STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification survey and complaint investigation was conducted on 04/28/25 through 05/01/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # NTY611.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted on 04/28/25 through 05/01/25. Event ID# NTY611. The following intakes were investigated NC00229744, NC00219835, NC00229325, NC00220987, NC00220031, NC00221615, NC00217801. 1 of the 24 complaint allegations resulted in deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		5/21/25

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

Electronically Signed | 05/19/2025

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F 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Medical Director (MD), and Physician Assistant (PA) interviews, the facility failed to notify the provider of significant weight gain greater than 5-pound discrepancy from the last weight for a resident with Congestive Heart Failure (CHF) and on diuretic medication (a medication that helps the body remove excess fluid) when the resident's	F 580	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction	

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F 580	Continued From page 2 weight indicated a 27 pound weight gain in one week. This deficient practice occurred for 1 of 1 sampled resident reviewed for notification of change. (Resident #108) Findings included: Resident #108 was admitted on 04/18/25. His medical diagnoses included Congestive Heart Failure (CHF), coronary artery disease (CAD), and pulmonary hypertension. An admission physician order written to start on 04/18/25 revealed weekly weight times four weeks than monthly, and Demadex (used to reduce swelling). Review of Resident #108's weekly weights revealed: 04/18/24 hospital weight was 148.6 pounds (lbs.) 04/18/25 was 126.6 lbs. 04/19/25 was 126 lbs. 04/26/25 was 153.2 lbs., a weight gain of 27.2 lbs. in 7 days 04/28/25 was 156 lbs. Further review of Resident #108's medical record revealed there were no additional weights. Further review of the medical record for Resident #108 revealed there was no evidence the physician was notified of weight changes. An interview was conducted on 04/30/25 at 10:05 AM with Nurse #1. He stated he helped the NA on 04/26/25 to weigh Resident #108 since two nursing staff were needed to do resident's weight using a mechanical lift. He said he noticed the	F 580	constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F580 The facility failed to notify the provider of significant weight gain greater than a 5-pound discrepancy from the last weight for a resident with Congestive Heart Failure and on Diuretic Medication when the residents weight indicated a 27-pound weight gain in one week, resident # 108. 1. Corrective action for the resident involved On 04/28/2025 the Director of Nursing notified the Medical Director regarding the weight discrepancy identified. New orders obtained to complete daily weights on resident # 108. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice All residents have the potential to be affected by the alleged deficient practice. On 4/30/2025, the Maintenance Director recalibrated the standing scale and weights were completed on 100% of residents on 5/1/25. On 05/01/2025, the Registered Dietician completed an 100% audit of resident's weights with no concerns identified. Registered Dietician did not recommend	

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F 580	Continued From page 3 resident's weight was more than 20 lbs. greater than his last weight, but since there was not a specific physician order telling him to notify the MD if resident's weight was greater or less than 5 lbs., he did not need to, even if the resident had a history of CHF. He said he just went by what he saw on the physician orders, and since it did not say to contact the MD with significant weight change, he did not need to. An interview on 04/30/25 at 10:15 AM with the Director of Nursing (DON) revealed it was her expectation that Resident #108's physician should have been notified by his nurse of the resident's greater than 5-lb. weight gain in a week, given the residents' history of CHF, even if there was no physician order. An interview was conducted on 04/30/25 at 10:25 AM with the Physician Assistant (PA). The PA stated this was the first time he heard of Resident #108's one week weight gain of 27 pounds since admission on 04/18/25. He stated no staff had reported to him any weight concerns. The PA expected he or the MD to be notified if Resident #108's weekly weights were greater than 5-lbs. from the previous weight, especially if the resident had a diagnosis of CHF. The PA said he expected the MD to have been notified, in order to treat the weight gain and to determine if related to CHF, and if additional medication was to be ordered or a change in treatment needed. An interview was conducted on 05/01/25 at 9:45 AM with the Medical Director (MD). The MD stated this was the first time she had heard of Resident #108's weight gain of 27 pounds from 04/26/25. The MD said she expected to be notified if residents' weights were greater than 5	F 580	reweights for any of the identified residents. Beginning on 05/01/2025, facility implemented corrective action to include Physician Order for any discrepancy of 5 pounds more/less resident requires a reweight utilizing the same method. If the weight discrepancy remains, the provider must be notified. 3. Systemic Changes On 05/01/25 the Director of Nursing and/or Designee will begin educating all full time, part time or as needed Registered Nurses, Licensed Practical Nurses and Medication Aides including agency on the following topic: F580. • Any discrepancy weights of 5 pounds more/less will be reweighed immediately utilizing the same method. If the weight discrepancy remains, the provider must be notified. The Director of Nursing or designee will ensure that any of the above identified staff who does not complete the in-service training by 05/21/2025 will not be allowed to work until the training is completed. This in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements	

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F 580	Continued From page 4 pounds after a re-weight, which would include any resident having a diagnosis of CHF. The MD said she was not made aware or notified by nursing staff of resident's weight gain and should have. The MD said Resident #108's weight gains had no health outcome, and she expected the PA, MD, or on-call physician to have been notified, so they could treat the weight gain, and determine if it was related to CHF.	F 580	The Director of Nursing or designee will monitor completion of ongoing audits for F580 weekly for three (3) weeks and monthly for two (2) months or until resolved. The audit will monitor to ensure any resident with a five-pound gain or loss is reweighed utilizing the same method and provider notification if necessary. If applicable, any concerns identified will be reviewed with the facility Quality Assurance nurse consultant for interventions or additional training. Any negative findings will immediately be addressed and reviewed with the facility Quality Assurance nurse consultant for interventions or additional training. Reports will be presented to the weekly Quality Assurance Committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance meeting. The weekly Quality Assurance meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager and the Dietary Manager. Date of Compliance: 05/21/2025	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		5/21/25

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F 658	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Medical Director (MD), and Physician Assistant (PA) interviews, the facility failed to determine the accuracy of a weekly weight for a resident with Congestive Heart Failure (CHF) and on diuretic medication (a medication that helps the body remove excess fluid) when the resident's weight indicated a 27 pound weight gain in one week for 1 of 4 residents reviewed for nutrition. (Resident #108) Findings included: Resident #108 was admitted on 04/18/25. His medical diagnoses included Congestive Heart Failure (CHF), coronary artery disease (CAD), and pulmonary hypertension. An admission physician order written to start on 04/18/25 revealed weekly weight times four weeks then monthly, and Demadex (used to reduce swelling). Resident #108's Admission Minimum Data Set (MDS) dated 04/24/25 indicated the resident was moderately cognitively impaired, had CHF, CAD, and needed total assistance with activities for daily living (ADLs). Review of Resident #108's weekly weights revealed: 04/18/24 hospital weight was 148.6 pounds (lbs.) 04/18/25 was 126.6 lbs. 04/19/25 was 126 lbs. 04/26/25 was 153.2 lbs., a weight gain of 27.2 lbs. in 7 days. 04/28/25 was 156 lbs.	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 the facility failed to determine the accuracy of a weekly weight for a resident with congestive heart failure and on diuretic medication when the residents weight indicated a 27-pound weight gain in one week for 1 of 4 residents reviewed for nutrition, Resident # 108. 1. Corrective action for the resident involved On 4/30/25 the weight for Resident #108 was obtained with provider notification completed. No new orders were received from the physician. Care plan was revised by MDS coordinator on 05/02/2025 to include congestive heart failure and daily weights that included any discrepancy of 5 pounds more/less than previous weight a reweight to be completed utilizing same method, any discrepancy identified requires Provider notification.	

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F 658	Continued From page 6 Further review of Resident #108's medical record revealed there were no additional weights. An interview was conducted on 04/29/25 at 1:15 PM with Resident #108. The resident was alert, resting in bed, with feet elevated. He stated he was breathing fine, was not on any oxygen, had swollen ankles and feet, ate very little breakfast, but ate a normal lunch. He said he did not know if he had any weight gain or loss since his admission. An interview was conducted on 04/30/25 at 10:05 AM with Nurse #1. He stated he helped the NA on 04/26/25 to weigh Resident #108 since two nursing staff were needed to do resident's weight using a mechanical lift. He said he noticed the resident's weight was 27 lbs. greater than his last weight, but since there was no order do a re-weight for weights greater or less than 5 pounds, he did not need to do a re-weight. Nurse #1 could not recall the NA that weighed Resident #108. An interview on 04/30/25 at 10:15 AM with the Director of Nursing (DON) revealed it was her expectation that Resident #108 should have been reweighed "immediately" after noting a possible 27 lb. weight gain on 04/26/25. The DON stated any weights with a 5-pound discrepancy from the last weight should be re-weighed, especially since the resident had a history of CHF. She said she did not know why Nurse #1 did not get the NA to re-weigh Resident #108 but should have. An interview was conducted on 04/30/25 at 10:25 AM with the Physician Assistant (PA). The PA stated this was the first time he heard of Resident	F 658	2. Corrective action for residents with the potential to be affected by the alleged deficient practice All residents are at potential risk of being affected by alleged deficient practice. On 4/30/2025, the Maintenance Director recalibrated the standing scale and weights were completed on 100% of residents on 5/1/25. On 05/01/2025, the Registered Dietician completed an 100% audit of resident's weights with no concerns identified. Registered Dietician did not recommend reweights for any of the identified residents. Beginning 05/01/25, the Director of Nursing reviewed all residents with weight orders and revised physician's order to include the following verbiage: any discrepancy of 5 pounds more/less from previous weight will require a reweight utilizing the same method. Provider notification required if 5 pounds more/less discrepancy. This was completed on 05/02/2025. Beginning 05/13/2025, MDS Coordinator began auditing all resident's diagnosis for Congestive Heart Failure and updated Care Plans. This was completed on 05/16/2025. No other concerns were identified. 3. Systemic Changes	

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F 658	Continued From page 7 #108's one week weight gain of 27 pounds since admission on 04/18/25. The PA stated if Resident #108's weekly weight was greater than 5-lbs. from the previous weight, and had a history of CHF, that a re-re-wight should have been done. The PA said Resident #108's weight 27 gain had no health outcome but could have. An interview was conducted on 05/01/25 at 9:45 AM with the Medical Director (MD). The MD stated this was the first time she had heard of Resident #108's weight gain of 27 pounds from 04/19/25 to 04/26/25. The MD stated it was expected that if any resident had a weight loss or gain greater than 5 pounds from the previous weight, to have a re-weight confirming the second weight, which was not done, and was important in this case due to the resident having a diagnosis of CHF. The MD said Resident #108's weight gain of 27 lbs. could not have been accurate, since the resident had no respiratory health outcome, and that the weight was not close to the hospital's discharge weight.	F 658	On 05/01/25 Director of Nursing and/or designee began educating all full-time, part-time and as needed Registered Nurses, Licensed Practical Nurses and Medication Aides, including Agency, on the following topic: F658 and the facility weight process for obtaining weights and needed reweights and the notification process. The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 05/21/2025 will not be allowed to work until the training is completed. This in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing will monitor completion of ongoing audits for F658 weekly for three (3) weeks and monthly for two (2) months or until resolved. This audit will include all new admissions with Congestive Heart Failure have daily weights for 7 days. All new admits with Congestive Heart Failure will have Care Plans in place. All weekly weights have appropriate verbiage. Any negative findings will immediately be addressed and reviewed with the facility Quality Assurance Nurse Consultant for interventions or additional training. Reports will be presented to the weekly	

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F 658	Continued From page 8	F 658	Quality Assurance Committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance meeting. The weekly Quality Assurance meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager and the Dietary Manager. Date of Compliance: 05/21/2025	
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide 8 hours of Registered Nurse (RN) coverage for 1 of 419 days reviewed for staffing (08/11/24). Findings included:	F 727	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of	5/21/25

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F 727	Continued From page 9 The PBJ (Payroll Based Journal) Staffing Data Report Fiscal Year - Quarter 4, 2024 (July 1 - September 30) documented the facility had no RN Coverage on 08/11/24. Review of the daily assignment sheets from 03/8/24 through 04/30/25 revealed the RN who was originally scheduled to work 7:00 PM - 7:00 AM beginning on 08/11/24 had called off. The staff member who replaced the RN on the schedule was a Medication Aide. In an interview with the Director of Nursing (DON) and the Administrator on 05/01/25 at 11:49 AM the DON stated she had been the nurse on call and had taken the call when the RN called off work on 08/11/24. She noted it was her responsibility to find RN coverage for the shift and she had not. The Administrator stated she expected the on call staff member who had the on call phone to find coverage for the assignment. The Administrator explained that the process when there was a call off was that the on call staff member or nurse who had the "call off" phone was responsible for filling the assignment on the schedule. On 8/11/24 the on call nurse was notified of the call off but she did not find a replacement and no RN coverage was in the building on 8/11/24.	F 727	correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F727 The facility failed to provide 8 hours of Registered Nurse coverage for 1 of 419 days reviewed for staffing 8/11/24. 1. Corrective action for the resident involved Nursing administration and Scheduler will review schedules and staffing sheets daily to maintain eight (8) consecutive registered nurse hours daily. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice All residents have potential to be affected by the alleged deficient practice. Administrator, Director of Nursing, Assistant Director of Nursing, RN Manager, and Scheduler met on 05/01/2025 to revise monitoring process to include: ¿ Nurse management assigned to on call phone designated responsible for ensuring eight (8) hour RN coverage while receiving staff member call outs. ¿ Scheduler or designee to provide Administrator with eight (8) hour RN coverage every Friday for week following. ¿ Eight (8) hour RN coverage validated daily Monday through Friday and on	

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F 727	Continued From page 10	F 727	Fridays review Friday through Sunday in IDT morning meeting by Administrator or designee. ¿ Administrator or designee to send eight (8) hour RN coverage to regional operations team daily Monday through Friday. 3. Systemic Changes On 05/01/2025, the Administrator educated the Director of Nursing, Assistant Director of Nursing, RN Manager, and Scheduler on the following topic: F727 facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. All training was completed on 05/01/2025. This in-service will be incorporated into any new nurse managers during facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements The Administrator or designee will monitor completion of ongoing audits for F727 weekly for three (3) weeks and monthly for two (2) months or until resolved. This audit will review the days of week and identify the Registered Nurse coverage and the hours worked to ensure compliance of regulation of 8 hour Registered Nurse consecutive hours per day. Any negative findings will immediately be addressed and reviewed with the facility Quality Assurance Nurse Consultant for interventions and/or	

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F 727	Continued From page 11	F 727	additional training. Reports will be presented to the weekly Quality Assurance Committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance meeting. The weekly Quality Assurance meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager and the Dietary Manager. Date of Compliance: 05/21/2025	
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, staff, the Nurse Practitioner, and Physician interviews the facility failed to obtain an ordered Pro BNP (pro-B-type natriuretic peptide) a blood test that measures the levels of Pro BNP, a protein produced by the heart and used to help diagnose and monitor heart failure. This occurred for 1 of 1 resident (Resident #23) reviewed for laboratory services. Findings included.	F 770	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged	5/21/25

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F 770	Continued From page 12 Resident #23 was admitted to the facility on 2/6/25 with diagnoses including hypertensive heart disease and Stage 5 chronic kidney disease with heart failure. The Minimum Data Set (MDS) admission assessment dated 2/27/25 revealed Resident #23 was cognitively intact. A physician's order dated 4/3/25 for Resident #23 entered by Nurse #3 revealed to obtain a Pro BNP level. Review of Resident #23's electronic medical record from 4/3/25 through 5/1/25 revealed no documentation of the Pro BNP lab result. Review of the progress notes from 4/3/25 through 5/1/25 revealed no documentation that Resident #23 had experienced any acute symptoms of heart failure such as shortness of breath, swelling in the abdomen or lower extremities, chest pain, or fatigue. Her blood pressure was stable. During an interview on 4/30/25 at 12:00 PM the Nurse Practitioner stated the Pro BNP was ordered for Resident #23 to monitor heart failure. He stated he reviewed the electronic medical record and could not find the lab result. He indicated Resident #23 was not symptomatic, and the lab would be reordered. During an interview on 05/01/25 at 10:30 AM the Physician stated the Pro BNP lab was ordered for Resident #23 to evaluate her cardiovascular status due to heart failure and chronic kidney disease. She stated Resident #23 received hemodialysis three days a week which pulled fluid	F 770	deficiencies cited have been or will be corrected by the dates indicated. F770 the facility failed to obtain an ordered Pro BNP a blood test that measures the levels of Pro BNP a protein produced by the heart and used to help diagnose and monitor heart failure. This occurred for 1 of 1 resident (Resident #23 reviewed for laboratory services). 1. Corrective action for the resident involved On 5/2/25 the Director of Nursing notified provider lab was not obtained. Provider gave orders to obtain BNP lab. Lab obtained on 5/2/25. Provider reviewed and signed lab with no new orders given. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice All residents are at potential risk of being affected by alleged deficient practice. Beginning on 05/01/25 the Director of Nursing audited all Provider orders for lab in April 2025 to ensure no other lab was missed. This audit was completed 05/02/25. Results included: Seven (7) residents identified with outstanding lab orders. MD was notified by Director of Nursing on 05/02/2025. Labs were collected and reviewed by 05/05/2025 with no concerns identified. 3. Systemic Changes	

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F 770	Continued From page 13 off to keep her at dry weight (the weight after excess fluid is removed) and therefore had no significant outcome from not obtaining the ordered lab and she had not been symptomatic of acute heart failure or fluid overload. She stated she expected labs to be obtained according to the physician orders. During an interview on 5/1/25 at 2:00 PM Resident #23 was observed sitting up in a bedside chair in her room. She was alert and oriented to person, place, and time. She was smiling and talkative and was not aware of the ordered lab. She stated she received hemodialysis three days a week, she felt fine, and stated she had no complaints at this facility. An attempt was made on 5/1/25 at 2:19 PM to contact Nurse #3 who entered the order for the Pro BNP on 4/3/25. There was no response. During an interview on 05/01/25 at 2:00 PM the Director of Nursing stated she completed a record review and could not find the Pro BNP lab result for Resident #23. She stated she determined that the Physician entered the order into the electronic medical record but then the nurse who completed the new order failed to edit the order so that it would trigger on the Medication Administration Record (MAR) which was why it continued to be missed. She stated the process included that the physician entered the orders into the residents electronic medical record, then the nurse would go in and edit the order so that it would flow to the Medication Administration Record (MAR). The nurse was supposed to print the residents face sheet (this provides the residents identifying information) and fill out the lab requisition form (informs the lab of	F 770	Beginning on 5/13/25 the Director of Nursing and/or RN Manager will begin educating all full-time, part-time and as needed Registered Nurses, Licensed Practical Nurses and Medication Aides including Agency on the following topic: F770. The facility must provide or obtain laboratory services to meet the needs of its residents. • Process of Lab Orders • How to enter Lab Orders in PCC • How to confirm Lab Orders entered in by Provider The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 05/21/2025 will not be allowed to work until the training is completed. This in-service will be incorporated into the new employee Facility Orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor completion of ongoing audits for F770 weekly for three (3) weeks and monthly for two (2) months or until resolved. This audit will review lab order in PCC to ensure the order was followed as indicated. Any negative findings will immediately be addressed and reviewed with the facility Quality Assurance Nurse Consultant for interventions or additional training. Reports will be presented to the	

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F 770	Continued From page 14 what tests to perform) and then records the order in the lab book located at the nurses station. She stated Nurse #3 who was responsible for the error no longer worked at this facility. She stated labs were reviewed daily in clinical meetings to ensure they were done and to ensure that the physician had reviewed the results. She stated they missed the lab in clinical meetings because of the order not being edited and completed by Nurse #3 therefore it did not show on her lab reports. She stated she planned to review the process for ordered labs and education would be provided to staff.	F 770	weekly Quality Assurance Committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance meeting. The weekly Quality Assurance meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager and the Dietary Manager. Completion Date: 05/21/2025	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		5/21/25

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F 880	Continued From page 15 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 16 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to implement infection control policies and procedures when Nurse Aide #1 failed to apply all the required Personal Protective Equipment (PPE) before entering a room with a resident on special contact-droplet precautions. This occurred for 1 of 1 staff observed for infection control practices (Nurse Aide #1). The findings included: Review of the facility's contact precautions signage last revised 01/20/22 read in part: "All healthcare personnel must: Clean hands before entering and when leaving room. Wear gloves when entering room and remove before leaving room. Wear a gown when entering room and remove before leaving." The facility's Infection Prevention and Control Program policy last revised on 08/2024 read in part: "When a resident is infected or colonized with any Multidrug-Resistant Organism (MDRO) that has secretions or excretions that are unable to be covered or contained then contact precautions should be used." Review of Resident #111's April/2025 physician orders included: Admit to skilled level of care for Extended Spectrum Beta Lactamase (ESBL), Escherichia Coli (E. coli), Methicillin Resistant Staphylococcus Aureus (MRSA), and chronic kidney disease stage IV, Vancomycin, and	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F880 The facility failed to implement infection control policies and procedures when nurse aide #1 failed to apply all the required Personal Protective Equipment before entering a room with a resident on special contact-droplet precautions. This occurred for 1 of 1 staff observed for infection control practices. 1. Corrective action for the resident involved On 4/30/25 employee # 1 was immediately educated on the appropriate Personal Protective Equipment to be worn when entering resident room with contact precautions. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice	

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F 880	Continued From page 17 contact precautions related to ESBL dated 04/29/25. An interview and observation were conducted on 04/30/25 at 8:05 AM with Nursing Assistant (NA#1). NA #1 was observed entering room #104 to deliver Resident #111's breakfast meal tray without first cleaning her hands or applying appropriate contact precaution personal protection equipment (PPE) of gown and gloves. She was observed leaning against the left side of resident's bed while setting up his meal tray. She then exited the resident's room without washing her hands. When NA #1 was asked in the hall why she did not clean hands, or apply PPE she said she did not have to if the resident was on enhanced barrier precautions. The NA then looked at the isolation sign hanging on the resident's door and realized the resident was on contact precautions and not on enhanced contact precautions. She said, after reading the sign, that she made a mistake, thinking the resident was on enhanced contact precautions and not contact precautions. She stated she should have washed her hands prior to entering and exciting resident's room and applied a gown and gloves while in the room. An interview was conducted on 04/30/25 at 8:10 AM with Nurse #2. Nurse #2 stated Resident #111 was on contact precautions for having multiple Multidrug-Resistant Organism (MDRO) with secretions or excretions so he was ordered by the Physcian to be on contact precautions, the only resident in the facility on contact precautions. Nurse #2 indicated staff were supposed to clean hands and put on the PPE prior to entering the room.	F 880	All residents have the potential to be affected by the alleged deficient practice. On 5/19/25 an audit was completed on all residents to identify residents on precautions. The audit results determined: One (1) resident on contact precaution, one (1) resident on droplet precautions and sixteen (16) residents on enhanced barrier precautions. On 5/19/25, five (5) staff observations to ensure appropriate PPE use and interviews to assess knowledge of identified precautions conducted by nurse management. The audit results determined: no concerns identified. 3. Systemic Changes Beginning 4/30/25 Director of Nurses and/or Designee began education with all staff on contact precautions and appropriate Personal Protective Equipment for all Full time, part time, as needed staff in all departments and Agency staff on the following topic: F880 Infection Control. • Appropriate Personal Protective Equipment utilized in contact precaution rooms • Determining difference in signs indicating what Personal Protective Equipment to utilize The Director of Nursing or designee will ensure that any of the above identified staff who does not complete the in-service training by 05/21/2025 will not be allowed to work until the training is completed.	

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F 880	Continued From page 18 An interview was conducted with NA #1 on 04/30/25 at 8:15 AM and she stated, "it's confusing, I thought as long as I was not providing patient care it was ok since I was just taking the tray in the room. I did not realize there was a resident in the facility on contact precautions. She said she needed to pay closer attention to the isolation signs on residents' doors." An interview was conducted on 04/30/25 at 12:15 PM with the Physician Assistant (PA). The PA indicated he expected staff to read the contact isolation signage and put on the PPE prior to entering Resident #111's room. An interview was conducted on 04/30/25 at 12:20 PM with the Director of Nursing (DON). She stated, "Sometimes her nursing staff were not reading the signs." The DON further stated, "we haven't had a contact precaution isolation in a while." The DON indicated she expected NA #1 to have read the signage on the resident's door and put on the appropriate PPE that was listed on the signage, which the NA did not do. An interview was conducted on 05/01/25 at 10:45 AM with the Administrator. She indicated staff should read the isolation signs to understand the precautions before entering a room.	F 880	This in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements The Director of Nursing will monitor completion of ongoing audits for F880 weekly for 3 weeks and monthly for 2 months or until resolved. This audit will review staff knowledge of precautions and appropriate PPE use. Any negative findings will immediately be addressed and reviewed with the facility Quality Assurance Nurse Consultant for interventions or additional training. Reports will be presented to the weekly Quality Assurance Committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance meeting. The weekly Quality Assurance meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager and the Dietary Manager. Date of Compliance: 05/21/2025	