ml for diarrhea. Give 15 Check for impaction	loose and watery stool at le HCL oral tablet 2 mg was se #8 at 8:07 PM and it was ing been effective.  It was completed with Nurse it 21 AM. Nurse #8 stated it sounded familiar, but she it any information about her. administered loperamide it on 2/13/2024 at 8:07 PM., it is ident must have reported liarrhea to her.  If movement documentation in following:  If documented 1 large loose 1:04 AM, 1 medium loose it is identified as and watery stool at eation was documented as	F 5	4 weeks and monthly for 3 resolved. Reports will be the weekly Quality Assurance by the Administrator to ensuraction initiated as appropriated Compliance will be monitored ongoing auditing program reweekly Quality Assurance Materials weekly QA Meeting is attented Administrator, Director of Niccoordinator, Therapy, Health Manager, and the Dietary Diete of Compliance:	presented to ce committed ure correctivente. ed and eviewed at the Meeting. The ded by the ursing, MDS th Information	ee ve the		

Facility ID: 923086

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 580	On 2/16/24 the bow MAR indicated NA iloose and mushy st loose and mushy st documented 1 med 11:58 AM. Bismuth administered by Nu documented as effect Nurse #9 was unabsurvey.  Resident #86's bow and MAR revealed  - 2/17/24 the bowel MAR indicated NA iloose and mushy st documented 1 large PM. No medication loose stools per the - 2/18/2024 NA #15 stool at 2:53 PM, 1 stool at 12:14 PM, a large loose and wat medication was documented 1 large loose and wat medication was documented 1 large large and formed/no Bismuth subsalicyla administered by Nu documented as effect A telephone interviews	well movement record and the #13 documented 1 medium fool at 3:26 AM, 1 medium fool at 3:26 AM, 1 medium fool at 3:58 PM, and NA #9 ium loose and mushy stool at a subsalicylate prn 15 ml was firse #9 at 5:05 PM and was fective.  Well movement documentation the following:  movement record and the #13 documented 1 medium fool at 4:44 AM and NA #10 formed/normal stool at 5:15 in was documented as given for the MAR.  Well documented 1 small putty like formedium loose and watery for and NA #9 documented 1 formal stool at 3:19 PM. No focumented as given for loose fool of the MAR is a fool of the MAR in the medium loose and watery for loose fool of the MAR is a fool of the MAR in the medium loose and watery fool at 3:19 PM. No focumented as given for loose fool of the MAR is a fool of the MAR in the medium loose and mushy stool and 1 formal stool at 11:33 AM. The medium stool at 11:33 AM. The medium stool at 9:14 PM and was	F 580			

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F 580	anything about her. Now was just not familiar with the was having physician was notified. Resident #86's bowe and MAR revealed the substituting of the waste of t	sident #86's name or recall lurse #10 explained that she with Resident #86 and didn't ing diarrhea or not or if the d.  I movement documentation is following:  M NA #13 documented 1 ing stool, at 11:44 AM NA #1 is oose and watery stool, at umented 1 large loose and in:14 PM NA #13 is loose and mushy stool. ing tablet prn was is e #10 at 5:09 AM and was itive; bismuth subsalicylate istered by Nurse #11 at 8:47 inted as effective; and ig tablet prn was is e #11 at 1:48 PM and was itive.  Indicate the proof of	F 58	0			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345207	B. WING		C 07/26/2024	
	ROVIDER OR SUPPLIER	F COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP CODE  1402 PINCKNEY STREET  WHITEVILLE, NC 28472	0112012024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
F 580	she worked at the fact had not worked in at indicated that she wa about Resident #86 a was having diarrhead medication.  Resident #86's bowel and MAR revealed the - 2/23/2024 NA #13 downward and mushy stool at 12:03 1 large loose and mu medication was docu stools per the MAR.  - 2/24/2024 NA #9 downward at 10:48 documented 1 large I 9:53 PM. Loperamid administered by Nursidocumented as effect A telephone interview #14 on 7/25/2024 at 3 that she worked at the could not remember a #86.  Resident #86's bowel and MAR revealed the - 2/25/2024 NA #9 downward and mushy stool at 2 documented 1 large I	1:28 PM. Nurse #13 stated bility prn (as needed) and least 3-4 months. Nurse #13 is unable to recall anything and did not remember if she for was taking antidiarrheal.  I movement documentation is following:  I movemented 1 medium loose 2:08 AM, 1 large loose and PM, and NA #9 documented shy stool at 4:57 PM. No mented as given for loose and AM and NA #19 oose and watery stool at it is 2 mg tablet prn was it is 2.00 PM and was tive.  I was completed with Nurse 3:00 PM. Nurse #14 stated is facility as needed, and she anything about Resident in movement documentation is following:	F 58			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345207	B. WING _			C <b>07/26/2024</b>
	ROVIDER OR SUPPLIER	F COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP CODE  1402 PINCKNEY STREET  WHITEVILLE, NC 28472	'	01120/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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) COMPLETION DATE
F 580	Continued From pag	e 10	F 5	80		
	watery stool at 10:37 and mushy stool at 8 loperamide 2mg tabl the Staff Developme one dose at 8:37 AM effective and the dose effectiveness was do - 2/27/2024 NA #13 of formed/normal stool documented 1 large 11:05 AM and 1 large 9:18 PM. Two doses prn were administere Coordinator (SDC) NPM and they were do A nurse's note for Refollowing secure con Nurse #15 to the Me 2/27/2024 at 3:33 PM "Daughter is concern lot of loose BMs [bow through her chart and watery stools but als we have an order to daughter also wants causing it if it were not medications are the Please advise. The Mack to Nurse #15 of the following message do a C. diff." Nurse # would inform the dau.	documented 1 medium at 1:32 AM. NA #1 loose and watery stool at a loose and mushy stool at a loose				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	COMPLETED		
		345207	B. WING		I	C / <b>26/2024</b>
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  1402 PINCKNEY STREET  WHITEVILLE, NC 28472	1 077	20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 580	February 2024, but the currently employed by was unable to recall Director or the reason. An interview was corn Development Coordin 7/23/2024 at 8:29 AM Resident #86 was or and that she could not she stated she was aide (NA) had report Resident #86 had remedication herself. The was unable to remer having a lot of loose odors.  The bowel movement 2/28/2024 indicated medium loose and min NA #9 documented for No medication was coloose stools per the IR Resident #86 was dison 2/28/2024.  A telephone interview at Resident #86 was dison 2/28/2024.  A telephone interview at Resident #86 be seed diarrhea when she wistated that when Resident #86 be seed diarrhea when she wistated that when Resident #86 be seed from the facility her first straight to her office. sample was obtained	nanager at the facility in hat she was no longer by the facility. She stated she messaging the Medical in she had contacted him.  Impleted with the Staff in the	F 58			

1 '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345207	B. WING			C <b>07/26/2024</b>		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1402 PINCKNEY STREET WHITEVILLE, NC 28472	E	07/20/2024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		DATE		
F 580	Resident #86's bowe sheets from the date of consenses through the date of the date o	esident #86 dated 2/29/2024 sitive for C. difficile infection.  If movement documentation of admission, 2/8/24, lischarge, 2/28/24, revealed aving 23 loose and watery mushy stools, 1 putty like tools.  If or February 2024 revealed d 3 doses of bismuth doses of loperamide HCL agh 2/27/2024.  If documentation sheets and sheet revealed NA #9 was Resident #86 on 2/9/2024, 4, 2/16/2024, 2/22/2024, 4, 2/26/2024, and 2/28/2024.  Inducted with NA #9 on M. NA #9 stated she was to care for Resident #86 was residing in the facility. The sident #86 was having mushy/watery stools with a lident kept asking why she bowel movements. NA #9 wort the frequent stools to the inable to remember which was usually a different	F 5					
		#10 on 2/15/2024, 2/17/2024,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345207	B. WING _			C 07/26/2024	
	ROVIDER OR SUPPLIER	OF COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 PINCKNEY STREET WHITEVILLE, NC 28472	•	01720/2024	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	7/23/2024 at 2:00 F able to remember F was incontinent of I frequent large loose resident was at the while the bowel mo odor, she did not be difficile odor she har resident had C. diff report the diarrhea able to remember v Review of the bowe sheets and daily as #1 was assigned to 2/19/2024, 2/20/202/2/26/2024.  An interview was co 7/25/2024 at 12:05 #86 was incontinent frequent and large foul odor when she and the odor was e outside her room. No resident had more in the shift he would indicated Nurse #16 was having loomovements but could have she was no longer to could not recall Resident and recall Resident and recall Resident and recall Resident Res	onducted with NA #10 on PM. NA #10 stated she was Resident #86 and the resident her bowels and was having the foul-smelling stools when the facility. NA #10 reported that exements did have a terrible believe it smelt like the C. d smelled before when a cile. She indicated she did to the nurse, but she was not	F5				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345207	B. WING			C		
NAME OF P	ROVIDER OR SUPPLIER	040201		STREET ADDRESS, CITY, STATE, ZIP COI		07/26/2024		
				1402 PINCKNEY STREET				
LIBERTY	COMMONS N&R CTR O	F COLUMBUS CTY		WHITEVILLE, NC 28472				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 580	0 Continued From page 14		F 5	80				
	#1 reported to her the diarrhea.	at Resident #86 was having						
	#1 reported to her that Resident #86 was having							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345207	B. WING _			07/2	) 26/2024		
	ROVIDER OR SUPPLIER  COMMONS N&R CTR OF	COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP CODE  1402 PINCKNEY STREET  WHITEVILLE, NC 28472		, 0.,,	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 580	with the Medical Dire AM. The Medical Dire AM. The Medical Dire depended on the nur of any changes or co residents. The Medic was clearly a commu Resident #86 was ha wasn't made aware of indicated that he wou multiple messages from weeks between the number and 2/27/2024. The Mass unaware she was would be no reason to the An interview was con Nursing (DON)/Infect (ICP) on 7/24/2024 a stated that she was usuand was not aware the stools when she was DON/ICP indicated so to provide the Medical description of the situand amount of loose antidiarrheal medicated A follow-up interview DON/IPC Nurse on 7 stated the information the Medical Director of accurately describe of situation, and they shamount and frequence with the medical describe of situation, and they shamount and frequence with the medical describe of situation, and they shamount and frequence with the medical describe of situation, and they shamount and frequence with the medical describe of situation, and they shamount and frequence with the medical describe of situation, and they shamount and frequence with the medical describe of situation, and they shamount and frequence with the medical describes of the medical descri	e interview was completed ctor on7/25/2024 at 10:36 ector stated that he sing staff to make him aware ncerns involving the al Director indicated that this nication problem because ving a lot of stools, and he of this by the nursing staff. He ald have expected to have om multiple nurses in the 2 otifications on 2/13/2024 Medical Director stated if he shaving any problems there to see her and assess her.  Inpleted with the Director of ion Control Preventionist at 1:51 PM. The DON/ICP infamiliar with Resident #86 hat she was having loose residing in facility. The the expected the nursing staff al Director with an accurate lation, such as the number watery stools and that the ions were ineffective.  Was conducted with the //25/2024 at 9:55 AM. She in the nursing staff provided was not sufficient to or paint a clear picture of the resould have told him the	F5	580					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345207	B. WING _				26/2024
	ROVIDER OR SUPPLIER	COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP CODE  1402 PINCKNEY STREET  WHITEVILLE, NC 28472			20/2027
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 580	allegation of immedial Identify those recipier are likely to suffer, as a result of the noncor. The facility failed to move a resident (Resident #8 watery stools or must through 2/27/24 despanti-diarrhea medicat. The facility did not immensure the physician changes.  The physician revealed the resident was having the further revealed was 2/27/24 he was not move a repetitive loose stools with anti-diarrheal medicated this was would have initiated to	ed at 4:45 PM.  comitted the following credible the jeopardy removal:  Ints who have suffered, or serious adverse outcome as impliance.  cotify the physician when a serious from 2/9/24 in the administration of ion.  plement effective systems to is notified of significant  and he was not notified that ing loose stools until 2/27/24. When he was notified on it is adea aware there were as for greater than 2 weeks edication being ineffective.  Indicative of c-diff and he in the diarrhea protocol to	F 5	580	(CY)		
	to diarrhea, order biss was ineffective, he we x-ray and if x-ray was stool sample to check Resident #86 was dis 02/28/2024 and is no	cations that could contribute muth subsalicylate if that buld obtain an abdominal a negative, he would obtain a a for C-diff.  scharged to home longer a resident of the rrective action could be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345207	B. WING _			C <b>07/26/2024</b>	
	ROVIDER OR SUPPLIER	F COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 PINCKNEY STREET WHITEVILLE, NC 28472	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	All residents are at risk for harm related to the deficient practice requiring a comprehensive		F 5	580			
	(Clostridium difficile)						
	all direct care nurses an assessment of 10 Beginning on 07/25/ Managers and Licer completed an audit of consisted of an asses	Director of Nursing met with so who were working to initiate 20% of current residents. 2024, the Registered Nurse used Practical Support Nurses of all residents. This audit essment of each resident for					
	diarrhea, fever, loss malodorous stool an in the last 7 days. In was a review of each documentation for the	nd symptoms: watery of appetite, nausea, d abdominal pain/tenderness cluded in this assessment n resident's bowel movement the last 7 days to identify diarrhea. If a resident had 3					
		y stools in 24 hours the er (NP)/PA will be notified for cile.					
	symptoms of C. difficereviewed to identify notified. If the MD/N	e identified with any signs and cile the medical record was if the MD/NP/PA had been P/PA had not been notified, n make the notification to the					
	audit identified that 2						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345207	B. WING			1	C <b>26/2024</b>		
	ROVIDER OR SUPPLIER	F COLUMBUS CTY	•	1402	EET ADDRESS, CITY, STATE, ZIP CODE PINCKNEY STREET TEVILLE, NC 28472				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG				(X5) COMPLETION DATE		
F 580	having signs and synthe provider was notice condition and orders were carried out by the Specify the actions the process or system far adverse outcome fround when the action On 07/25/2024 the Degistered Nurse Mall licensed nurses, Faciensed Practical Nursing assistants (Oprn including agency C. difficile including vappetite, nausea, about the above staff were of documenting bowed addition, the CNA's vacchanges in condition nurse when noted.  RN's and LPN's were resident has 3 or mo hours then notify the difficile, initiate Enter	rrective action was residents identified as nptoms of C. difficile when fied of the change in for the change in condition he direct care staff.  ne entity will take to alter the ilure to prevent a serious m occurring or reoccurring	F	580					
	and notifying the MD are not effective.  The DON will ensure	, completing an assessment, /NP/PA when interventions  that all licensed nurses, A's (full time, part time, and							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345207	B. WING				26/2024
	ROVIDER OR SUPPLIER	COLUMBUS CTY	1	14	TREET ADDRESS, CITY, STATE, ZIP CODE 802 PINCKNEY STREET VHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULI			(X5) COMPLETION DATE
F 580	in-service training by allowed to work until This in-service was in employee facility and licensed nurses and of (full time, part time, a Alleged date of IJ ren The immediate jeopa 7/26/2024 was validad of 100% of current resymptoms of C. difficinursing staff on 7/25/20 and nurses) regarding C. difficile. In addition were educated regard dashboard in the elect alerts, initiating Enter difficile is known or suresidents for signs and notifying the physiconfirmed education the signs and symptot the residents for sign isolation precautions, alerts. Staff interview that education was resymptoms of C. difficile.	who do not complete the 07/26/2024 will not be the training is completed.  Incorporated into the new agency orientation for all certified nursing assistants and prn including agency.)  Incoval 07/27/2024  Incoval 07/27/2024  Incoval 07/27/2024  Incoval 07/26/2024. The audit sidents for signs and ille was conducted by the 2024. The education sign in d for the in-services 1024 for all nursing staff (NA's go the signs and symptoms of any the licensed nursing staff ding checking the clinical extronic medical record for its Contact Isolation when Couspected, and assessing and symptoms of C. difficile sician. Staff interviews was received on recognizing and symptoms, enteric and the clinical dashboard is with the nurses confirmed exceived regarding signs and	F	580			
	<b>'</b>	2024 was validated.  admitted to the facility on included type 2 diabetes					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345207	B. WING		07/26/2024		
	ROVIDER OR SUPPLIER	OF COLUMBUS CTY	1	STREET ADDRESS, CITY, STATE, ZIP CODE 402 PINCKNEY STREET VHITEVILLE, NC 28472	,		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 580	Continued From pa	age 20	F 580				
	dated 06/11/24 revice cognitively intact are hypoglycemic (mediations.  A review of the phyorder was written for units subcutaneous glucose is less than A review of the Jun Administration Reciblood sugar reading The medication and Resident #59 receivers.	-					
	blood sugar reading 113 mg/dl on 07/03 07/06/24, 114 on 0 on 07/22/24, and 1 medication adminis Resident #59 recei 07/01/24, 07/03/24 evidenced by a che An interview was co 07/24/24 at 9:45 Al initials on the Medicon 06/22/24, 07/01 07/24/24 were hers under each of the comedication was administration of the comedication of the comedication was administration of the comedication of the comedication was administration of the comedication of the comedication of the comedication was administration of the comedication of	y 2024 Medication ord revealed Resident #59's g was 107 mg/dl on 07/01/24, 1/24, and 109 mg/dl on 07/10/24, 117 on 07/21/24, 100 16 on 07/24/24. The stration record revealed wed the Novolog Insulin on 07/10/24, and 07/24/24 as eckmark and nursing initials.  Inducted with Nurse #1 on M. Nurse #1 confirmed the cation Administration Record 1/24, 07/03/24, 07/10/24, and 1/24, 07/03/24, 07/10/24, and 1/24, 07/03/24, 07/10/24, and 1/24 seekmark dates meant that the ministered. Nurse #1 stated the Novolog Insulin even					

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		345207	B. WING _			C 07/26/2024	
	ROVIDER OR SUPPLIER	F COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP CODE  1402 PINCKNEY STREET  WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 580	though the order real blood sugar level was because the resident #1 stated the resident wanted the medicati administer it. Nurse the physician that the receive the 10 units blood sugar was less. An interview was concerned was a concerned	d to hold the insulin if the is less than 120 mg/dl to stated she wanted it. Nurse in thad rights and if she on, then she would #1 stated she did not notify the resident was requesting to of insulin even though her is than 120 mg/dl.  Inducted with the facility 24 at 10:17 AM. The shad the parameter for sulin in place because he did 59's blood sugar level to get the was not notified that requesting to receive her sher blood sugar level was the stated had he been notified ged the parameter to hold the mber. Additionally, the the ursing had notified him he dent's blood sugar results to led to change the order or r.  Director of Nursing (DON) PM revealed she would have gestaff to notify the physician p to nursing to decide minister a medication if it was	F 5	80			
F 684 SS=K	Physician. Quality of Care CFR(s): 483.25  § 483.25 Quality of c	discussing the order with the care undamental principle that	F 6	84		7/27/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING		MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NG _		,	C
		345207	B. WING			1	26/2024
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS N&R CTR	OF COLUMBUS CTY		14	402 PINCKNEY STREET		
LIDEIXII		OI GOLOMBOO OI I		V	/HITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	facility residents. Be assessment of a re that residents recei accordance with propractice, the comprese plan, and the rather that resident resident resident resident resident resident who was possible to compresident resident resi	ent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of rehensive person-centered residents' choices.  NT is not met as evidenced review and family, staff, Medical cian Assistant interviews, the aprehensively assess a presenting with signs of (C. difficile) (According to the endered and inflammation of the fe-threatening; symptoms but smelling watery stools a chan 1 day, and abdominal mine the cause of the watery seriousness of the symptoms, ctive interventions to treat swhich started on 2/09/2024. Well movement documentation the of admission, 2/8/24, discharge, 2/28/24, revealed thaving 23 loose and watery domushy stools, 1 putty like stools. The resident was sees of anti-diarrheal the 20 days the resident was	F	584	This Plan of Correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the facility or community as to the accuracy of the surveyors findings or conclusions drawn therefrom.  Submission of this Plan of Correction and does not constitute an admission that the findings constitute an admission that the scope and severity regarding the deficiency cited are correctly applied. And changes to the facility so or community policies and procedures should be considered subsequent remedial measures as that concept is employed Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The facility / community submits this Plan of Correction with the intention that it be inadmissible by any third party any civil or criminal action against the facility / community or any employee, agent, officer, director, attorney, or shareholder of the facility / community of affiliated entities.  F684: The facility failed to	w. on e the lso he he in s in	

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		245207	B. WING				
		345207	B. WING _			07/	26/2024
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
I IBERTY (	COMMONS N&R CTR OF	COLUMBUS CTY		1	402 PINCKNEY STREET		
		0010111200011		۷	VHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG				(X5) COMPLETION DATE
F 684	Continued From page	e 23	F 6	384			
F 684	Resident #86 was dis was transported by a her Primary Care Phy was tested for C. Difficile deficient practice place developing complicated dehydration, skin breacases death. This deficient dehydration, skin breacases death. This deficient graft failed to neurological checks for falls (Resident #2) scope and severity.  Immediate Jeopardy Resident #86 was not possible cause or efficient reventions for contistools after the admin medication. Immediate on 7/27/2024 when the acceptable plan of Im The facility remains of scope and severity of potential for more that Immediate Jeopardy) completed and monitor was tested for the property of potential for more that Immediate Jeopardy) completed and monitor was tested for C. Difficient positions and the property of potential for more that Immediate Jeopardy) completed and monitor was tested for C. Difficient positions and the property of potential for more than Immediate Jeopardy) completed and monitor was tested for C. Difficient positions and the property of potential for more than Immediate Jeopardy) completed and monitor was tested for C. Difficient positions and the property of the proper	scharged on 2/28/2024 and family member directly to visician's office where she icile, and the lab test was e on 2/29/2024. This ced Resident #86 at risk for ions from C. difficile such as akdown, and in extreme ficient practice was residents reviewed for ds (Resident #86); and the perform complete or 1 of 1 resident reviewed of which was cited at a lower began on 02/15/2024 when t assessed to determine	F	684	determine the cause and implement interventions to treat repeat loose water stools or mushy stools from 2/9/24 through 2/27/24. She was administered anti-diarrhea medication that was not effective.  The facility did not implement effective systems to ensure that nurses identify signs and symptoms of C-Diff and communicate with the physician to ensure the ensure implemented.  Address how corrective action will be accomplished for those residents found have been affected by the deficient practice.  1. Resident #86 was discharged to hom 02/28/2024 and is no longer a resident the facility. No further corrective action could be completed specific to Resider #86.  2. Address how the facility will identify other residents having the potential to affected by the same deficient practice.  All residents are at risk for harm related the deficient practice requiring a comprehensive assessment for signs a symptoms of C. difficile (Clostridium).	d the ure d to ne of not be obtained.	
	severity "E." Findings included:	i. ne vice at scope and			difficile). Signs and symptoms for C. difficile include: watery diarrhea, fever loss of appetite, nausea, malodorous s and abdominal pain/tenderness. On		
	Per an article by the I	National Institute in Health			07/25/2024 the Director of Nursing me	t	
	•	Clinic, dated November			with all direct care nurses who were		
		motility agents such as			working to initiate an assessment of 10	0%	
		nide in active C difficile			of current residents. Beginning on		
		ed because use of these			07/25/2024, the Registered Nurse		

Facility ID: 923086

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345207	B. WING _				C <b>26/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	20/2024	
					402 PINCKNEY STREET			
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY			/HITEVILLE, NC 28472			
040.15	CHMMADY CT	ATEMENT OF DEFICIENCIES	ID.		· 		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	F 684 Continued From page 24		F6	84				
	agents may result in i	more severe colitis.			Managers and Licensed Practical Supp	oort		
	T. ( ):::   O. ( : ::	D.(C. )			Nurses completed an audit of all			
		um Difficile policy last			residents. This audit consisted of an			
		read in part, "The following nes to prevent the spread of			assessment of each resident for the following signs and symptoms: watery			
	_	linical features include			diarrhea, fever, loss of appetite, nause			
		r, loss of appetite, nausea,			abdominal pain/tenderness in the last			
	_	erness. General diagnostic			days. Included in this assessment was			
	_	e MD [Medical Director]			review of each resident⊡s bowel			
		atery diarrhea in 24 hours.			movement documentation for the last 7	,		
		the resident has symptoms			days to identify symptoms of watery			
	received antibiotics."	nospital and/or recently			diarrhea. This audit was completed on 07/25/202	24		
	received antibiotics.				The audit identified that 2 of 80 resider			
	The facility's Physicia	n's Standing Orders			had signs or symptoms of C. difficile	110		
		a means for physician or			which are: watery diarrhea, fever, loss	of		
		rovider to legally convey to a			appetite, nausea, malodorous stool an			
		rovide routine medical			abdominal pain/tenderness. On			
		ident based on subjective			07/25/2024, a corrective action was			
		s) revealed the following:			completed for 2 of 80 residents identified	∍d		
		e (antidiarrheal medication) ers) after each diarrhea			as having signs and symptoms of C. difficile when the provider was notified	of		
	,	ction before giving. Notify			the change in condition and orders for			
		vement after 8 hours or in			change in condition were carried out by			
	the morning if stable.				the direct care staff.			
		and physical dated 2/1/2024			3. Address what measures will be pu			
		6 was admitted to the			into place or systemic changes made t			
		es to include right hip pain,			ensure that the deficient practice will n	ot		
	,	re life-threatening muscle			recur.			
		breakdown and lead to			On 07/25/2024 the Director of November			
	muscle death. When	this occurs, toxic uscle fibers enter the blood			On 07/25/2024 the Director of Nursing and the Registered Nurse Managers			
	•	d kidneys, resulting in kidney			began in servicing all licensed nurses,			
	_	ous muscle condition can			Registered Nurses (RN) and Licensed			
		on, trauma (such as fall), or			Practical Nurses (LPN) and certified			
		nd-level fall at home, and			nursing assistants (CNA) (full time, par	t		
		perimposed on chronic			time, and prn including agency) on sign			
	kidney disease, and g				and symptoms of C. difficile including			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		(	С
		345207	B. WING _			07/	26/2024
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIDEDTY	COMMONG NOD CTD O	E COLUMBIA CTV		14	402 PINCKNEY STREET		
LIBERTY	COMMONS N&R CTR O	F COLUMBUS CTY		W	VHITEVILLE, NC 28472		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
					DEFICIENCY)		
F 684	Continued From pag		F	684			
	list Resident #86 was antibiotics while she	g to the hospital medication s not administered any was in the hospital. She was hospital on 2/8/2024 to the			watery diarrhea, fever, loss of appetite, nausea, malodorous stool and abdomin pain/tenderness. The above staff were educated on the importance of documenting bowel movements including consistency of bowel movements	nal	
	Resident #86 was admitted to the facility on 02/08/2024, with diagnoses to include Type 2 diabetes mellitus with chronic kidney disease, muscle weakness, and urinary retention. She had a planned discharge to home on 02/28/2024.  The admission Minimum Data Set (MDS) assessment dated 02/10/2024 revealed Resident #86 was cognitively intact, had an indwelling catheter, and was frequently incontinent of bowels.  The baseline Care Plan initiated on 2/8/2024 for Resident #86 revealed a plan of care for activities of daily living (ADL) self-care performance deficit. Interventions included allowing plenty of time to complete tasks, providing incontinence care as needed, and monitoring/documenting/reporting to the nurse as needed any changes in ADL abilities and reasons for self-care deficit/decline.				accurately.  RN□s and LPN□s were additionally educated on checking the clinical dashboard in the electronic medical record each shift for bowel movement alerts to identify diarrhea documented.	lf a	
					resident has 3 or more loose watery stools in 24 hours then notify the MD for evaluation of C. difficile, initiate Enterior Contact Isolation when C. difficile is known or suspected, when to report changes in condition, completing an	or	
					assessment, and notifying the MD/NP/ when interventions are not effective. The DON will ensure that all licensed nurses, RN□s, LPN□s, and CNA□s (fu time, part time, and prn including agen who do not complete the in-service training by 07/26/2024 will not be allow to work until the training is completed. This in-service will be incorporated into	ıll cy) ed	
	**	el movement documentation inistration record (MAR) g:			the new employee facility and agency orientation for all licensed nurses and certified nursing assistants (full time, patime, and prn including agency.)		
	2/9/2024 NA #9 documented1 large and loose and watery stool at 1:49 PM and 1 medium loose and watery stool at 5:40 PM. No medication was documented as given for loose stools per the MAR.  2/10/2024 NA #9 documented 1 large and				4. Indicate how the facility plans to monitor its performance to make sure t solutions are sustained.  The Administrator and/or Director of Nursing will monitor tag F684 for Chan in Condition related to C. difficile week	ge y	
	formed/normal stool	at 1:16 PM, 1 large loose			for 4 weeks and monthly for 3 months	or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		345207	B. WING_				C <b>26/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 077	20/2024
	101.52.1 0.1 00.1 2.2.1				PINCKNEY STREET		
LIBERTY (	COMMONS N&R CTR OF	COLUMBUS CTY			ITEVILLE, NC 28472		
				****			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	⊋ 26	F 6	884			
	and mushy stool at 4: documented one larg 11:49 PM. No medication for loose stools 2/11/2024 NA #12 do mushy stool at 12:26 watery stool at 3:18 F 1 medium loose and No medication was doloose stools per the No 2/12/2024 NA #12 do and mushy stool at 1: documented 1 small at PM. No medication voloose stools per the No A nurse's note written Resident #86 revealed conversation text mes message from the nursaved and uploaded relectronic medical reconstructions.	e loose and watery stool at ation was documented as per the MAR.  cumented 1 large loose and PM, 1 large loose and PM, and NA #11 documented watery stool at 11:39 PM. ocumented as given for MAR.  cumented 1 medium loose 1:30 AM and NA #13 and putty like stool at 7:57 was documented as given for MAR.			until resolved. The Administrator/Direct of Nursing will ensure that all shifts have been covered during the monitoring period. Reports will be presented to the weekly Quality Assurance committee bethe Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at tweekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Director.  Date of Compliance:	e e yy the e	
	which read in part, "R	Resident has had diarrhea we have no [brand name of					
	an order for loperami	=					
	11:46 AM with an ord	onded back on 2/13/2024 at er for loperamide 2 milligrams (mg) three					
	an order for loperami	rs for Resident # 86 revealed de (HCL) 2mg tablets; give 1 times a day as needed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345207	B. WING _			07/:	26/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	E	, 0	
LIDERTY	COMMONE NOD CTD OF	COLUMBUS CTV		1402 PINCKNEY STREET			
LIDERIT	COMMONS N&R CTR OF	COLUMBUS CIT		WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIA		(X5) COMPLETION DATE
F 684	Continued From page	e 27	F 6	584			
	(prn) for diarrhea was on 2/13/2024.	initiated by MDS Nurse #2					
	on 7/25/2024 at 9:44 she was a unit managor of 2024. She further shanager for the hall of MDS Nurse #2 stated Resident #86 or why the text message to the 2/13/2024 regarding that the nurse working her about the diarrheout of bismuth subsall the Physician's Standexplained that lopera was not on the facility and if the facility was that must have been the Medical Director. a resident was having was given and it was should have assess symptoms of C. difficitles he was positive that reported that Resider odor, because that we she might have a C. of #2 reported that if a redifficile, they were to precautions, and place because it was very of that if C. difficile was skin breakdown and control of 2/13/2024 NA #13 do 2/13/2	ile. She further stated that none of the staff members at #86's stools had a foul could have been a sign that difficile infection. MDS Nurse resident was positive for C. be placed on enteric red in a private room contagious. She indicated left untreated it could lead to dehydration.					
	and watery stool at 6	cumented 1 large and loose 10 AM, 1 large loose and ᠕, and NA #9 documented 1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345207	B. WING_				C		
NAME OF D	ROVIDER OR SUPPLIER	343207	B: Willo	CT	REET ADDRESS, CITY, STATE, ZIP CODE	07/	26/2024		
NAIVIE OF PI	ROVIDER OR SUPPLIER								
LIBERTY (	COMMONS N&R CTR OF	COLUMBUS CTY			02 PINCKNEY STREET				
				W	HITEVILLE, NC 28472				
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ICIENCY MUST BE PRECEDED BY FULL PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 28	F 6	884					
	documented as havin	tablet 2 mg was te #8 at 8:07 PM and it was tg been effective.							
	#8 on 7/25/2024 at 8:	was completed with Nurse 21 AM. Nurse #8 stated sounded familiar, but she							
	was not able to recall any information about her. She indicated if she administered loperamide								
		on 2/13/2024 at 8:07 PM.,							
		sident must have reported							
		iarrhea to her. She stated if							
	-	lent was having loose stools,							
		an antidiarrheal medication							
		e sure it was effective.							
		IA reported a resident's stool							
		would assess them for C.							
		her stated the facility's							
	•	e was to collect a stool							
		st an order for a lab culture							
	from the Medical Dire								
		e indicated she was unable							
		tering loperamide HCL to							
		3/2024 at 8:07 PM or recall							
	NA # 9 informing her	of the diarrhea.							
	Further review of Res	sident #86's bowel ation and MAR revealed the							
	following:	ation and MAR revealed the							
		ocumented 1 large loose 1:04 AM, 1 medium loose 5 PM, and NA #14							
	documented 1 small I	oose and watery stool at							
	11:34 PM. No medica	ation was documented as							
	given for loose stools	per the MAR.							
	2/15/2024 NA #10 do	cumented 1 medium							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L , IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345207	B. WING		07/26/2024		
	ROVIDER OR SUPPLIER	COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP CODE  1402 PINCKNEY STREET  WHITEVILLE, NC 28472	1 0	720/2024	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	4 Continued From page 29 formed/normal stool at 10:42 AM and 1 large		F 68	34			
	loose and mushy stoo	at 10:42 AM and 1 large ol and at 3:24 PM. No mented as given for loose					
	262 mg/15 ml; give 1 (prn) for diarrhea. Giv stool. Check for impa physician if there was hours or in the mornin Further review of Res movement document following:  2/16/2024 NA #13 do and mushy stool at 3: mushy stool at 8:58 F 1 medium loose and Bismuth subsalicylate	order for bismuth spension 262 mg/15 siated by Nurse #9 on ubsalicylate oral suspension 5 ml by mouth as needed re 15 ml after each loose ction first. Notify the s no improvement after 8 ng if stable.  Sident #86's bowel ation and MAR revealed the  cumented 1 medium loose 26 AM, 1 medium loose and PM, and NA #9 documented mushy stool at 11:58 AM. re prn 15 ml was re #9 at 5:05 PM and was					
	and mushy stool at 4 documented 1 large f	ormed/normal stool at 5:15 was documented as given for					
	stool at 2:53 PM, 1 m stool at 12:14 PM, an large loose and water	cumented 1 small putty like edium loose and watery d NA #9 documented 1 ry stool at 3:19 PM. No mented as given for loose					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		345207	B. WING _			C <b>07/26/2024</b>	
	ROVIDER OR SUPPLIER	F COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP CO 1402 PINCKNEY STREET WHITEVILLE, NC 28472	ODE	01/20/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA		ON
F 684	watery stool at 6:27 large loose and must formed/normal stool subsalicylate prn 15 Nurse #10 at 9:14 Pl effective.  2/20/2024 at 4:43 Al large loose and water documented 1 large 9:05 PM NA #13 documented 1 small Loperamide HCL 2 madministered by Nurse documented as effect prn 15 ml was admin AM and was documented as effect prn 15 ml was admin AM and was documented as effect prn 15 ml was admin AM and was documented as effect prn 15 ml was admin AM and was documented as effect prn 15 ml was admin AM and was documented as effect prn 15 ml was admin AM and was documented as effect prn 15 ml was admin AM and was documented as effect prn 15 ml was admin AM and was documented as effect prn 15 ml was admin AM and was documented as effect prn 15 ml was administered by Nurse #10 on 7/25/2024 at she usually did not was Resident #86 resident #86's name Nurse #10 explained with Resident #86 ar having diarrhea or no remember administe 2/19/2024 or loperan 2/20/2024 to Resident #86's name 2/20/2024 to Resident Province	coumented 1 large loose and AM. NA #15 documented 1 hy stool and 1 large and at 11:33 AM. Bismuth ml was administered by M and was documented as M NA #13 documented 1 hy stool, at 11:44 AM NA #1 loose and watery stool, at umented 1 large loose and 11:14 PM NA #13 loose and mushy stool. In the stool of t	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345207	B. WING _			C <b>07/26/2024</b>		
	ROVIDER OR SUPPLIER	F COLUMBUS CTY		STREET ADDRESS, CITY, STATE, Z 1402 PINCKNEY STREET WHITEVILLE, NC 28472	IP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)				
F 684	9:15 AM. NA #13 do loose and mushy store HCL 2 mg tablet prins #12 at 6:13 AM and verificative.  2/22/2024 NA #9 door watery stool at 2:59 F watery stool at 5:03 F tablet prins was admin PM and was document A telephone interview #13 on 7/25/2024 at she worked at the fact stated that she did now where Resident #86 in the state was table to the state of th	rge loose and mushy stool at cumented and 1 medium ol at 11:11 PM. Loperamide was administered by Nurse was documented as cumented 1 large loose and PM and one large loose and PM. Loperamide HCL 2 mg istered by Nurse #13 at 3:01	F	584				
	Resident #86 resided recall anything about recall administering leto her on 2/22/2024 ft  2/23/2024 NA #13 do and mushy stool at 12:03 1 large loose and mu medication was docu stools per the MAR.  2/24/2024 NA #9 documented 1 large legistrates with the stool at 10:48 documented 1 large legistrates administered by Nurse documented as effective administered as effective to her or call the stool at 10:48 documented as effective to her or call the stool at 10:48 documented as effective to her or call the stool at 10:48 documented as effective to her or call the stool at 10:48 documented as effective to her or call the stool at 10:48 documented as effective to her or call the stool at 10:48 documented as effective to her or call the stool at 10:48 documented as effective to her or call the stool at 10:48 documented as effective to her or call the stool at 10:48 documented as effective to her or call the stool at 10:48 documented as effective to her or call the stool at 10:48 documented as effective to her or call the stool at 10:48 documented as effective to her or call the stool at 10:48 documented as effective to her or call the stool at 10:48 documented as effective to her or call the stool at 10:48 documented as effective to her or call the stool at 10:48 documented as effective to her or call the stool as the	ocumented 1 medium loose 2:08 AM, 1 large loose and PM, and NA #9 documented shy stool at 4:57 PM. No mented as given for loose  cumented 1 large loose and AM and NA #19 loose and watery stool at e 2 mg tablet prn was se #14 at 2:00 PM and was						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345207	B. WING _			C 07/26/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 1402 PINCKNEY STREET WHITEVILLE, NC 28472		07720/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IENCY MUST BE PRECEDED BY FULL PREFIX		DRRECTION N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	#14 on 7/25/2024 at 3 she worked at the face could not remember at 486. She further state resident's name. Nursunable to recall admining tablet to Resident 2/24/2024.  2/25/2024 NA #9 doc and mushy stool at 2 documented 1 large I medication was docustools per the MAR.  2/26/2024 NA #9 doc watery stool at 10:37 and mushy stool at 8 loperamide 2mg table the Staff Developmer one dose at 8:37 AM effective and the dose effectiveness was documented 1 large I 11:05 AM and 4:38 PM and effective.  An interview was com Development Coordin 7/23/2024 at 8:29 AM was working the 7 AM where Resident #86 I	3:00 PM. Nurse #14 stated cality as needed, and she canything about Resident ed she couldn't recall the se #14 stated she was nistering loperamide HCL 2 at #86 for diarrhea on cumented 1 medium loose and mushy stool. No mented as given for loose cand and NA #1 large loose and AM and NA #1 large loose and AM and NA #1 large loose and and was documented as eat 7:06 PM the cumented as unknown.  Cumented 1 medium can at 1:32 AM. NA #1 coose and watery stool at a loose and mushy stool at of loperamide 2 mg tablet d by the SDC Nurse at 8:29 they were documented as	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD			، ا	
		345207	B. WING				26/2024
NAME OF P	ROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE	, ,,,,	
LIDEDTY		E OOLUMBUO OTV		14	402 PINCKNEY STREET		
LIBERIY	COMMONS N&R CTR O	F COLUMBUS CTY		W	VHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	she could not recall a stated she was unable (NA) had reported the Resident #86 had remedication herself. Telectronic medical redocumentation had a residents' dashboard information), it would resident was having she was unable to rethe screen. The SDC unable to remember lot of loose stools or SDC Nurse was unahad contacted the Mon 2/27/2024, becaud on the hall. She state #86's family member thought her mother hot requested her to for a C. difficile test.  A follow-up interview SDC Nurse indicated if she loperamide HCL to Fand 2/27/2024, the Nowas having loose storequested it. She state manager in February Resident #86's daug test, she was not matexplained if she suspositive for C. difficile Medical Director and	facility for 20 days and that anything about her. She alle to recall if a nurse aide are diarrhea to her or if quested the antidiarrheal. The SDC Nurse explained the ecord the facility used for an alert system on the display a red bell if the diarrhea or constipation, but ecall if the alert had been on a Nurse indicated she was if Resident #86 was having a if it had any foul odors. The ble to recall why Nurse #15 edical Director instead of her is she was certain Resident rhad never informed her she had contact the Medical Director.  It was completed with the 2024 at 9:10 AM. The SDC e administered the Resident #86 on 2/26/2024 NA must have told her she	F	684			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345207	B. WING _			C <b>07/26/2024</b>		
	ROVIDER OR SUPPLIER	COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP CODE  1402 PINCKNEY STREET  WHITEVILLE, NC 28472	'			
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F 684	and initiate enteric prestated if the stool test. Director would order would remain on isolated the course having loose watery stated the course having loose watery stated and mushy stool at 1 documented 1 large from the date of the was coded as has stools per the MAR.  Resident #86's bowe sheets from the date of dishe was coded as has stools, 19 loose and stool and 5 normal stated through the date of dishe was coded as has stool and 5 normal stated and 2/24/2024.  An interview was con 7/23/2024 at 2:00 PM able to remember Rewas incontinent of he frequent large loose fresident was at the fawhile the bowel move odor, she did not belif difficile odor she had resident had C. difficile report the diarrhea to able to remember who was able to remember who was a stool to remember who was a stool of the diarrhea to able to remember who was a stool of the diarrhea to a stool of the diarrhea t	resident in a private room ecautions. The SDC Nurse it was positive the Medical antibiotics, and the resident ation precautions until they e of antibiotics and was not stools.  I movemented 1 medium loose 2:06 AM and NA #9 formed/normal stool. No mented as given for loose  I movement documentation of admission, 2/8/24, ischarge, 2/28/24, revealed ving 23 loose and watery mushy stools, 1 putty like ools.  It documentation sheets and sheet revealed Resident #86 #10 on 2/15/2024, 2/17/2024,  I ducted with NA #10 on 1. NA #10 stated she was sident #86 and the resident or bowels and was having foul-smelling stools when the acility. NA #10 reported that ements did have a terrible eve it smelt like the C. smelled before when a le. She indicated she did the nurse, but she was not ich one.	F 6	84				
	The bowel movemen	t documentation sheets and						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		345207	B. WING _			C 07/26/2024	ı
	ROVIDER OR SUPPLIER	F COLUMBUS CTY		STREET ADDRESS, CITY 1402 PINCKNEY STRE WHITEVILLE, NC 28	ET	01723/2024	
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F 684	F 684 Continued From page 35		F	884			
	assigned to care for F 2/10/2024, 2/14/2024	sheet revealed NA #9 was Resident #86 on 2/9/2024, , 2/16/2024, 2/22/2024, , 2/26/2024, and 2/28/2024.					
	7/23/2024 at 1:50 PM frequently assigned to when Resident #86 w	ducted with NA #9 on  I. NA #9 stated she was  c care for Resident #86  vas residing in the facility.  nt #86 was unable to					
	She reported Resident #86 was unable to ambulate and was receiving physical therapy. NA #9 stated Resident #86 was incontinent of bowels and had an indwelling catheter. She further stated Resident #86 was having frequent loose and						
	mushy/watery stools resident kept asking wany bowel movemereport the frequent st	with a foul odor and the why she was having so ents. NA #9 indicated she did cools to the nurse, but she aber which one, because					
	sheets and daily assi #1 was assigned to c	movement documentation gnment sheet revealed NA are for Resident #86 on ., 2/21/2024, 2/25/2024, and					
	7/25/2024 at 12:05 P #86 was incontinent of frequent and large loof foul odor when she wand the odor was everoutside her room. NA resident had more that the shift he would not	an 1 bowel movement during ify the nurse. NA #1 nad been informed Resident					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345207	B. WING			C <b>07/26/2024</b>
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STAT 1402 PINCKNEY STREET WHITEVILLE, NC 28472	TE, ZIP CODE	07/20/2024
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F 684	#16 on 7/25/2024 at 2 she was no longer wo could not recall Resid her. She further state at the facility, she had the time and she just resident or if she was diarrhea. Nurse #16 in recall if NA #1 reported was having diarrhea, remember that far backnessed was administered subsalicylate and 10 from 2/13/2024 through A nurse's note for Residle for the following secure convolutes where the following secure convolutes was administered subsalicylate and 10 from 2/13/2024 through She was administered subsalicylate and 10 from 2/13/2024 through form 2/13/2024 at 3:33 PM member] is concerned to folloose BMs [bow through her chart and watery stools but also we have an order to the daughter also wants to causing it if it were not medications are the selection of the following message do a C. difficile test."	not recall the date.  I was completed with Nurse 2:34 PM. Nurse #16 stated orking at the facility, and she lent #86 or anything about d when she was employed d worked on different halls all could not remember the having any issues with indicated she was unable to ed to her that Resident #86 because she just couldn't ck.  for February 2024 revealed d 3 doses of bismuth doses of loperamide HCL gh 2/27/2024.  sident #86 revealed the rersation text message from	F	684		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345207	B. WING			C <b>07/26/2024</b>
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP OF 1402 PINCKNEY STREET WHITEVILLE, NC 28472	CODE	07/26/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIA	
F 684	#15 on 7/24/2024 at she was a unit mana 2024, but that she was a unit mana 2024, but that she was facility. She further s sounded familiar, but any information abous he did not recall Re asking her to reques Resident #86 having stated she was unab Medical Director or thim. Nurse #15 state anything about Resident was a family member expresident's diarrhea and C. difficile.  An interview was con Nursing (DON)/Infect (ICP) on 7/24/2024 at stated she was unfar was not aware that Floose stools when should further stated the fact diarrhea was for bish loperamide HCL required Medical Director. The examining the bowel sheet, the nursing profor Resident #86, the assessed the resider difficile infection such	y was conducted with Nurse 9:13 AM. Nurse #15 stated ger at the facility in February as no longer employed by the tated Resident #86's name to she was unable to recall at her. Nurse #15 indicated sident #86's family member to a C. difficile test or recall frequent loose stools. She le to recall messaging the ne reason she had contacted do she did not remember	F 6	684		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION	(2	X3) DATE SURVEY COMPLETED	
		345207	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	343207		STREET ADDRESS, CITY, STATE, ZIP (	I	07/26/2024	_
				1402 PINCKNEY STREET			
LIBERTY	COMMONS N&R CTR	OF COLUMBUS CTY		WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE	1
F 684	Continued From pa	ige 38	F 6	684			
F 684	indicated she experior provide the Medical description of the sand amount of loos antidiarrheal medical pontion of the sand amount of loos antidiarrheal medical DON/IPC on 7/25/2 DON/IPC stated it a having diarrhea from to the facility, and thought that was he stated MDS Nurse unit managers at the staff members that Medical Director. The was made aware of would have assess and symptoms of a abdominal pain and foul-smelling stools nursing staff had not assessing her from the fever, abdominal pain and contacting the Medical Director. The stated in the spitalization or a contacting the Medical Director. The fever, abdominal pain and foul-smelling stools nursing staff had not assessing her from the spitalization or a contacting the Medical Director. The spitalization or a contacting the Medical Director. The fever, abdominal pain and the spitalization or a contacting the Medical Director. The spitalization or a contacting the Medical Director Director. The spitalization or a contacting the Medical Director Direct	cted the nursing staff to I Director with an accurate ituation, such as the number to watery stools and that the ations were ineffective.  W was conducted with the 2024 at 9:55 AM. The appeared Resident #86 was in the time she was admitted the nursing staff might have the time, and they were also the were communicating with the he DON/IPC explained if she of the loose watery stools, she the determination of the signs of the control of the signs of the control of the signs of the properties of the staff of the loose watery stools in as a sin/tenderness, recent intibiotic use, and by not ical Director for testing order more watery stools in 24 hours. Resident #86's risk factors for she was recently discharged and she was having loose and DON indicated alerts for pation light up a red bell on	F	584			
	medical record and nursing staff to ass information. She st the MDS Nurse #2,	board in the facility's electronic should have triggered the ess the resident for more ated the text message sent by and Nurse #15 to the Medical we been more detailed and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRI	UCTION	(X3) DATE COMP	SURVEY LETED
		345207	B. WING _			1	26/2024
	ROVIDER OR SUPPLIER	F COLUMBUS CTY	,	1402 PINCI	DRESS, CITY, STATE, ZIP CODE  KNEY STREET  LLE, NC 28472	1 011	20/2027
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 39	F 6	884			
		umber of stools she was iarrheal medication was					
	revealed an Admission which was completed 2/9/2024 and a progregarding discharge. diarrhea in the Histornote for discharge. The notes written by the Mealth care provider.  An interview was complicator on 7/24/2022 Director on 7/24/2022 Director stated that we the nursing staff that stools, he would not a C. difficile test. He fullook at the medication they could be having such as laxatives or stop the medications the loose stools would Director confirmed R administered any mediarrhea during her seed Medical Director reproverflow was the most stools in a nursing far precautions would not had other symptoms informed Resident #8 2/13/2024 when MDS order for loperamide indicated that if the resident was the most stools in the context of the precaution of the pre	dications that could cause tay at the facility. The orted that constipation with st common cause of loose cility, so a C. difficile test and of be indicated, unless they He stated that he was first 86 was having diarrhea on S Nurse #2 requested an HCL. The Medical Director esident was continuing to					
	indicated that if the re have loose stools and						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	, ,	TE SURVEY MPLETED
		345207	B. WING			C 07/26/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1402 PINCKNEY STREET WHITEVILLE, NC 28472	•	1/120/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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 684	He further indicated protocol was if the methen he would order for constipation with Director stated that the communication probit that she was having stools and the antidial ineffective. He furthe at Resident #86's bo documentation sheet frequency of loose at having, that this was had C. difficile infecti stated that he was unwas continuing to hawhen he had ordered because the nursing until 2/27/2024.  A follow-up telephonowith the Medical Director that he wood nursing staff to mechanges or concerns further stated he wood nursing staff to assess infection if she was a diarrhea and the antil ineffective. The Medical Director further stated mentioner antidiarrheal medications that loose stools, and the order antidiarrheal mineffective, he would rule out constipation Director further stated	ct him within 24-48 hours. chat part of the diarrhea edication were ineffective an abdominal x-ray to check overflow. The Medical here was clearly a em because he had no idea so many loose and watery arrheal medications were r stated that just by looking	F 6	84		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		ATE SURVEY DMPLETED
		345207	B. WING _			C 07/26/2024
	ROVIDER OR SUPPLIER	OF COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP COD 1402 PINCKNEY STREET WHITEVILLE, NC 28472	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CC  (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO THE  DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 684	healthy immune syseradicate C. difficile that most C. difficile treated with a 10-da Medical Director ind developing a C. diffi hospitalization, post immunocompromise stated that if a C. diff untreated, it could design pseudomembranous (large), and in extreand death. He further whether the resident with other comorbid indicated that isolating they had other signs infection.  The facility's infection information for 2024 on 7/24/2024 at 1:5. Trending information residents who were during the time of Resident #86's Resign 7/25/2024 at 3:23 P.	reported that people with tems were usually able infection on their own, and infections were usually y course of antibiotics. The icated the risk factors for cile infection was a recent antibiotic use, and being ed. The Medical Director ficile infection was left evelop into a colitis and toxic megacolon me cases rupture the colon er stated it just depends on the was immunocompromised eties. The Medical Director on was not necessary unless and symptoms of C. difficile was reviewed with the DON 1 PM. The Tracking and revealed no record of diagnosed with C. difficile esident #86 or after up	F	584		
	Resident #86 was d had already made a straight to her Prima office because of the explained the Physic	e further stated when ischarged on 2/28/2024 she n appointment to take her ary Care Physician's (PCP) e continued diarrhea. The RP cian's Assistant (PA) at the dered a C. difficile test based				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345207	B. WING _		,	C 07/26/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1402 PINCKNEY STREET WHITEVILLE, NC 28472	•	37720/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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 684	report of the frequent further stated at the awas obtained and seresults were reported and the PA ordered Resident #86.  A telephone interview at Resident #86's Prion 7/25/2024 3:40 Ptick 2/28/2024 the family requesting Resident to having loose wate the facility. She furth was discharged from brought her straight of The PA stated a stock sent to the lab and the difficile infection on 2 she had ordered 10 created the Resident #86 and installuids because of the The lab results for Rerevealed she was portallegation of Immedia Removal Plan F684.  Identify those recipies	ort of diarrhea and the RP's a stools with foul odor. She appointment a stool sample not to the lab. She said the dias positive on 2/29/2024 10 days of antibiotics for a was completed with the PA mary Care Physician's office M. The PA stated that on had called on 2/27/2024 #86 be seen in the office due ry stools when she was in er stated when Resident #86 the facility her family had to her office from the facility. I sample was obtained and the results were positive for C. 1/29/2024. She further stated days of antibiotics for structed her to drink lots of risk of dehydration.  The sident #86 dated 2/29/2024 sitive for C. difficile infection.  The sident #86 dated 2/29/2024 sitive for C. difficile infection.  The short of the Immediate 24 at 4:45 PM.  The who have suffered, or serious adverse outcome as	F 6	84		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG		DATE SURVEY COMPLETED
		345207	B. WING _			C <b>07/26/2024</b>
	ROVIDER OR SUPPLIER	COLUMBUS CTY		STREET ADDRESS, CITY, STATE, 2 1402 PINCKNEY STREET WHITEVILLE, NC 28472	ZIP CODE	0112012024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 684	Resident #86 to deter implement intervention watery stools or must through 2/27/24. She anti-diarrhea medicate.  The facility did not implement that nurses identify symptoms of C-Diff and physician to ensure not implemented.  Resident #86 was dis 02/28/2024 and is not facility. No further concompleted specific to the All residents are at rist deficient practice requassessment for signs (Clostridium difficile). difficile to include: water appetite, nausea, main abdominal pain/tender Director of Nursing more working to 100% of current reside 07/25/2024, the Registicensed Practical Suaudit of all residents. assessment of each resigns and symptoms: of appetite, nausea, at in the last 7 days. Increase a review of each	comprehensively assess raine the cause and ans to treat repeat loose by stools from 2/9/24 was administered ion that was not effective.  In the signs and and communicate with the ecessary interventions were charged to home longer a resident of the rective action could be Resident #86.  It for harm related to the siring a comprehensive and symptoms of C. difficile Signs and symptoms for C. atery diarrhea, fever, loss of lodorous stool and remess. On 07/25/2024 the et with all direct care nurses initiate an assessment of ents. Beginning on stered Nurse Managers and apport Nurses completed an This audit consisted of an resident for the following watery diarrhea, fever, loss abdominal pain/tenderness luded in this assessment resident's bowel movement as last 7 days to identify	F	584		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		345207	B. WING			C 07/26/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1402 PINCKNEY STREET WHITEVILLE, NC 28472		1/120/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	audit identified that a symptoms of C. difficilarinea, fever, loss malodorous stool and pain/tenderness. On action was complete identified as having difficile when the prochange in condition condition were carried. Specify the actions the process or system for adverse outcome from and when the actions. On 07/25/2024 the Expressed Practical North Including assistants (Orth Including assistants) (Orth Including assistants) (Orth Including appetite, nausea, mathodominal pain/tendeducated on the improvements accurated. RN's and LPN's were checking the clinical medical record each alerts to identify diar resident has 3 or mothours, then notify the difficile, initiate Enternal pain/tendeducated, initiate Enternal stool of the clinical medical record each alerts to identify the difficile, initiate Enternal pain/tendeducated on the improvements accurated.	bleted on 07/25/2024. The 2 of 80 residents had signs or cile which are: watery of appetite, nausea, id abdominal 07/25/2024, a corrective ed for 2 of 80 residents signs and symptoms of C. ovider was notified of the and orders for the change in ed out by the direct care staff.  The entity will take to alter the ailure to prevent a serious om occurring or reoccurring will be completed.  Director of Nursing and the anagers began in servicing Registered Nurses (RN) and Jurses (LPN) and certified CNA) (full time, part time, and y) on signs and symptoms of watery diarrhea, fever, loss of alodorous stool and terness. The above staff were ortance of documenting including consistency of bowel	F 68	34		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION  NG	(>	(3) DATE SURVEY COMPLETED
		345207	B. WING _			C <b>07/26/2024</b>
	ROVIDER OR SUPPLIER	F COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP CO 1402 PINCKNEY STREET WHITEVILLE, NC 28472	DDE	31723/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 684	are not effective.  The DON will ensure RN's, LPN's, and CN prn including agency in-service training by allowed to work until  This in-service will be employee facility and licensed nurses and (full time, part time, a Alleged date of IJ rer  The immediate jeopa 7/26/2024 was validate facility's immediate revealed an audit of signs and symptoms by the nursing staff ocompleted on 7/25/20 were identified as exiof C. difficile. The core 80 was verified as exiof C. difficile. The core staff (NA's and nurse symptoms of C. difficinursing staff were ed the clinical dashboard record for alerts, initial Isolation when C. difficilent was a context of the clinical dashboard record for alerts, initial Isolation when C. difficilent was a context of the clinical dashboard record for alerts, initial Isolation when C. difficilent was a context of the clinical dashboard record for alerts, initial Isolation when C. difficilent was a context of the clinical dashboard record for alerts, initial Isolation when C. difficilent was a context of the clinical dashboard record for alerts, initial Isolation when C. difficilent was a context of the clinical dashboard record for alerts, initial Isolation when C. difficults are the clinical dashboard record for alerts, initial Isolation when C. difficults are the context of the clinical dashboard record for alerts, initial Isolation when C. difficults are the context of the	that all licensed nurses, A's (full time, part time, and ) who do not complete the 07/26/2024 will not be the training is completed.  e incorporated into the new I agency orientation for all certified nursing assistants and prn including agency.)  moval 7/27/2024  ardy removal plan of ted on 7/26/2024. Review of te jeopardy removal plan 100% of current residents for of C. difficile was conducted in 7/25/2024. The audit was 024 and 2 of 80 residents hibiting signs and symptoms rective action plan for 2 of completed on 2/25/2024. The events were reviewed for the d on 7/25/2024 for all nursing events w	F	584		
	of C. difficile. Staff in	terviews confirmed education ognizing the signs and ille, assessing the residents				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345207	B. WING _			C <b>07/26/2024</b>
	ROVIDER OR SUPPLIER	F COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP  1402 PINCKNEY STREET  WHITEVILLE, NC 28472	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	
F 684	The facility's immedia 7/27/2024 was valida 2) Resident #2 was 5/14/24 with diagnos Metabolic encephalo Diabetes Mellitus, a la Review of a significa (MDS) assessment of Resident #2 had sevon She was always incompleted and a life expectancy live.  Review of a care plant Resident #2 docume area: At risk for falls weakness and a historisks to be minimized interventions x 90 da part: Monitor and do for pain, bruising, me onset of confusion, significant manifestation and proper frequently used object as possible.  Review of the Medica for Resident #2 reveals.	ate jeopardy removal date of ated. admitted to the facility on es that included, in part: pathy, stroke, Type 2 history of falls, and dementia.  Int change Minimum Data Set lated 06/11/24 revealed erely impaired cognition. Intinent of bowel and bladder. Iticoagulant medication. She of less than six months to an dated 06/11/24 for inted the following focus related to dementia, overall for of falls. The goal was for a through the current ys. Interventions included, in cument x 72 hours post fall ental status change, or a new deepiness, inability to agitation and report any sician; anticipate and meet as possible; check frequently ensure the call light is within in wheelchair is in good by functioning, keep cits within her reach as much	F	684		
		thinner twice a day July 1, , 2024 per the following				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE	SURVEY
		345207	B. WING			1	C / <b>26/2024</b>
	ROVIDER OR SUPPLIER			140	REET ADDRESS, CITY, STATE, ZIP CODE  2 PINCKNEY STREET  IITEVILLE, NC 28472	1 077	20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 684	Continued From pag	e 47	F	584			
		Eliquis 5 Milligrams-give by ay for atrial fibrillation					
	at 3:27 am documen unwitnessed fall on 7 Resident #2 denied h injury was noted, bru and left arm were pre pain at present. Curr thinner). Vital signs v rate 76, respirations and oxygen saturation	were started. The medical					
	included: 1) Neurolo assessment and a fa assessment dated 07	sments completed post fall gical assessment flow sheet lls review and follow up 7/12/24 at 1:35 am, and 2) a w up assessment dated					
	PM she stated she h check on Resident #. between 9:30 am an neglected to docume could not explain who neurological assessman policy was to comple hour for the first 4 ho total of 48 hours afte stated the neurologic completed per the fa fell. She explained sand reported she wa	the DON on 7/24/24 at 12:17 ad completed a neurological 2 on 07/12/24 sometime d 10:00 am but she had but her assessment. She by she had not completed a ment. She stated the facility the neurological checks every burs then every shift for a gran unwitnessed fall. She had investigated the fall the had investigated the fall the the following on the 16 am Nurse #7 was in the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345207	B. WING		_	C 07/26/2024		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE	1 077.	20/2024	
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY		1402 PINCKNEY STREET WHITEVILLE, NC 28472				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page	÷ 48	F	684				
F 684	hallway, she heard "haides from the room a Resident #2 was on the door; the bed was could not explain why not done by nursing the following times: 0 07/12/24 at 3:35 am, 07/12/24 on night shir and 07/13/24 on night and 07/13/24 on night An interview was con Practitioner #1 on 07/ stated she assessed am on 07/12/24 becarduring the night. She rolled out of the bed to bruise on her left upp like a new bruise becarder color not red like the nurse told her she but she was alone in assessment and coul so she stuck her hand and palpated the area pain and actually see neurological checks where the color is the she was an un resident was on a blo the fall put the reside bleed (subdural hemathreatening. She explain were not visible but coneurological check ar important. She did not be sent to the ER for the subdural to the total part of t	lelp", and immediately got 2 across the hall because the floor left of the bed facing in the lowest position. She is neurological checks where according to their policy at 107/12/24 at 2:35 am, 107/12/24 at 4:45 am, 107/12/24 at 4:45 am, 107/12/24 at 2:07 pm. She Resident #2 around 10:00 use the resident had fallen if elt the resident could have by herself. She noted a ter arm which did not look ause it was a dull grayish are a new bruise. She stated to had bruising to her back, the room during her do not roll the resident to look dunder the resident denied any med happy. She stated would be very important witnessed fall, and the od thinner (Eliquis 5mg bid). The resident could be life ained bleeds of this type ould be detected with a not that's why they were very of feel the resident needed or assessment, but she felt		584				
	if something was goir	vere necessary to determine ng on that warranted the nt for further testing. It was						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
		345207	B. WING _	B. WING		C 07/26/2024	
	ROVIDER OR SUPPLIER	F COLUMBUS CTY		1402	EET ADDRESS, CITY, STATE, ZIP CODE PINCKNEY STREET TEVILLE, NC 28472	1 011	20/2027
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 49 at any resident who had an	F	684			
	unwitnessed fall was neurological checks of amount of time. She						
	at 3:00 pm she stated fall or Resident #2 be different facilities. She she would assess the family and the provide completed a post fall neurological assessmedid not know the neurological stated on protocological stated she vague	gency Nurse #7 on 07/24/24 If she vaguely recalled the locause she works at many le explained that normally le resident, then call the ler. She then recalled she lassessment that included a linent section. She stated she lirological check policy for this listated she had not been list for falls by this facility. lely remembered the fall, litessed and that the aides					
	on 07/24/24 at 3:36 prounds at the beginni at 11:00 on 07/11/24 went across the hall to changed that residen the nurse called her for doesn't move that much erself onto the floor. back into bed. She with the rest of the night.	t, but before she could finish or the fall. Resident #2 uch but managed to roll She got the lift and put her atched Resident #2 closely She reported she had not injuries. She noted Resident					
	Coordinator) Nurse o	ne SDC (Staff Development n 07/24/24 at 4:10 pm she if were required to complete					

		(X3) DATE SURVEY COMPLETED	
345207 B. WING		C <b>07/26/2024</b>	
NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS N&R CTR OF COLUMBUS CTY	STREET ADDRESS, CITY, STATE, ZIP CODE  1402 PINCKNEY STREET  WHITEVILLE, NC 28472	07/26/2024	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)		
orientation for Agency Staff prior to starting their first shift at the facility. She explained she personally went through the book and explained each section topic and asked the agency staff member to read the details in each section and sign off that that it was done and understood. She noted staff had the opportunity to ask questions after reading the orientation materials. She recalled Nurse #7 did sign she had completed the agency orientation and had not asked her any questions. She concluded Nurse #7 signed the orientation book on 07/10/24 in acknowledgement that she had read and understood the facility policies.  Review of the Agency Orientation Book verified Nurse #7 had initialed the agency orientation sign in sheet on 07/10/24 indicating she had read and understood the facility policies that included the in-service, "Falls", that documented neurological follow up assessments were completed every hour x 4 then every shift x 72 hours after a fall.	727	8/18/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
345207		345207	B. WING		C 07/26/2024			
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE				
				1402 PINCKNEY STREET				
LIBERTY COMMONS N&R CTR OF COLUMBUS CTY		COLUMBUS CTY		WHITEVILLE, NC 28472				
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 727	Continued From page	÷ 51	F 72	27				
	This REQUIREMENT by: Based on record revi facility failed to sched (RN) for at least 8 con	ncy of 60 or fewer residents.  is not met as evidenced  lews and staff interview, the lule a Registered Nurse hersecutive hours 12 of 122		The statements made on this procurection are not an admission not constitute an agreement with	to and do			
	06/11/23, 06/24/23, 0	days included 06/10/23, 7/02/23, 07/09/23, 07/23/23, 1/12/23, 11/18/23, 11/19/23,		alleged deficiencies.  To remain in compliance with all and state regulations the facility or will take the actions set forth plan of correction. The plan of co	has taken in this			
	Findings included:			constitutes the facility□s allegati compliance such that all alleged	ion of			
	month of June 2023, 1, 2023, through Nov conducted on 07/26/2	24. The daily schedules		deficiencies cited have been or corrected by the dates indicated F727 The plan of correcting the specific forms.	l. fic			
	88 from June 2023 th daily schedules reveal	census ranged from 75 to rough November 2023. The aled a Registered Nurse led for at least 8 consecutive		deficiency. The plan should add processes that lead to the defici cited:  The facility failed to staff Registe	ency			
	hours a day on the fo 06/11/23, 06/24/23, 0	llowing dates: 06/10/23, 7/02/23, 07/09/23, 07/23/23, 1/12/23, 11/18/23, 11/19/23,		Nurse coverage for 8 consecutive daily.  1. Corrective action for resident	e hours			
	and 11/26/23.			affected by the alleged deficient	practice:			
	PM with the facility 's interview, inquiry was hours indicated on the	ducted on 07/26/24 at 12:55 Administrator. During the made in regards to the RN e staffing schedule. The		At least eight consecutive hours registered nurse staffing will be maintained daily by 8/18/2024.				
				<ol><li>Corrective action for resider the potential to be affected by the deficient practice.</li></ol>				
		egulations. The as of January 2024 the to provide RN coverage 8		8/15/2024, staffing sheets were by the Director of Nurses for the days to monitor that at least eigl consecutive hours of registered staffing was in place daily. 30 o	last 30 nt nurse			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		345207	B. WING			C	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  1402 PINCKNEY STREET  WHITEVILLE, NC 28472		07/26/2024	
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 727	Continued From pag	e 52	F 72	days had at least 8 consecutive registered nurse hours in place. process to maintain eight conse hours of registered nurse staffin and use of a contracted agency registered nurses will be develouse by 8/18/2024.  3. Measures /Systemic chang prevent reoccurrence of alleged practice:  On 08/15/2024, the Nurse Conseducated the Administrator and Nurses on the requirement of the to staff Registered Nurse Cover least 8 consecutive hours daily. by a Registered nurse for a least consecutive hours will be maint 8/18/2024.  4. Monitoring Procedure to enthe plan of correction is effective specific deficiency cited remains and/or in compliance with regular requirements.  The Director of Nurses will mon compliance utilizing the F272 Q Assurance Tool weekly for staffir registered nurse hours daily x 2 then monthly x 3 months. The D Nursing will monitor staffing for compliance with the requiremer least 8 hours of registered nurse daily. Reports will be presented weekly Quality Assurance commithe Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be	An oncall ecutive on decutive of daily of for oped and in oped active of active of active of oped and in oped active of oped active oped active oped active of oped active oped a		

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		345207	B. WING			C <b>07/26/2024</b>	
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP COD  1402 PINCKNEY STREET  WHITEVILLE, NC 28472	<u>I</u>	07/26/2024	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE		
F 727	Continued From page  Drug Regimen Revie	e 53 w, Report Irregular, Act On	F 7	and the ongoing auditing progreviewed at the weekly Quality Meeting. The weekly QA Mee attended by the Administrator Nursing, MDS Coordinator, TI Manager, Health Information and the Dietary Manager.  Date of Compliance:8/18/2024	y Assuran ting is , Director herapy		
SS=E	CFR(s): 483.45(c)(1)(1)(1)(1)(2)(1)(2)(1)(2)(1)(1)(2)(1)(2)(1)(1)(2)(1)(2)(1)(2)(1)(2)(2)(1)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)	imen Review.  lag regimen of each resident east once a month by a view must include a review cal chart.  armacist must report any tending physician and the ctor and director of nursing, st be acted upon.  de, but are not limited to, any riteria set forth in paragraph an unnecessary drug.  noted by the pharmacist st be documented on a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345207	B. WING _	B. WING		C <b>07/26/2024</b>		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	· · · · · ·	<u></u>	
LIBERTY	COMMONS N&R CTR O	F COLUMBUS CTY		1402 PINCKNEY STREET WHITEVILLE, NC 28472				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 756	Continued From pag	e 54	F 7	56				
	be no change in the	n to address it. If there is to medication, the attending cument his or her rationale in al record.						
	maintain policies and drug regimen review limited to, time frame the process and step when he or she ident requires urgent actio	cility must develop and I procedures for the monthly that include, but are not es for the different steps in es the pharmacist must take tifies an irregularity that n to protect the resident. T is not met as evidenced						
	Based on record rev Pharmacist Consulta the Pharmacy Consu- resident (Resident #5 Novolog Insulin befo- order to "hold if gluco- less than 120 milligra- times during two mor (June 2024 and July reviewed for unneces	riew, staff interviews, ant and Physician interviews altant failed to identify that a 59) received 10 units of the meals for diabetes for an abse (blood sugar level) was alms per deciliter (mg/dl)" 10 anthly drug regimen reviews 2024) for 1 of 5 residents assary medications.		The statements made correction are not an not constitute an agrealleged deficiencies. To remain in complia and state regulations or will take the action plan of correction. The constitutes the facility compliance such that deficiencies cited have	admission to and eement with the ement with all federa the facility has tall as set forth in this ne plan of corrections's allegation of tall alleged	ıl ken		
	12/07/21. Diagnoses mellitus.  The Minimum Data S dated 06/11/24 revea cognitively intact and hypoglycemic (medic medications.  A review of the Physical medications.	Imitted to the facility on sincluded type 2 diabetes  Set quarterly assessment aled Resident #59 was I she received insulin and cations to treat diabetes)  ician's order revealed an Novolog Insulin, inject 10		corrected by the date F756 The Pharma to identify that a reside received 10 units of I before meals for diab "hold if glucose (bloodless than 120 milligra (mg/dl)" 10 times dur regimen reviews (Jur 2024) for 1 of 5 reside unnecessary medica 1. Corrective action affected by the allege On 7/24/2024 Reside	acy Consultant failed dent (Resident #58 Novolog Insulin petes for an order to sugar level) was ams per deciliter ring two monthly dine 2024 and July lents reviewed for titions.  In for resident(s) ded deficient practice	to s		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345207	B. WING		C <b>07/26/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	2.02-0		STREET ADDRESS, CITY, STATE, ZIP CODE	0772072024	
NAME OF T	TO VIDER OR OUT FIER			, , ,		
LIBERTY (	COMMONS N&R CTR OF	COLUMBUS CTY		1402 PINCKNEY STREET		
			WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475	
F 756	Continued From page	÷ 55	F 756	6		
	units subcutaneously	with meals and hold if		assessed by the Director of Nursing fo	r l	
	glucose is less than 1			any adverse events related to		
	J	ŭ		hypoglycemia. There were no identifie	ed	
	A review of the June	2024 Medication		concerns. On 7/24/2024 resident #59		
	Administration Record	d revealed an order Novolog		Novolog order was reviewed by the		
	Insulin, inject 10 units	subcutaneously with meals		medical director with clarification order	s	
	and hold if glucose is			received and initiated.		
		sugar reading was 109				
		04 mg/dl on 06/24/24, and		Corrective action for residents wit		
	114 mg/dl on 06/30/24			the potential to be affected by the alleg	ged	
		d revealed Resident #59		deficient practice.		
		receiving the Novolog Insulin		All residents in the facility who take		
		06/24/24, and 06/30/24 as		medications have the potential to be		
	evidenced by a check	kmark and nursing initials.		affected.		
	A rovious of the June	2024 drug regimen review		On 08/15/2024 the DON began auditir 100% of resident medication	lg	
		nsultant Pharmacist revealed		administration records of residents wit	<u> </u>	
		nendation recognizing that		active orders for Insulin with paramete		
		rder to hold if blood glucose		to identify any administration of		
		g/dl was administered even		medications outside of the parameters		
	_	ar reading was less than		within the past 14 days.		
		4, 06/24/24, and 06/30/24.		On 8/15/2024 The Director of Nurses a	and	
				nursing team completed corrective act	ion	
	A review of the July 2	024 Medication		for those residents including review of		
		d revealed an order for		audit findings with medical director,		
		t 10 units subcutaneously		clarification in orders and updating ord	ers	
		f glucose is less than 120		per medical director direction.		
		s blood sugar reading was				
		4, 113 mg/dl on 07/03/24,		0. Management (Occatage) in the constant		
	and 109 mg/dl on 07/			3. Measures /Systemic changes to		
	07/10/24, 117 mg/did 07/22/24, and 116 mg	on 07/21/24, 100 mg/dl on		prevent reoccurrence of alleged deficient practice:	#IIL	
		ation Record revealed		Beginning on 8/15/2024 the Pharmaci	et	
		cumented as receiving the		Manager educated the Pharmacy	οι 	
		nits on 07/01/24, 07/03/24,		Consultant The drug regimen of each		
	_	7/21/24, 07/22/24, and		resident must be reviewed at least one	e a	
		ed by a checkmark and		month by a licensed pharmacist. Th		
	nursing initials.	,		pharmacist must report any irregulariti		
				to the attending physician and the faci		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345207	B. WING			C 7/26/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		7772072024	
				1402 PINCKNEY STREET			
LIBERTY	COMMONS N&R CTR O	F COLUMBUS CTY		WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 756	Continued From pag	e 56	F 7	56			
F 756	A review of the July 2 conducted by the Co there was no recommer the Novolog Insulin of was less than 120 m though the blood sug 120 mg/dl on 07/01/2 07/10/24, 07/21/24, 07/21/24, 07/21/24, 07/21/24, 07/21/24, 07/21/24, 07/21/24, 07/21/24, 07/21/24, 07/21/24, 07/21/24, 07/21/24, 07/21/24, 07/21/28 PM. The Pharmacist 1:28 PM. The Pharmacist 1:29 PM. The Pharmacist 1:20 mg/dl. She that the medication via given despite the ord doing her drug regimes the did not alert the error. The Pharmacist 1:20 Pharmacist	nsultant Pharmacist revealed nendation recognizing that order to hold if blood glucose g/dl was administered even par reading was less than 24, 07/03/24, 07/06/24, 07/22/24, and 07/24/24.  The Consultant on 07/24/24 at nacist Consultant reported by on 07/23/24 and completed the review for the month of the nursing staff had diadministered the ordered ons even though the order olood glucose level was less a stated she had overlooked was documented as being the to hold it when she was ten reviews and as a result, nursing staff regarding the st Consultant stated it was sing staff to follow the en administering insulin to from getting hypoglycemia (a levels below normal).  Inducted with the facility that 10:17 AM. The nad the parameter for holding recause he did not want I sugar level to get too low.	F 7	medical director and director of Beginning on 8/14/2024 the State development Coordinator begins education to all full time, part of RN, LPN, Med aide, Med tech following topics: Unnecessary administration and Preventing errors by following Hold medicordered parameters.  This information has been into the standard orientation training required in-service refresher of all staff identified above and were viewed by the Quality Assurprocess to verify that the charbeen sustained. Any staff where eviewed by the allowed training has been completed.  4. Monitoring Procedure to the plan of correction is effect specific deficiency cited remain and/or in compliance with regrequirements.  The Director of Nurses or desmonitor compliance utilizing the Quality Assurance Tool for conwith the Drug Regimen Revierelated to Medications with Hoparameters. Reports weekly then monthly x 3 month or until The Director of Nursing will medications with parameters.	staff gan time, prn n staff on the y medication g medication cation per egrated into ng and in the courses for vill be rance nge has o does not training by to work until ensure that ive and that ins corrected ulatory eignee will ne F756 mpliance w Process old x 2 weeks til resolved. sonitor 5 emic to ensure		
	this order not being f	l if the facility was alerted to ollowed than the resident ed the insulin unnecessarily.		orders were followed per med direction. Reports will be pres weekly Quality Assurance cor	sented to the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			1			С
		345207	B. WING _		07/	/26/2024
	ROVIDER OR SUPPLIER  COMMONS N&R CTR OF	COLUMBUS CTY		STREET ADDRESS, CITY, STATE, ZIP CODE  1402 PINCKNEY STREET  WHITEVILLE, NC 28472		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756 F 757 SS=E	Continued From page  Drug Regimen is Free  CFR(s): 483.45(d)(1)-	e from Unnecessary Drugs	F 7	the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be moni and the ongoing auditing program reviewed at the weekly Quality Assur Meeting. The weekly QA Meeting is attended by the Administrator, Direct Nursing, MDS Coordinator, Therapy Manager, Health Information Manage and the Dietary Manager.  Date of Compliance: 8/18/2024	ance or of	8/18/24
35-L	§483.45(d) Unnecess Each resident's drug unnecessary drugs. Adrug when used- §483.45(d)(1) In exceduplicate drug therap §483.45(d)(2) For exceduplicate drug therap §483.45(d)(3) Without use; or §483.45(d)(5) In the processed or discontinut §483.45(d)(6) Any co	sary Drugs-General. regimen must be free from An unnecessary drug is any essive dose (including by); or cessive duration; or at adequate monitoring; or at adequate indications for its coresence of adverse indicate the dose should be				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _	c		
		345207	B. WING				26/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIDEDTY	COMMONO NOD OTO	OF OO! !!!!!!!!! OT!!		14	102 PINCKNEY STREET		
LIBERTY	COMMONS N&R CTR	OF COLUMBUS CTY		W	/HITEVILLE, NC 28472		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL  OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 757	Continued From pa	nge 58	F	757			
	-	NT is not met as evidenced					
	by:	VI IS NOT MET AS EVIDENCED					
		eview, staff interviews,			The statements made on this plan of		
		tant and Physician interviews			correction are not an admission to and	do	
		low a physician's order when a			not constitute an agreement with the		
	resident (Resident	#59) received 10 units of			alleged deficiencies.		
		fore meals for diabetes when			To remain in compliance with all federa		
		old if glucose (blood sugar			and state regulations the facility has tal	ken	
	-	n 120 milligrams per deciliter			or will take the actions set forth in this		
		received the medication 6			plan of correction. The plan of correction	n	
		e 22, 2024, and July 24, 2024,			constitutes the facility's allegation of		
	medications.	reviewed for unnecessary			compliance such that all alleged deficiencies cited have been or will be		
	medications.				corrected by the dates indicated.		
	Findings included:			F757 The facility failed follow a			
	i mamgo moradoa.			physician's order when a resident			
	Resident #59 was a	admitted to the facility on			(Resident #59) received 10 units of		
		es included type 2 diabetes			Novolog Insulin before meals for diabe	tes	
	mellitus.				when the order read to "hold if glucose		
					(blood sugar level) was less than 120		
		Set quarterly assessment			milligrams per deciliter (mg/dl).		
		ealed Resident #59 was			<ol> <li>Corrective action for resident(s)</li> </ol>		
		nd she received insulin and			affected by the alleged deficient practic	e:	
		lications to treat diabetes)			On 7/24/2024 Resident #59 was	_	
	medications.				assessed by the Director of Nursing for		
	A review of the phy	sician's order revealed an			any adverse events related to hypoglycemia. There were no identifie	d	
		or Novolog Insulin, inject 10			concerns. On 7/24/2024 resident #59	ч	
		sly with meals and hold if			Novolog order was reviewed by the		
	glucose is less than				medical director with clarification orders	S	
		, and the second			received and initiated.		
	A review of the Jun	e 2024 Medication					
		ord revealed an order for			2. Corrective action for residents with		
		ect 10 units subcutaneously			the potential to be affected by the alleg	ed	
		d if glucose is less than 120			deficient practice.		
	mg/dl. Resident #59's blood sugar reading was				All residents in the facility who take		
	109 mg/dl on 06/22			medications have the potential to be			
		ord revealed Resident #59			affected.	_	
	i received the Novol	og Insulin on 06/22/24 as			On 08/15/2024 the DON began auditing	g	I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		<b>345207</b> B.		B. WING			C 07/26/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	20/2024
					402 PINCKNEY STREET		
LIBERTY COMMONS N&R CTR OF COLUMBUS CTY		F COLUMBUS CTY			VHITEVILLE, NC 28472		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 757	Continued From pag	ne 59	F 7	757			
		kmark and nursing initials.			100% of resident medication		
	Sylashood by a shookmank and harding initials.				administration records of residents with	) 1	
	A review of the July 2024 Medication				active orders for Insulin with parameter		
		rd revealed an order for			to identify any administration of		
		ct 10 units subcutaneously			medications outside of the parameters		
		if glucose is less than 120			within the past 14 days.		
	mg/dl. Resident #59's blood sugar reading was				On 8/15/2024 The Director of Nurses a	ınd	
	107 mg/dl on 07/01/24, 113 mg/dl on 07/03/24,				nursing team completed corrective acti	on	
		7/06/24, 114 mg/dl on			for those residents including review of		
		g/dl on 07/24/24. The			audit findings with medical director,		
		ration Record revealed			clarification in orders and updating ord	ers	
		ed the Novolog Insulin on			per medical director direction.		
		07/06/24, 07/10/24, and			2 Management (Constanting observation to		
	07/24/24 as evidence			Measures /Systemic changes to	nt		
	nursing initials.				prevent reoccurrence of alleged deficient practice:	TIL	
	An interview was cor	nducted with Nurse #1 on			Beginning on 8/14/2024 the Staff		
		. Nurse #1 confirmed the			development Coordinator began		
		ation Administration Record			education to all full time, part time, PRI	٧.	
		24, 07/03/24, 07/10/24, and			RN, LPN, Med aide, Med tech staff on		
		She stated the checkmark			following topics: Unnecessary medicat		
	under each of the da	ites meant that the			administration and Preventing medicat		
	medication was adm	inistered. Nurse #1 stated			errors by following Hold parameters pe	r	
		e Novolog Insulin even			Medical provider orders.		
		d to hold the insulin if the					
	•	is less than 120 mg/dl			This information has been integrated in		
		t stated she wanted it. Nurse			the standard orientation training and in		
		nt had rights and if she			required in-service refresher courses for	r	
	wanted the medication	on, then she would			all staff identified above and will be		
	administer it.				reviewed by the Quality Assurance		
	An intonvious with No.	rse #2 on 07/26/24 at 10:10			process to verify that the change has been sustained. Any staff who does not	ot	
		med the initials on the			receive scheduled in-service training b		
		ration Record on 07/06/24			8/18/2024 will not be allowed to work u	•	
		to the checkmark under the			training has been completed.	11411	
		was administered meant that			aaming had boom completed.		
		administered. She stated she			4. Monitoring Procedure to ensure th	at	
		if she administered the			the plan of correction is effective and the		
		d she may have signed it as			specific deficiency cited remains correct		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
	<b>345207</b> B. WING			C <b>07/26/2024</b>			
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<b></b> E	01120/2024	
				1402 PINCKNEY STREET			
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY		WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			
F 757	Continued From page	e 60	F 7	757			
	An interview was come Physician on 07/24/24 Physician stated he has the insulin in place be Resident #59's blood. He stated he would have staff to follow the order insulin when the glucon.	ad the parameter for holding ecause he did not want sugar level to get too low. ave expected the nursing er as written and hold the lose reading was below 120 dent would not receive a		and/or in compliance with regarequirements.  The Director of Nurses or desimonitor compliance utilizing the Quality Assurance Tool for convith the Drug Regimen Review related to Medications with Hoparameters. Reports weekly then monthly x 3 month or unterested to followed per medical provider Reports will be presented to the Quality Assurance committee Director of Nurses to ensure of action is initiated as appropriated Compliance will be monitored ongoing auditing program reviweekly Quality Assurance Meweekly QA Meeting is attended Administrator, Director of Nurse Coordinator, Therapy Manage Information Manager, and the Manager.	ignee will ne F757 mpliance w Process old x 2 weeks til resolved onitor 5 ns with were direction. he weekly by the corrective tte. and the iewed at the eting. The d by the sing, MDS er, Health	d.	
F 880 SS=E			F 8	Date of Compliance:8/18/	2024	8/18/24	
		blish and maintain an nd control program safe, sanitary and ent and to help prevent the asmission of communicable					

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345207	B. WING				C <b>26/2024</b>	
NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS N&R CTR OF COLUMBUS CTY				1402 PINCK	DRESS, CITY, STATE, ZIP CODE KNEY STREET LE, NC 28472	1 017	2012024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 880	§483.80(a) Infection program. The facility must esta and control program a minimum, the follow \$483.80(a)(1) A systereporting, investigating and communicable distaff, volunteers, visit providing services unarrangement based usonducted according accepted national staff system of surveincedures for the procedures for the procedure	prevention and control ablish an infection prevention (IPCP) that must include, at wing elements:  em for preventing, identifying, ng, and controlling infections iseases for all residents, tors, and other individuals ader a contractual upon the facility assessment to §483.70(e) and following andards;  In standards, policies, and rogram, which must include, it illiance designed to identify ble diseases or y can spread to other (i) im possible incidents of ise or infections should be insmission-based precautions ivent spread of infections; blation should be used for a ut not limited to:	F	380				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345207	B. WING		07/26/2024	
NAME OF PROVIDER OR SUPPLIER  LIBERTY COMMONS N&R CTR OF COLUMBUS CTY				STREET ADDRESS, CITY, STATE, ZIP CODE  1402 PINCKNEY STREET  WHITEVILLE, NC 28472	1 07720/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)			TION
F 880	contact will transmit to (vi)The hand hygiene by staff involved in dispersion of the staff involved in	s or their food, if direct he disease; and procedures to be followed rect resident contact.  In for recording incidents acility's IPCP and the en by the facility.  Ile, store, process, and to prevent the spread of view.  In it is not met as evidenced it is not met	F 88	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 federal and state regulations the facility has taken or wil take the actions set forth in this plan o correction. The plan of correction constitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.  F880 the facility failed to maintain infection control prevention by: (1) touching medications with bare hands during medication preparation for 1 of medication administration observation completed; and (2) failed to follow enhanced barrier precautions while ca	3 6	

OLIVILIN	CT OIL MEDIO/ IIL G	MEDIO/ (ID CEITVICE)				<del></del>	0.0000 0001
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		` ′	E SURVEY IPLETED
			A. BOILDI				С
		345207	B. WING			07	7/26/2024
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
LIDEDTY	COMMONE NOD CTD OF	E COLLIMBUS CTV		14	402 PINCKNEY STREET		
LIBERTY	COMMONS N&R CTR OF	F COLUMBUS CTT		W	/HITEVILLE, NC 28472		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		COMPLETION DATE
F 880	Continued From page 63			880			
		s with her bare hands: Lasix,	•		for a resident ' s feeding tube for 1 of 2	,	
	Protonix, Docusate, (				residents observed for tube feeding ca		
		loft. She popped the pills out			(Resident #37).	10	
					(resident wer).		
		of the bubble packs into her bare hand then placed them in a medication cup. She was not			" Address how corrective action will	be	
	·	d sanitizer or wash her			accomplished for those residents found		
	hands prior to prepar	ing the medications. During			have been affected by the deficient		
	medication preparation			practice;			
	keyboard, and multip			Medication aide #4 was immediately			
	packs. She was stop			redirected and educated by the directo	r of		
	threshold of the door	into the resident 's room.			nursing on medication administration		
					policy to include never touch pills or		
		Medication Aide #4 on			tablets with bare hands. The medication	ons	
		she stated she intended to			were discarded at time of education.		
		ations to the resident. She					
		used her bare hands to			Nurse #5 was received immediately 1	:1	
		and she was not aware she			education on Enhanced Barrier		
	should not because s	ht it was fine to handle the			Precautions by the Staff development coordinator to include: Perform hand		
	_	out wearing gloves and that			hygiene with alcohol based hand rub o	ır	
	I -	do it as well. The Director of			wash with soap and water before enter		
		n the hallway and present			and leaving roomWear gown and	"'9	
	_ , ,	with Medication Aide #4.			gloves for the following High-Contact		
					Resident Care Activities which include	:	
	In an interview with the	ne DON on 7/23/24 at 9:40			Dressing, bathing/showering,		
	am she stated nurses	s are taught in orientation to			Transferring, Changing linens, changir	ıg	
	pop medications into	the cap of the bottle or into			briefs or assisting with toileting, and		
	the medication cup, r	not into a bare hand. She			Device Care or use: central line, urinar	у	
	I -	ledication Aide #4 was hired			catheter, feeding tube, tracheostomy,		
		not a Medication Aide, she			Wound Care: any skin opening requirir		
	_	orientation as a Medication			dressing.		
		I medications should never					
		hands then given to a			H. Address based 6 99 99 9	<b>c</b> .	
	resident.				" Address how the facility will identi	-	
	In an additional inter-	view with the DON or			other residents having the potential to		
	In an additional interv	= +			affected by the same deficient practice	,	
		she recanted her statement #4 had not been trained on			All residents receiving oral medication	are	
	how to handle medical				at risk to be affect by the deficient	aı <del>c</del>	
	I HOW TO HAITUIE HIEUICA	anona ana providea			at non to be affect by the deficient		1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED	
		345207	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	040207		STREET ADDRESS, CITY, STATE, ZIP CODE	•	/26/2024	
NAME OF T	NOVIDEIX OIX 301 1 EIEIX			1402 PINCKNEY STREET			
LIBERTY	COMMONS N&R CTR	R OF COLUMBUS CTY					
				WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	Continued From p	age 64	F 8	80			
	documentation that	at showed Medication Aide #4		practice.			
	had been educate	d to not touch pills or tablets		On 8/15/2024 the Director of N	lursing and		
	with her bare hand	ds and had passed a return		Nurse management team bega	an auditing		
	demonstration skil	lls test.		staff compliance with adhering			
				control practices during medica			
		dication Aide Technician (SNF)		administration by completing 5			
		vealed that on 8/15/23 4 was observed one time in a		observations to include all shif			
		ion to administer PO		completed on 8/16/2024. The included: _5 of _5 staff fo			
		ne facility policy successfully.		Medication Administration police			
		4 had signed the facility policy		never touching pills or tablets	•		
		er touch pills or tablets with		hands. No corrective action re			
	bare hands" on 08	•			•		
				All residents requiring Enhance	ed Barrier		
	In an interview wit	h the facility physician on		Precautions (EBP) are at risk t	o be affect		
		am he stated he would not		by the deficient practice.			
		ndle medications with their bare		On 8/15/2024 the Director of N	-		
	•	ninistration to a resident in an		Nurse management team bega			
	· ·	ne spread of infection.		staff adherence to EBP by con observations of staff to include			
		ed Barrier Precautions sign was ident 37's door. The sign read		during high contact resident ca			
		and hygiene with alcohol		activities. This completed on			
		wash with soap and water		The results included: 10 of			
		nd leaving roomWear gown		were in compliance with follow			
		following High-Contact		Enhanced Barrier Precautions	-		
	Resident Care Act	tivities which include: Dressing,		Corrective action required.			
		յ, Transferring, Changing linens,					
		assisting with toileting, and					
		e: central line, urinary catheter,					
	_	neostomy, Wound Care: any		" Address what measures v			
skin opening r		ırıng a dressing.		into place or systemic changes			
	An observation of	Nurse #5 performing bolus		ensure that the deficient practi	re Mili LIOI		
		ent #37 was conducted on		recur;			
		9 AM. Nurse #5 applied gloves		On 8/14/2024, the Director of I	Vursing and		
		I providing bolus feeding		the Staff Development Coordin	-		
		#37's gastrostomy tube without		began in-servicing all clinical s			
	a protective gown	· ·		include agency staff on Medica			
	.			Administration Policy with focu			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345207	B. WING _			C <b>07/26/2024</b>	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD			
				1402 PINCKNEY STREET			
LIBERTY	COMMONS N&R CTR O	F COLUMBUS CTY		WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	Continued From page	e 65	F 8	80			
F 880	An interview with Nur 7/22/2024 at 12:20 P was supposed to have when performing tube that she just forgot be and the use of enhancew.  An interview with the Coordinator (SDC) N 7/23/2024 at 8:30 AN staff were educated r Enhance Barrier Precon 4/1/2024. She fur Nurse had educated Barrier Precautions of education was contin 3/26/2024. The SDC Assistant Director of assisted her in provice in-services regarding Precautions on 4/24/2024. She frontinuing to monitor conducting audits an education regarding Precautions. The SD #5 was supposed to while performing bold.  An interview with Director on 7/24/2024 at 2:09 Nurse #5 was supposed Barrier Precautions to	rse #5 was completed on M. Nurse #5 stated that she re worn a protective gown a feeding. She further stated ecause she was nervous, aced barrier precautions was staff Development urse was conducted on M. The SDC stated the facility multiple times regarding the cautions that went into effect ther stated that the prior SDC the staff on Enhanced on 3/21/2024 and hat the nued on 3/21/2024 and Nurses indicated that the Nursing (ADON) had ling additional staff Enhanced Barrier 2024, 4/25/2024, 5/8/2024 further indicated that she was the progress of the staff by d providing continuing Enhanced Barrier C Nurse stated that Nurse have been wearing a gown as feeding for Resident #37.  Sector of Nursing (DON) and of Nursing was completed PM. The DON stated that seed to follow the Enhanced hat were put in place	F8	Infection Control and Enhance Precautions. The Director of the Staff Development Coordi will ensure that any of the abostaff who does not complete the training will not be allowed to 8/18/2024 or until the training completed. Education on Infection Control during Medication Adrand Enhanced Barrier Precausincorporated in the new emploorientation for clinical staff and provided to agency staff workifacility. This will be reviewed Quality Assurance process to the change has been sustained.  Indicate how the facility promotion its performance to massolutions are sustained.  The Administrator and Director and/or designee will monitor the ensure Enhanced Barrier Precentation control during Medic Administration weekly for 2 words will be presented to the Quality Assurance committee Administrator and/or Director ensure corrective action initiated appropriate. Compliance will the and ongoing auditing program the weekly Quality Assurance. The weekly QA Meeting is atternation of the staff of the weekly QA Meeting is atternation.	Nursing and nator (SDC) ove identified the in-service work on is ection ministration tions is over facility d also ing in the by the verify that ed.  Islans to ake sure that or of Nursing ag F880 to cautions and ation eeks and resolved. The weekly by the of Nursing to ted as or enonitored in reviewed at Meeting, ended by the		
	Resident #37. She fu was supposed to have	ming bolus tube feeding for or o		Administrator, Director of Nurs Coordinator, Therapy, Health Manager, and the Dietary Dire	Information		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER		IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
345207		B. WING _			C		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		7/26/2024	
	(0.115 E. (0.11 E. E. (1.11 E			1402 PINCKNEY STREET	_		
LIBERTY	COMMONS N&R CTR OF	COLUMBUS CTY		WHITEVILLE, NC 28472			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	Continued From page	e 66	F8	80			
	the staff had received	N and the ADON indicated multiple in-services and to continue auditing for		" Date of Compliance 8/18/2024			
	7/26/2024 at 12:51 Pl that Enhanced Barrie the facility and that sh nervous and forgot to administering bolus to She further stated that expected the staff to the	ube feeding to Resident #37. It at the end of the day, she follow policies and proper use of personnel					