### Statement of Deficiencies and Plan of Correction

**A. Building Information**

**(X1) Provider/Supplier/CLIA Identification Number:** 

**B. Wing Information**

**(X2) Multiple Construction**

**(X3) Date Survey Completed:**

**R-C**

09/16/2020

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**Name of Provider or Supplier:**

LIBERTY COMMONS NRSG & REHAB CNTR OF SOUTHPORT LLC

**Street Address, City, State, Zip Code:**

630 FODALE AVENUE

SOUTHPORT, NC  28461

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**Summary Statement of Deficiencies**

**F 000 INITIAL COMMENTS**

A desk review follow up survey was completed on 09/16/20, Event ID# CJ3Q12. The facility was back in compliance effective date 09/09/20.

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**Provider's Plan of Correction**

**ID Prefix Tag**

**COMPLETION DATE**

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**Laboratory Director's or Provider/Supplier Representative's Signature**

ELECTRONICALLY SIGNED

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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.