DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	СОМ	E SURVEY PLETED
		345519	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	343313		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	07	/12/2024
					315 HIGHWAY 242 NORTH		
LIBERTY	COMMONS NSG & REHA	AB CTR OF JOHNSTON CTY			ENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 004 SS=F	-	view and Update Annually	E	004			8/12/24
	§403.748(a), §416.54 §441.184(a), §460.84 §483.475(a), §484.10 §485.542(a), §485.62 §485.920(a), §486.36 §494.62(a).	l(a), §482.15(a), §483.73(a),)2(a), §485.68(a), 25(a), §485.727(a),					
	Federal, State and loo preparedness require develop establish and emergency prepared requirements of this s	ments. The [facility] must d maintain a comprehensive ness program that meets the section. The emergency m must include, but not be					
	and maintain an eme	The [facility] must develop rgency preparedness plan d], and updated at least lan must do all of the					
	CAH] must comply wi State, and local emer requirements. The [h develop and maintain	ency Plan. The [hospital or ith all applicable Federal, gency preparedness iospital or CAH] must a comprehensive ness program that meets the section, utilizing an					
	Plan. The LTC facility	at §483.73(a):] Emergency must develop and maintain redness plan that must be ed at least annually.					
		SUPPLIER REPRESENTATIVE'S SIGNATUR	2F		TITLE		(X6) DATE
	cally Signed	COLLECTED RECEIVANTE O ORNATOR					08/09/2024

Electronically Signed

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.

				PRINTED: 08/27/2024 FORM APPROVED OMB NO. 0938-0391
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDPLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
	345519	B. WING		C 07/12/2024
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• • •
COMMONS NSG & REH	AB CTR OF JOHNSTON CTY			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
* [For ESRD Facilities Plan. The ESRD facil maintain an emergen	s at §494.62(a):] Emergency ity must develop and cy preparedness plan that	E 004	1	
by: Based on record rev facility failed to ensur facilities that would be evacuation of the faci Emergency Prepared practice had the pote residents. Findings included: The facility's EP plan Administrator as last A review of the EP plan skilled nursing facilitie evacuation during an In an interview with th 7/12/2024 at 12:30 pl Maintenance Director updating the EP plan alternative facilities in evacuation were inco stated the facility use company as alternative evacuation. In an interview with th	iew and staff interviews, the e alternative skilled nursing e used in an emergency ility were updated in the lness (EP) plan. This ntial to affect all staff and was signed by the reviewed on 4/2/2024. an on 7/12/2024 listed three es as alternative sites for emergency disaster. The Administrator on m, she stated the r was responsible for , and stated the listed o the EP plan for emergency rrect. The Administrator d sister facilities within the ve facilities for emergency		The statements made on this pla correction are not an admission to not constitute an agreement with a alleged deficiencies. To remain in compliance with all fa and state regulations the facility h or will take the actions set forth in plan of correction. The plan of corr constitutes the facility's allegation compliance such that all alleged deficiencies cited have been or w corrected by the dates indicated. E004 DEVELOP AN EP PLAN AN UPDATE ANNUALLY 1. Plan for correcting specific def The process that led to deficiency On 7/12/24 the Emergency Prepa Plan was reviewed and the outdat transfer contracts were removed a current contracts for sister facilitie #13, #14 were added to the plan. 2. Corrective action for residents potential to be affected by the alled deficient practice. The Emergency Preparedness Pl taken to the Quality Assurance Performance Improvement meetin 8/9/24 and reviewed by the Comm The Committee consists of the	o and do the ederal as taken this rrection of ill be ND ficiency. / cited. aredness ted and the es #12, with the eged an was
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER COMMONS NSG & REH/ SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page * [For ESRD Facilities Plan. The ESRD facili maintain an emergen must be [evaluated], years. This REQUIREMENT by: Based on record rev facility failed to ensur facilities that would be evacuation of the facilities that would be evacuation during facilities and in interview with the 7/12/2024 at 12:30 pm Maintenance Directors updating the EP plan alternative facilities in evacuation. In an interview with the 7/12/2024 at 2:00 pm Company as alternative evacuation. Company as alter	CORRECTION IDENTIFICATION NUMBER: 345519 ROVIDER OR SUPPLIER COMMONS NSG & REHAB CTR OF JOHNSTON CTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure alternative skilled nursing facilities that would be used in an emergency evacuation of the facility were updated in the Emergency Preparedness (EP) plan. This practice had the potential to affect all staff and residents. Findings included: The facility's EP plan was signed by the Administrator as last reviewed on 4/2/2024. A review of the EP plan on 7/12/2024 listed three skilled nursing facilities as alternative sites for evacuation during an emergency disaster. In an interview with the Administrator on 7/12/2024 at 12:30 pm, she stated the Maintenance Director was responsible for updating the EP plan, and stated the listed alternative facilities in the EP plan for emergency evacuation were incorrect. The Administrator stated the facility used sister facilities within the company as alternative facilities for emergency	SPOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER: Ast519 ROVIDER OR SUPPLIER COMMONS NSG & REHAB CTR OF JOHNSTON CTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure alternative skilled nursing facilities that would be used in an emergency evacuation of the facility were updated in the Emergency Preparedness (EP) plan. This practice had the potential to affect all staff and residents. Findings included: The facility's EP plan was signed by the Administrator as last reviewed on 4/2/2024. A review of the EP plan on 7/12/2024 listed three skilled nursing facilities as alternative sites for evacuation during an emergency disaster. In an interview with the Administrator on 7/12/2024 at 12:30 pm, she stated the Maintenance Director was responsible for updating the EP plan, and statef the listed alternative facilities in the EP plan for emergency evacuation. In an interview with the Maintenance Director on 7/12/2024 at 2:00 pm, she stated she was	S FOR MEDICARE & MEDICAID SERVICES OF DEFIDENCIES (X) PROVIDERSUPPLIERCLIA (22) MULTPLE CONSTRUCTION A BUIDING

Facility ID: 970198

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		ND HUMAN SERVICES			FC	TED: 08/27/202 DRM APPROVEI
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION G	(X3) D	NO. 0938-039 ATE SURVEY OMPLETED
		345519	B. WING	. WING		C 07/12/2024
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		01712/2024
				2315 HIGHWAY 242 NORTH		
LIBERTY	COMMONS NSG & REH	AB CTR OF JOHNSTON CTY		BENSON, NC 27504		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		N OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	COMPLETION
E 004	Continued From page	e 2	EO	04		
	she updated the EP	olan in April 2024, she stated		Maintenance Director,	Medical Director.	
		cate the information that		Social Workers, Rehal		
		cilities served as the facility's		Dietary Manager, Med	ical Records	
		mergency evacuation. She		Manager, Business Of		
		nould have been updated to		the Admission Team.		
	reflect the sister facili	u		reviewed the plan to e		
	alternative facilities to	or evacuation in the EP plan		contents of the plan we the information was ac	•	
	On 7/12/2024 at 2:44	pm, the Administrator		3. Systemic Measures		
		acts dated 1/1/2024 for the		The Emergency Prepa		
	-	facilities for emergency		reviewed by the Qualit	-	
		ility: Sister Facility #12,		Performance Improver		
	Sister Facility #13 an	d Sister Facility #14.		annually. The Commit		
				Maintenance Director		
	In an interview with the			will participate in the re-		
	7/12/2024 at 2:44 pm	r updated the EP plan in April		with updating the man 4. Monitoring Procedu		
		the corporate office had		the plan of correction i		
	•	n regarding use of sister		specific deficiency cite		
		e facilities for emergency		and/or in compliance v		
		book, and she was not		requirements.	0 ,	
	aware the information	n was in the book. She		The results of the revie	ew by the Quality	
		ities (Sister Facility #12,		Assurance Performan		
		d Sister Facility #14) should		(QAPI) Committee will		
		ne EP plan as the alternative		Quality Assurance me		
	facilities for emergen	cy evacuation.		Maintenance Director Emergency Preparedr		
				reviewed through a QA	-	
				Committee monthly for		
				quarterly for three qua		
				annually. Negative find	lings will be	
				corrected by the Comr		
				Addition interventions		
				monitored by the Com		
F 000	INITIAL COMMENTS	3	F 0	continued compliance.		
	A recertification and	complaint investigation				
	7(02-99) Previous Versions Ob	solete Event ID: 8290		Facility ID: 970198		sheet Page 3 of 3

Facility ID: 970198

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 08/27/2024 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	345519		B. WING		0	C 7/12/2024
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COL		
LIBERTY	COMMONS NSG & REHA	AB CTR OF JOHNSTON CTY		2315 HIGHWAY 242 NORTH BENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 000 F 645 SS=D	07/12/24. Event ID# intakes were investig: NC00217163, NC002 2 of the 14 complaint deficiency. PASARR Screening f CFR(s): 483.20(k)(1)- §483.20(k) Preadmiss individuals with a mer with intellectual disab §483.20(k)(1) A nursi or after January 1, 19 (i) Mental disorder as (i) of this section, unle authority has determi independent physical performed by a perso State mental health a (A) That, because of condition of the indivi- the level of services p and (B) If the individual re services, whether the specialized services; (ii) Intellectual disability of authority has determi (k)(3)(ii) of this sectio intellectual disability of authority has determi (A) That, because of condition of the indivi	d from 07/08/24 through 829011. The following ated: NC00216518, 218448, and NC00219148. allegations resulted in for MD & ID -(3) sion Screening for ntal disorder and individuals ility. ng facility must not admit, on 89, any new residents with: defined in paragraph (k)(3) ess the State mental health ned, based on an and mental evaluation on or entity other than the uthority, prior to admission, the physical and mental dual, the individual requires provided by a nursing facility; equires such level of individual requires or ity, as defined in paragraph n, unless the State or developmental disability ned prior to admission- the physical and mental dual, the individual requires or	F 04			8/12/24

Facility ID: 970198

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/27/2024 FORM APPROVED OMB NO, 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345519	B. WING		C 07/12/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
LIBERTY	COMMONS NSG & REHA	AB CTR OF JOHNSTON CTY		2315 HIGHWAY 242 NORTH BENSON, NC 27504	
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONHE APPROPRIATEDATE
F 645	§483.20(k)(2) Exceptions section- (i)The preadmission sparagraph(k)(1) of this for determinations in the to a nursing facility of being admitted to the transferred for care in (ii) The State may choor preadmission screeni paragraph (k)(1) of the to a nursing facility of (A) Who is admitted to hospital after receiving hospital, (B) Who requires nurse condition for which the the hospital, and (C) Whose attending before admission to the is likely to require less facility services. §483.20(k)(3) Definitions section- (i) An individual is condisorder if the individual disorder defined in 48 (ii) An individual is condisored if the individual or is a person with a red described in 435.1010 This REQUIREMENT by:	individual requires for intellectual disability.	F 64		
		with staff and record review,		The statements made on the	iis plan of

Facility ID: 970198

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		ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 08/27/20 ORM APPROVE NO. 0938-03
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345519		B. WING _				C 07/12/2024
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NSG & REHA	AB CTR OF JOHNSTON CTY			15 HIGHWAY 242 NORTH ENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 645	the facility failed to er (Residents #58) who schizophrenia and an Screening and Resid admission. The findings were: The North Carolina M Tool (NC MUST) reco revealed the resident serious mental illness through 3/29/22. On changed to a Level I evidence a PASRR st since 3/30/22. Resident #58 was ad 4/18/24 with diagnose and anxiety disorder. Review of Resident # Data Set (MDS) date severe cognitive impa diagnoses of schizop and had not received the past 7 days. Review of Resident # revealed a note by th 6/18/24 indicating Re moved to a long-term facility care. In an interview on 7/0 Administrator revealed dated 3/30/22 was th	had diagnoses of patiety had a Preadmission ent Review (PASRR) prior to dedicaid Uniform Screening ord for Resident #58 had a Level II PASRR for in place from 4/02/15 3/30/22 Resident #58 was PASRR. There was no creening was conducted mitted to the facility on es including schizophrenia 58's quarterly Minimum d 5/8/24 revealed he had airment, no behaviors, had hrenia and anxiety disorder, psychotropic medication in	F	545	correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all fed and state regulations the facility has or will take the actions set forth in the plan of correction. The plan of correc constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will corrected by the dates indicated. F645 The facility failed to refer a rest for a level II Preadmission Screenin Resident Review(PASRR) upon a significant change in status assess 1. Corrective action for resident(s) affected by the alleged deficient pra On 07/ 09 /2024, the Social Worker submitted through NCMUST. a Preadmission Screening and Resid Review (PASRR) for resident # 58 . was submitted and accepted on 7/09/2024. 2. Corrective action for residents w potential to be affected by the alleged deficient practice. All residents in the facility have the potential to be affected. On 8/8/202 Social Workers completed 100 % a all residents who have had a new diagnosis assigned to them from Ap 2024 to date, in order to validate tha State Mental Health Authority was r and a new resident review request sent through the NCMUST system for resident who received a new diagno Severe Mental Illness or Intellectual Disability/Mental Retardation	e leral s taken his ection f be sident g and ment. dctice : ent It ith the ed 24, the udit of oril I, at the hotified was for any osis of	

Facility ID: 970198

If continuation sheet Page 6 of 32

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 08/27/2024 RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345519	B. WING		07	C 7/12/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
LIBERTY	COMMONS NSG & REHA	AB CTR OF JOHNSTON CTY		2315 HIGHWAY 242 NORTH BENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 645	admitted for short-tern did not submit a new until they knew if a re transition to long-term further explained, a n submitted because th was going to stay lon was made, a new PA submitted. The Admir Worker was going to 7/09/24 because a de made that he would b The Administrator wa diagnosed with a seri a PASRR evaluation In an interview on 7/1 Marketing Director sa PASRR that was subb a resident was admitt was to accept a PASF active, regardless of I would not submit a new	m rehabilitation, the facility Level I PASRR to the state sident was going to in care. The Administrator ew Level I PASRR was not be facility did not know if he g term. Once that decision SRR request would be histrator said the Social submit a PASRR request on ecision had recently been be staying for long-term care. s not aware residents ous mental illnees required prior to admission. 0/24 at 9:05 AM, the hid the facility accepted the mitted by the hospital when ted. The policy in the facility RR that was open and how old it was. The facility ew Level I PASRR at use the information in the	F	 3. Measures/Systemic prevent reoccurrence of practice: Education: On 8/5/2024, the Nurse completed education w Social Worker/Admission Health Information Marin included the PASRR as and requirements for w PASARR is to be comp Information Manager w Worker when a new dia added that would poter level II PASARR. On, 8 Administrator made the Information Manager ar responsibility of notifyin Worker of when a new been added that would a resident for a level II Administrator also, on 0 educated the Social Wor responsibility of reques PASRR reviews when i Social Worker, Health I Manager or Admissions did not receive in-servic 08/12/2024 will not be a until training is complet information has been in standard orientation tra required in-service refra all newly hired Social W Personnel and Health I Managers and will be ro Quality Assurance Proo the change has been s 	of alleged deficient a Consultant with the facility on Coordinator and hager which assessment process when a level II bleted. The Health will notify the Social agnosis has been ntially qualify for a w/06/2024 the bleted. The Health ware of the agnosis has been ntially qualify for a w/06/2024 the bleted. The Definition the Social diagnosis has potentially qualify PASRR. The D8/06/2024 orkers of the thing Level II indicated. Any information is Coordinator who ce training by allowed to work ted. This htegrated into the inining and in the esher courses for Vorkers, Admission nformation eviewed by the cess to verify that	

Event ID: 829O11

Facility ID: 970198

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LIBERTY COMMONS NSG & REHAB CTR OF JOHNSTON CTY STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX 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 ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED OT THE APPROPRIATE DEFICIENCY) F 645 Continued From page 7 F 645 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 Social Worker or designee will monitor compliance with negulatory records for the need of a Level II PASARR screening. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored with engolia guidting program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager.	08/27/202 APPROVEI 0938-039
345519 B. WING OT11 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2/P CODE 2315 HIGHWAY 242 NORTH ED CODE 2315 HIGHWAY 242 NORTH 2315 RIGHWAY 242 NORTH<	ETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LIBERTY COMMONS NSG & REHAB CTR OF JOHNSTON CTY STREET ADDRESS, CITY, STATE, ZIP CODE (M) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL) TAG ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL) TAG ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED OT THE APPROPRIATE DEFICIENCY) F 645 Continued From page 7 F 645 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 Social Worker or designee will monitor compliance utilizing the F644 Quality Assurance Tool weekly A weeks then monthy x 2 months. The Social Worker or designee will monitor for compliance with audit of new resident records for the need of a Level II PASARR screening. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager.	2/2024
LIBERTY COMMONS NSG & REHAB CTR OF JOHNSTON CTY BENSON, NC 27504 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO HE APPROPRIATE DEFICIENCY) F 645 Continued From page 7 F 645 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 Social Worker or designee will monitor compliance with regulatory requirements. The Social Worker or designee will monitor compliance with regulatory requirements. The Social Worker or designee will monitor compliance with assurance Tool weekly x 4 weeks then monthly x 2 months. The Social Worker or designee will monitor for compliance with audit of new resident records for the need of a Level II PASARR screening. Reports will be presented to the weekly Quality Assurance Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager.	
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the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Social Worker or designee will monitor compliance utilizing the F644 Quality Assurance Tool weekly x 4 weeks then monthly x 2 months. The Social Worker or designee will monitor for compliance with audit of new resident records for the need of a Level II PASARR screening. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager.	
monitor compliance utilizing the F644 Quality Assurance Tool weekly x 4 weeks then monthly x 2 months. The Social Worker or designee will monitor for compliance with audit of new resident records for the need of a Level II PASARR screening. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager.	
F 690 Bowel/Bladder Incontinence, Catheter, UTI F 690 F 690 SS=D CFR(s): 483.25(e)(1)-(3) 8 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. 8	3/12/24
§483.25(e)(2)For a resident with urinary	

Event ID: 829O11

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/27/202 FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	345519		B. WING _		C 07/12/2024
	ROVIDER OR SUPPLIER	AB CTR OF JOHNSTON CTY		STREET ADDRESS, CITY, STATE, ZIP CC 2315 HIGHWAY 242 NORTH BENSON, NC 27504	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 690	ensure that- (i) A resident who enti- indwelling catheter is resident's clinical com- catheterization was n (ii) A resident who en- indwelling catheter or is assessed for remo- as possible unless that demonstrates that ca- and (iii) A resident who is receives appropriate prevent urinary tract if continence to the exter §483.25(e)(3) For a re- incontinence, based of comprehensive assess ensure that a residen receives appropriate restore as much norm possible. This REQUIREMENT by: Based on record rev- physician interview, th collected urine specir laboratory for an anal reviewed for urinary to catheters. This result specimen having to b	on the resident's sement, the facility must ers the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to nfections and to restore ent possible. esident with fecal on the resident's sement, the facility must t who is incontinent of bowel treatment and services to nal bowel function as is not met as evidenced iew, staff interviews, and a he facility failed to ensure a nen was delivered to the tysis for 1 of 1 resident ract infections and urinary ed in another urine e collected for analysis and eatment for a urinary tract 73).	F	The statements made on the correction are not an admission of constitute an agreement alleged deficiencies. To remic compliance with all federal aregulations the facility has the take the actions set forth in correction. The plan of correction the plan of correction constitutes the facility's allege compliance such that all alled deficiencies cited have beer corrected by the date or dated the correction.	sion to and do t with the nain in and state aken or will this plan of ection gation of eged n or will be

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 08/27/2024 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345519 B. WING			C 07/12/2024			
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				23	15 HIGHWAY 242 NORTH		
LIBERTY	COMMONS NSG & REHA	AB CTR OF JOHNSTON CTY		в	ENSON, NC 27504		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 690	Continued From page	<u>-</u> 9	F 6	an			
	-	mitted to the facility on	10	30	F690		
		oses including pneumonia.			The facility failed to ensure that a		
	o, i i 202 i mar diagn				collected urine specimen was delivered	d to	
	Nursing documentation	on dated 5/18/2024 at 6:40			the lab for analysis for 1 of 1 resident.		
	pm by Nurse #1 repo	rted Resident #73			Corrective Action for Affected Residen	ts	
		g on urination and a urine			For resident #73 the ordered urine		
	specimen was collect				specimen was recollected on 05/21/20		
		an, and Resident #73's			and picked up by the laboratory on 05		
		aware of Resident #73's with urination and a urine			21/2024. The results were received or 22/2024 and the physician was notified		
	specimen was collect				the results on 05/ 22/2024. Antibiotic		
					therapy was ordered by the physician		
	A review of the labora	atory patient log sheet dated			based on the results of the urine cultu	re	
		a urine for Resident #73 in a			and sensitivity received from the lab o	n	
		rehabilitation nursing station			05/23/2024.		
		ulture and sensitivity test.			Corrective Action for Potentially Affect	ed	
		signature on the laboratory			Residents		
		ed 5/18/2024 that laboratory			All residents who reside in the facility		
	5/18/2024.	l up the urine specimen on			the potential to be affected by this alle deficient practice. On 08/ 6 /2024 the	gea	
	5/10/2024.				Director of Nurses identified residents	that	
	There were no urinal	ysis results for the urine			were potentially impacted by this prac		
		n 5/18/2024 for Resident			by completing a lab order audit on all		
	#73.				current residents for the last 14 days t	0	
					assure that the ordered lab had been		
	The admission Minim				to the lab timely, results obtained and		
		21/2024 indicated Resident			physician notified of the results timely		
	#73 was moderately				The results included: No concerns we identified.	re	
	assistance with toileti	tinent of urine and required			Identified. This was completed on 08/7 /2024.		
	องจางเล่าเป็ย พาแท เปมียน	ing.			Systemic Changes		
	Nursing documentation	on dated 5/21/2024 at 2:33			On 8/06/2024 the Director of		
	-	rted a urine specimen was			Nursing/Assistant Director of Nurses		
	collected for a urinaly				began in-servicing all current full time,		
	sensitivity test and pi	cked up by the laboratory			part time and as needed licensed nurs		
	staff on 5/21/2024 at	2:30 am.			This in-service included the following topics:		
	A review of the labora	atory patient log sheet dated			 Follow through on any lab order v 	vhen	
		a urine for Resident #73 in a			entered/confirmed or signing off on		

Facility ID: 970198

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-03 ATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· · ·			OMPLETED	
						с	
		345519	B. WING			07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP			
				2315 HIGHWAY 242 NORTH			
LIBERTY	COMMONS NSG & REH/	AB CTR OF JOHNSTON CTY		BENSON, NC 27504			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETIO DATE	
F 690	Continued From page	e 10	F 69	0			
		rehabilitation nursing station		resident's electronic medio	cal record for		
	-	ulture and sensitivity test.		their shift.			
		t log sheet dated 5/21/2024		Confirming the lab slip			
		ersonnel had signed picking n collected on 5/21/2024.		lab book and that the spec appropriately in the lab ref			
	up the unite specifie			pick up by the lab.	ngerator ior		
	The urine specimen of	dated 5/21/2024 recorded		Assuring that all spec	imens have		
		alysis was reported at		been picked up timely by t			
		. The urinalysis report did		reviewing the laboratory p	•		
	not specify who recei	ved the urinalysis report or		each shift.			
		rinalysis was reported to the		Notifying the lab time			
	facility.			was not picked up by the I			
	A review of the uring	voia datad E/21/2024 for the		notification of the physicia documentation.	n with		
		ysis dated 5/21/2024 for the cted on 5/21/2024 reported		Notification of the phy	sician timely of		
	-	is present in the urine: white		the lab results and docum			
		squamous epithelial cells		notification and any orders			
	and moderate amour	nt of mucous.		The Director of Nursing wi			
				any staff clinical who has i			
		note dated 5/22/2024		training by 08/11/2024 will			
		73's Representative stated		to work until the training is	•		
	-	ined of dysuria (painful or		This information has been			
	difficulty urinating) a few days ago but not on 5/22/2024, and Resident #73's urine looked like it			the standard orientation tra required in-service refresh	-		
	could be infected.			all staff identified above ar			
				reviewed by the Quality As			
	The culture and sens	itivity test on the urine		process to verify that the c			
		/2024 indicated the urine		been sustained.	-		
	-	specimen was obtained by conducting straight		Quality Assurance			
		tion of a tube into the urinary		The Director of Nurses or	-		
	bladder to collect urin			monitor this issue using th			
		ed on 5/23/2024 at 9:14 am		Quality Assurance Tool for	•		
	the microorganism, e	BL), was present in Resident		with obtaining lab specime the lab specimen was pick			
		he greatest sensitivity to		timely and that the physici			
		imethoprim (an combination		the results timely. This will			
		d to treat urinary tract		weekly for 2 weeks then m			
	infections).	-		months or until resolved.	Reports will be		
				presented to the weekly Q	uality		

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DICAID SERVICES				APPROVED 0. 0938-0391
			(X3) DATE COMP	SURVEY LETED
345519	B. WING			C 12/2024
		STREET ADDRESS, CITY, STATE, ZIP CODE		
TR OF JOHNSTON CTY		2315 HIGHWAY 242 NORTH BENSON, NC 27504		
IST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE
hoprim 800-160 b times a day for a ten days. June 2024 Medication IAR) for Resident #73 ble-Trimethoprim dministered from 5/2/2024 at 9:00 am last reviewed on e a focus for urinary tract in an interview with 5/18/2024 a urine from Resident #73 and rator for the laboratory ng the night hours. She bry personnel was not a weekends and the ne laboratory personnel Resident #73's urine 4, another urine llected. She explained a e discarded if in the forty-eight hours. ne laboratory personnel pecimen collected on elay in obtaining results start antibiotics for ct infection. in an interview with the she had a contract with	F 69	Assurance Committee by the Administrator or Director of Nurse ensure corrective action is initiat appropriate. The weekly Quality Assurance Meeting is attended to Administrator, Director of Nurses Minimum Data Set Coordinator,	ed as by the s, Therapy,	
	TR OF JOHNSTON CTY TENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION) In order was written for thoprim 800-160 times a day for a ten days. June 2024 Medication MAR) for Resident #73 ole-Trimethoprim dministered from 5/2/2024 at 9:00 am last reviewed on a focus for urinary tract in an interview with 5/18/2024 a urine from Resident #73 and from Resident #73 and from Resident #73 and from Resident #73 and from Resident #73 urine from Resident #73 urine from Resident #73 urine from Resident #73 urine from Resident #73 urine a discarded if in the te laboratory personnel Resident #73's urine A, another urine lected. She explained a a discarded if in the forty-eight hours. te laboratory personnel pecimen collected on elay in obtaining results start antibiotics for ct infection. in an interview with the she had a contract with at came to the facility	IDENTIFICATION NUMBER: A. BUILDING 345519 B. WING STR OF JOHNSTON CTY ID MENT OF DEFICIENCIES ID IST BE PRECEDED BY FULL PREFIX DENTIFYING INFORMATION) F 69 n order was written for thoprim 800-160 ten days. June 2024 Medication MAR) for Resident #73 De-Trimethoprim dministered from 5/2/2024 at 9:00 am last reviewed on a focus for urinary tract in an interview with 5/18/2024 a urine from Resident #73 and rator for the laboratory ng the night hours. She pry personnel was not n weekends and the e laboratory personnel Resident #73's urine another urine Hected. She explained a e discarded if in the forty-eight hours. ne laboratory personnel pecimen collected on elay in obtaining results start antibiotics for ct infection. in an interview with the she had a contract with at came to the facility	IDENTIFICATION NUMBER: A. BUILDING 345519 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504 PENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION) TAG PROVIDERS PLAN OF CORR DENTIFYING INFORMATION) TAG PRECED BY FULL DENTIFYING INFORMATION) TAG PROVIDERS PLAN OF CORR DENTIFYING INFORMATION) TAG PROWIDERS PLAN OF CORR DENTIFYING INFORMATION) TAG PRECED BY FULL DENTIFYING INFORMATION) TAG DENTIFYING INFORMATION) TAG DENTIFYING INFORMATION TAG Assurance Committee by the Administrator, Director of Nurse Minimum Data Set Coordination June 2024 Medication Minimum Data Set Coordination Size and the ea focus for urinary tract in an interview with 5/18/2024 a urine rom Resident	IDENTIFICATION NUMBER: A BUILDING COMP 345519 B. WING 07/ TR OF JOHNSTON CTY STREET ADDRESS, CITY, STATE, ZIP CODE 235 HIGHWAY 242 NORTH BENSON, NC 27204 STREET ADDRESS, CITY, STATE, ZIP CODE 235 HIGHWAY 242 NORTH BENSON, NC 27204 BENSON, NC 2700 PROVIDER'S PLAN OF CORRECTION IND PROFILE D PROVIDER'S PLAN OF CORRECTION SHOULD BE IND OTHER VIEW INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Assurance Committee by the Administrator, Director of Nursing to ensure corrective action is initiated as appropriate. The weekly Quality Assurance Neeting is attended by the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Dietary Manager. 3/2/2024 at 9:00 am afocus for urinary tract In an interview with 5/18/2024 a urine row exection and the e laboratory personnel Resident #73 surine another urine another urine Iecked. She explained a discarded if in the forty-eight hours. ie laboratory personnel Besident #73 surine another urine Iecked. She ex

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 08/27/2024 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345519	B. WING		_	(07/	C 12/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				2315 HIGHWAY 242 NORTH	4		
LIBERTY	COMMONS NSG & REHA	B CTR OF JOHNSTON CTY		BENSON, NC 27504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page nightly to pick up uring and was unable to rec notification that the la be reporting to the fac specimens. On 7/12/2024 at 2:06 Director of Nursing, sl was collected on 5/18 was not aware why th not pick up the urine s Resident #73's urine s laboratory patient log further stated Nurse # follow up and check to have been picked up She stated treatment tract infection was del personnel not picking specimen and staff has specimen for analysis On 7/12/2024 at 8:39 Administrator, she state other laboratory patie	a 12 e specimens for analyzing call a time receiving poratory company would not ility to collect urine or blood pm in an interview with the ne stated a urine specimen /2024 for Resident #73 and e laboratory personnel did specimen. She explained specimen was listed on a dated 5/18/2024. She 1 and nursing staff need to b ensure urine specimens by the laboratory personnel. for Resident #73's urinary ayed due to laboratory up the 5/18/2024 urine wing to recollect a urine		CROSS-REFEREI	NCED TO THE APPROPRIA		DATE
	urine or blood specim on other residents. S personnel should hav	ens that had been collected he explained laboratory e picked up the collected					
	and Nurse #1 should the next day to ensure	sident #73 on 5/18/2024 had checked the refrigerator e the urine specimen was					
	due to having to recol specimen, there was	rinary tract infection and					
	On 7/12/2024 at 12:5) pm in a phone interview					

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/27/202 FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345519	B. WING		C 07/12/2024	
	ROVIDER OR SUPPLIER	AB CTR OF JOHNSTON CTY	2:	TREET ADDRESS, CITY, STATE, ZIP CODE 315 HIGHWAY 242 NORTH ENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO	
F 690 F 695 SS=D	stewardship program ordered when Reside burning with urination was waiting for the ur #73 had a urinary tra- and sensitivity report would receive the con- tract infection. He sta of the urinalysis from 5/21/2024 on 5/22/20 antibiotics until 5/23/2 sensitivity results wer Resident#73 received and did not require fu- urinary tract infection Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care and The facility must ensu- needs respiratory car care and tracheal sud care, consistent with practice, the compret care plan, the resider and 483.65 of this su This REQUIREMENT by: Based on record rev- interviews, the facility physician order for th oxygen (Resident #19 signage indicating the residents' rooms (Res	explained with the antibiotic , antibiotics were not ent #73 complained of on 5/18/2024. He stated he inalysis to confirm Resident ct infection and the culture to ensure Resident #73 rrect antibiotic for the urinary ted he reviewed the results the specimen sent on 024 and did not order 2024 when the culture and re available also. He stated d one course of antibiotics in ther treatment for the stomy Care and Suctioning my care, including nd tracheal suctioning. ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of nensive person-centered nts' goals and preferences, bpart. T is not met as evidenced iew, observations and staff r failed to ensure there was a e use of supplemental	F 690	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 federa and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of correction	al aken	

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-				FORM	08/27/202 APPROVE 0938-039
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		COMPL	ETED	
	345519	B. WING		07/12/2024	
ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
COMMONS NSG & REHA	AB CTR OF JOHNSTON CTY				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE
Continued From page	e 14	F 695	5		
Findings included:			constitutes the facility's allegati compliance such that all allege	d	
7/3/2024 with diagnos	ses including pneumonia		F695 The facility failed to ensure the		
oxygen therapy was i	required and a goal to not		supplemental oxygen and faile signage outside the resident's	room for 2	
absorption that was d included observing fo	lated 7/4/2024. Interventions or and reporting sign and		Corrective action for resident(s) affected	
and providing extensi	ion tubing or portable oxygen		1. For resident #197, on 07/0 order was obtained from the ph	9 /24 an nysician for	
			of resident #197's room. For re	sident #	
use of oxygen located			2. Corrective action for reside	ents with	
On 7/8/2024 at 10:11					
liters per minute via n oxygen signage obse	nasal cannula. There was no rved outside Resident		Nurses/Assistant Director of Nu	urses	
On 7/9/2024 at 1:07 p	om in an interview with		receiving Oxygen Therapy to e all residents receiving supplem	nsure that ental	
red (oxygen in use) s indicating oxygen wa	ign on Resident #197's door s in use. She stated it was		use of supplemental oxygen. T included: No concerns were ide	he results entified.	
was admitted to gath sign outside Residen gathering the oxygen	er and post an oxygen in use t #197's door when regulator. She stated she		Assistant Director of Nurses au resident receiving ordered sup	udited all plemental ⁄gen	
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER COMMONS NSG & REH/ SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page Findings included: 1. Resident #197 was 7/3/2024 with diagnot and congestive heart Resident #197's base oxygen therapy was a have signs or symptot absorption that was of included observing for symptoms of respirat and providing extensi equipment for ambula The physician progref recorded Resident #1 minute of oxygen. On 7/8/2024, there w use of oxygen located record. On 7/8/2024 at 10:11 observed lying in bed liters per minute via r oxygen signage obse #197's door indicating On 7/9/2024 at 1:07 p Nurse Aide (NA) #1, 3 red (oxygen in use) s indicating oxygen wa the nurse's responsit was admitted to gath- sign outside Residen gathering the oxygen	CORRECTION IDENTIFICATION NUMBER: SUMMONS NSG & REHAB CTR OF JOHNSTON CTY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 Findings included: 1. Resident #197 was admitted to the facility on 7/3/2024 with diagnoses including pneumonia and congestive heart failure. Resident #197's baseline care plan indicated oxygen therapy was required and a goal to not have signs or symptoms of poor oxygen absorption that was dated 7/4/2024. Interventions included observing for and reporting sign and symptoms of respiratory distress to the physician and providing extension tubing or portable oxygen equipment for ambulation as needed. The physician progress note dated 7/4/2024 recorded Resident #197 was receiving 2 liters per minute of oxygen. On 7/8/2024, there was no physician order for the use of oxygen located in Resident #197's medical	S FOR MEDICARE & MEDICAID SERVICES PF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A BUILDING. 345519 B. WING ROVIDER OR SUPPLIER 345519 COMMONS NSG & REHAB CTR OF JOHNSTON CTY ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WINS BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX Continued From page 14 F 695 Findings included: 1. 1. Resident #197 was admitted to the facility on 7/3/2024 with diagnoses including pneumonia and congestive heart failure. F 695 Resident #197's baseline care plan indicated oxygen therapy was required and a goal to not have signs or symptoms of poor oxygen absorption that was dated 7/4/2024. Interventions included observing for and reporting sign and symptoms of respiratory distress to the physician and providing extension tubing or portable oxygen equipment for ambulation as needed. The physician progress note dated 7/4/2024 recorded Resident #197 was receiving 2 liters per minute of oxygen. On 7/8/2024 at 10:11 am, Resident #197 was observed lying in bed receiving oxygen at 2 ½ liters per minute via nasal cannula. There was no oxygen signage observed outside Resident #197's door indicating oxygen was in use. On 7/9/2024 at 1:07 pm in an interview with Nurse Aide (NA) #1, she stated there was no ta red (oxygen in use) sign on Resident #197's door indicating oxygen was in use. She stated it was the nurse's responsibility when Resident #197 was admitted to gather and post an oxygen in use sign outside	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDERSUPPLIERCULA (X2) MULTIPLE CONSTRUCTION A BUILDING	MENT OF HEALTH AND HUMAN SERVICES FORM MEDICARE & MEDICALD SERVICES OWB NO. SPOR MEDICARE &

Facility ID: 970198

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TATEMENT C	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		0.000	B. WING	С		
		345519			07/12/2024	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NSG & REH	AB CTR OF JOHNSTON CTY		2315 HIGHWAY 242 NORTH BENSON, NC 27504		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	• • •	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		
F 695	Continued From pag	le 15	F 695	5		
		#197's door and said extra		The results included: No concerns we	ere	
		were stored in the nurse aide		identified.		
	supply room.			3. Measures /Systemic changes to		
				prevent reoccurrence of alleged defic	ient	
	On 7/9/2024 at 1:20	pm in an interview with		practice:		
	Nurse #2, she stated					
		erapy and should have an		On 8/06/2024, the Director of Nurses	/	
		outside the door, and she		Assistant Director of Nurses began		
		ther Resident #197 had the		education to all full time, part time, an		
		outside the door, She said		PRN Nurses (including agency) on th	e	
		des both had access to the ge and were responsible for		following:		
		in use signage was posted		All residents who require the use	of	
	outside Resident #19			supplemental oxygen must have an a		
				physician order in place.		
	On 7/9/2024 at 1:56	pm in an interview with		All residents who have ordered		
		stated Nurse #1 was		supplemental oxygen must a have ox	xygen	
		ng oxygen signage that		signs in place outside of their room	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		noking oxygen in use,		indicating that oxygen is in use.		
	outside residents' do	oors when conducting the		This information has been integrated	into	
	admission and did no	ot realize Resident #197 did		the standard orientation training and i	in the	
	not have an oxygen	in use sign outside on the		required in-service refresher courses	for	
	door.			all staff identified above and will be		
	0= 7/0/0004 =+ 4 44			reviewed by the Quality Assurance		
		pm in an interview with		process to verify that the change has		
	· · · ·	ined it was the assigned / or herself (Nurse #1)		been sustained. The facility specific in-service will be provided to all agend	cv/	
		e the oxygen in use sign		Nurses and CNA's who give residents	-	
	outside Resident #19			care in the facility. As of 8/11/2024 ar		
		ed ensuring oxygen in use		nursing staff who does not receive	,	
		Resident #197's door was		scheduled in-service training will not l	be	
		d she had been too busy with		allowed to work until training has bee		
		that an oxygen in use sign		completed.		
	was outside Resider	nt #197's door.				
				4. Monitoring Procedure to ensure t		
		pm in an interview with the		the plan of correction is effective and		
		xplained there had not been		specific deficiency cited remains corre	ected	
	a constant Lead Nur	se, the person who was		and/or in compliance with regulatory		

Facility ID: 970198

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	<u>0. 0938-039</u> E SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		СОМ	PLETED
		245540		С		
	ROVIDER OR SUPPLIER	345519		STREET ADDRESS, CITY, STATE, ZIP CODE	07	/12/2024
	NOVIDER ON SOLT EIER			2315 HIGHWAY 242 NORTH		
LIBERTY COMMONS NSG & REHAB CTR OF JOHNSTON CTY				BENSON, NC 27504		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 695	Continued From page	e 16	F 695			
	in use signage outsid stated Nurse #1 was she had not decided responsibility for ensu- outside residents' doo The admission Minim assessment with an a (ARD) of 7/10/2024 w and was incomplete. In a follow up intervie 7/11/2024 at 3:45 pm have been an order e Resident #197's med the facility. She expla physician's orders. SI standing orders for oo the physician for an o She explained the ad usually her (Nurse #1 ensuring Resident #1 of oxygen. She stated completing Resident # assessment, and ther on Resident # 196's r when it was brought t On 7/12/2024 at 9:07 Director of Nursing, s been an order for the #197's medical record outside Resident#197 and/or the nurses ass should have ensured Resident #197's med	e Resident #197's door. She acting as Lead Nurse and who would assume the uring oxygen signage was ors at this time. um Data Set (MDS) admission reference date vas recorded as in progress w with Nurse #1on , she stated there should intered for oxygen in ical record when admitted to ined all nurses could enter he said the facility had kygen, and nurses could call order for oxygen as needed. mitting nurse, who was), was responsible for 97 had an order for the use d she could not recall #197's admission re was no order for oxygen nedical record until 7/9/2024		The Director of Nurses or designee monitor compliance utilizing the F63 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or resolved. The Director of Nursing w monitor that residents receiving oxy have a physician order in place and oxygen signage posted outside of t room. Reports will be presented to weekly Quality Assurance committee the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be mo and the ongoing auditing program reviewed at the weekly Quality Assu Meeting or until deemed not necess compliance with ADL Care. The we Quality Assurance Meeting is attend the Administrator, Director of Nursin Minimum Data Set Coordinator, Th Manager, Health Information Mana and the Dietary Manager.	95 2 until /gen J have heir the eby onitored urance sary for ekly ded by ng, erapy	

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 08/27/2024 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		SURVEY LETED
		345519	B. WING				C 12/2024	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
LIBERTY	COMMONS NSG & REHA	AB CTR OF JOHNSTON CTY			315 HIGHWAY 242 NORTH			
				В	BENSON, NC 27504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE		(X5) COMPLETION DATE
F 695	Continued From page	e 17	F	695				
		admitted to the facility on ses including pneumonia ve pulmonary disease						
	Resident #196's base 7/2/2024 included a for interventions included therapy as ordered by	ocus for COPD, and I administering oxygen						
	Resident #196 to rece	n order dated 7/5/2024 for eived oxygen at 3 liters per ria nasal cannula every shift nt.						
	Administration Record	#196's July 2024 Medication d (MAR) recorded Resident n at 3 liters per minute daily ission.						
	observed wearing oxy nasal cannula. There	en was in use no smoking						
		um Data Set (MDS) Idmission reference date recorded as in progress and						
	Nurse Aide (NA) #2, s assigned to Resident placing oxygen in use Resident #196's door use signs were stored	om in an interview with she explained nurses #196 were responsible for no smoking signs outside . She stated the oxygen in d in the medication room s. She said she didn't know						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345519	B. WING _				C 12/2024
NAME OF PF	ROVIDER OR SUPPLIER		[S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY COMMONS NSG & REHAB CTR OF JOHNSTON CTY					315 HIGHWAY 242 NORTH ENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	outside Resident #19 On 7/9/2024 at 1:20 p Nurse #2, she stated oxygen in use no smo #196's door because continuously. She exp morning Resident #19 use sign outside on th was not in her room a return to Resident #19 smoking, oxygen in us Resident #196's door On 7/9/2024 at 1:56 p Central Supply, she s responsible for placin communicated no sm outside residents' doo admission and did no not have an oxygen in door. On 7/9/2024 at 1:14 p Nurse #1, she explain nurse, central supply responsibility to place outside Resident #19 admission. She state signage was outside I one of her duties, and other tasks to check t was outside Resident On 7/9/2024 at 1:31 p Director of Nursing, si been a no smoking, o	nage for oxygen in use 6's door. om in an interview with there should have been an oking sign outside Resident she was receiving oxygen olained she realized that 26 did not have an oxygen in ne door but Resident #196 and she (Nurse#2) forgot to 96's room with a no se sign to place outside om in an interview with tated Nurse #1 was g the signage that toking oxygen in use, ors when conducting the t realize Resident #196 did in use sign outside on the om in an interview with hed it was the assigned or herself (Nurse #1) a the oxygen in use sign 6's door prior or on ed ensuring oxygen in use Resident #196's door was d she had been too busy with hat the oxygen in use sign a she had been too busy with hat the oxygen in use sign a she had been too busy with hat the oxygen in use sign a she had been too busy with hat the oxygen in use sign a she had been too busy with hat the oxygen in use sign a she had been too busy with hat the oxygen in use sign a she had been too busy with hat the oxygen in use sign a she had been too busy with hat the oxygen in use sign a she the oxygen in use sign a she had been too busy with hat the oxygen in use sign a she had been too busy with hat the oxygen in use sign a she pad been too busy with hat the oxygen in use sign a she pad been too busy with hat the oxygen in use sign a she pad been too busy with hat the oxygen in use sign a she pad been too busy with hat the oxygen in use sign a she pad been too busy with hat the oxygen in use sign a she pad been too busy with hat the oxygen in use sign a she pad been too busy with hat the oxygen in use sign a she pad been too busy with hat the oxygen in use sign a she pad been too busy with hat the oxygen in use sign a she pad been too busy with hat be oxygen in use sign a she pad been too busy with hat be oxygen in use sign a she pad been too busy with hat be oxygen in use sign a she pad been too busy with hat be oxygen in use sign a she bad been too busy with hat be oxygen in use sign a she bad been too busy with hat be oxygen in use sig	F	995			
	Director of Nursing, s	he stated there should have xygen in use sign posted					

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CENTER STATEMENT	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI	ECONSTRUCTION	PRINTED: 08/27/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION		A. BUILDING	C	
		345519	B. WING		07/12/2024
	ROVIDER OR SUPPLIER	AB CTR OF JOHNSTON CTY	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504	
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 695	Continued From page	e 19	F 695		
F 698 SS=D	Administrator, she ex a constant Lead Nurs responsible on admis in use signage outsid stated Nurse #1 was she had not decided responsibility for ensu- outside residents' doo Dialysis CFR(s): 483.25(I) §483.25(I) Dialysis. The facility must ensu- require dialysis receiv with professional star comprehensive perso- the residents' goals a This REQUIREMENT by: Based on record revi- interview with Dialysis failed to maintain ong the dialysis treatment reviewed for dialysis f The findings included Resident #69 was ad 6/10/2024 with diagno- renal disease. An active physician o Resident #69 receive	ure that residents who ve such services, consistent adards of practice, the on-centered care plan, and nd preferences. is not met as evidenced wew, staff interviews, and s Center Nurse, the facility poing communication with center for 1 of 1 resident (Resident #69).	F 698	The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all feder and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of correct constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F698 The facility failed to maintain ongoing communication with the dialysis treatr center for resident #69. 1. Corrective action for resident(s)	al aken ion

Event ID: 829O11

Facility ID: 970198

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			()(0)			NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			ATE SURVEY MPLETED	
			A. BUILDING	<u> </u>			
		345519	B. WING		С		
		545519	B. WING			07/12/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
LIBERTY	COMMONS NSG & REH	AB CTR OF JOHNSTON CTY		2315 HIGHWAY 242 NORTH			
				BENSON, NC 27504			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE	
E 609	O	- 00					
F 698	1 0		F 69				
	The care plan dated			affected by the alleged deficie			
	Resident #69 was sc			For resident # 69 the facility p			
		mes per week due to renal		dialysis communication sheet			
		complications: infection, fluid		completed by the assigned nu			
	imbalances and hem			going for dialysis treatment of			
	vascular access port			11/2024. The information inclusion inclusin inclusion inclusion inclusion inclusion in			
		d checking Resident #69		resident's pre-dialysis vital sig	ins, weight		
		bleeding episodes to ensure		On 7 / 11 /2024 a current lis	of		
	-	bserving, documenting and finfection to the access site		medications for resident # 69			
	and assisting Reside			to the requesting dialysis cen			
		g from dialysis treatments.					
		g nom dialysis deathents.		2. Corrective action for resi	dente with		
	The admission Minim	num Data Set (MDS)		the potential to be affected by			
		16/2024 indicated Resident		deficient practice.	the dileged		
		ntact and was receiving		All residents receiving dialysis	s have the		
	dialysis.	naet and the recenting		potential to be affected by this			
	_			deficient practice. On 8/7/2	-		
	A review of Resident	#69's dialvsis		Director of Nursing and nursi			
		book on 6/9/2024 at 3:30 pm		began auditing 100% of dialy			
		13 dialysis communication		to ensure that the facility port			
		k were not completed by the		dialysis communication sheet			
		ialysis treatment for Resident		residents receiving dialysis, w			
		to the facility (6/13/2024,		completed prior to being sent			
	6/18/2024, 6/27/2024	, 6/29/2024, 7/2/2024,		treatment. The results include			
	7/4/2024, 7/6/2024 a	nd 7/9/2024.) The 8 dialysis		communication sheets are be			
		s did not have the following		completed prior to resident le	aving the		
		from the facility: pre-dialysis		facility.			
		ascular access or information		On 8 / 7/2024 all residents r	-		
	-	center. There were blank		dialysis were audited by the [
	-	on forms in Resident #69's		Nurses/Assistant Director of I			
		on notebook. On 7/6/2024,		assure that any requested inf			
	the post dialysis infor			communicated by the dialysis			
		from the dialysis center		been submitted to the dialysis			
	requested a current li			was completed by a review o			
		nt on the next dialysis day		dialysis communication sheet			
	, ,)24 post Resident #69's		for the last 14 days. The resu			
	dialysis treatment, the			No further MARS or other info			
	communicated with the	he facility to send a list of		been requested from the dial	isis center.		

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	OMB NC	0. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	A. BUILDING			LETED
		345519	B. WING			C 07/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NSG & REHA	AB CTR OF JOHNSTON CTY			315 HIGHWAY 242 NORTH JENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 698	Continued From page	e 21	F	698			
		nt medications on a yellow	•	000	This was completed on 8/7/2024		
		on the outside of Resident					
	#69's dialysis commu				3. Measures /Systemic changes to		
	, ,				prevent reoccurrence of alleged deficie	ent	
	On 7/9/2024 at 3:55 p	pm in an interview with			practice:		
	Nurse Aide (NA) #2, s						
	responsible for ensui	•			On 08/06/2024, the Director of		
		eakfast and obtain vital signs			Nurse/Assistant Director of Nurses be	gan	
		lysis, and she couldn't recall			education of all full time, part time, as		
		vital signs on Resident #69			needed (PRN) nurses and agency nur		
		could not state a reason why			on the following: Dialysis Communicat	ion	
	Resident #69's vital s	signs were not obtained.			Process		
	$O_{\rm D}$ 7/0/2024 at 2.42	om in on intorvious with			This in-service included the following		
		pm in an interview with when she went to give			topics:The dialysis communication form		
		ing medications on 7/9/2024,			facility portion is to be completed prior	to	
		company had arrived and			the resident being sent for dialysis	10	
		ent #69 to the dialysis center.			treatment. The pre-dialysis vital signs,		
	-	t completed the dialysis			weight and vascular access are to be		
	communication form,				included on the communication form a	nd	
		dent #69's or administered			to be sent each time the resident is se	nt	
		ing medications on 7/9/2024			for dialysis.		
		going to the dialysis center.			Upon return from dialysis the nurs	e is	
		ht Resident #69's scheduled			to review the communication sheet se		
	dialysis days had cha				back from dialysis to assure that		
		ay. When Nurse #2 checked			requested information is followed up o	n	
		she stated Resident #69 was			timely.		
	scheduled to receive				Any information needed by the dialysis		
	Thursday and Saturd	ay.			center should be sent timely by the nu		
	On 7/14/0004 -+ 44 5				assigned. Any information sent should	be	
		4 pm in a phone interview			documented as being sent and		
	-	ter Nurse, she stated the cility were not completing			information sent.	.+	
	the dialysis communi				The Director of Nursing will ensure that any nurse who has not received this	ii ii	
	communicated vital s				training by 08/11/2024 will not be allow	ved	
	Resident #69 to the d				to work until the training is completed.		
		ng dialysis treatments. She			This information has been integrated in	nto	
		er had requested twice on			the standard orientation training and ir		
		24 for the facility to send a list			required in-service refresher courses f		

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ATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	C 07/12/2024	
		345519	B. WING		
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•
LIBERTY	COMMONS NSG & REHA	AB CTR OF JOHNSTON CTY		2315 HIGHWAY 242 NORTH BENSON, NC 27504	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE COMPLET
F 698	Continued From page	e 22	F 698		
	facility had not sent the dialysis center. She shad not spoken to an facility about the nurse communication form of On 7/9/2024 at 5:40 p Director of Nursing, s assigned to Resident completing the dialys included vital signs an prior to Resident #69 dialysis treatment, an pre-dialysis communic completed on 7/9/2022	om in an interview with the		 all staff identified above and will b reviewed by the Quality Assurance process to verify that the change been sustained. 4. Monitoring Procedure to ensure the plan of correction is effective a specific deficiency cited remains of and/or in compliance with regulate requirements. The Director of Nurses or designed monitor compliance utilizing the F Quality Assurance Tool weekly x 2 then monthly x 3 months or until r The Director of Nursing will monit compliance with the dialysis communication process an follow all dialysis residents. Reports will 	ee has ure that and that corrected ory ee will F698 2 weeks resolved. for
F 755 SS=D	CFR(s): 483.45(a)(b) §483.45 Pharmacy S	ervices	F 755	presented to the weekly Quality Assurance committee by the Dire Nurses to ensure corrective action initiated as appropriate. Complian be monitored and the ongoing au program reviewed at the weekly (Assurance Meeting. The weekly (Assurance Meeting is attended by Administrator, Director of Nursing Minimum Data Set Coordinator, T Manager, Health Information Mar and the Dietary Manager.	n is nce will diting Quality Quality y the I, Therapy
	The facility must prov	ride routine and emergency to its residents, or obtain ment described in			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345519	B. WING				_ 12/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LIBERTY COMMONS NSG & REHAB CTR OF JOHNSTON CTY					315 HIGHWAY 242 NORTH ENSON, NC 27504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 755	personnel to administ permits, but only unde a licensed nurse. §483.45(a) Procedure pharmaceutical servic that assure the accura dispensing, and admi biologicals) to meet th §483.45(b) Service C must employ or obtain pharmacist who- §483.45(b)(1) Provide aspects of the provisi- the facility. §483.45(b)(2) Establis receipt and disposition sufficient detail to ena- reconciliation; and §483.45(b)(3) Determo- order and that an acc is maintained and per This REQUIREMENT by: Based on record revi- pharmacist interview, document the return of medication, Hydroxyz used to help control a itching) to the pharmacist	er drugs if State law er the general supervision of es. A facility must provide ces (including procedures ate acquiring, receiving, nistering of all drugs and he needs of each resident. onsultation. The facility in the services of a licensed es consultation on all on of pharmacy services in shes a system of records of n of all controlled drugs in able an accurate sines that drug records are in ount of all controlled drugs iodically reconciled. is not met as evidenced ew, staff interviews and a the facility failed to of a discontinued ine HCI (an antihistamine nxiety or symptoms of acy for 1 of 1 resident yed for the provision of	F	755	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 federa and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of correctio constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be	al ken	

Event ID: 829O11

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/27/2 FORM APPROV OMB NO. 0938-03
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C
		345519	B. WING		07/12/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	
LIBERTY	COMMONS NSG & REHA	AB CTR OF JOHNSTON CTY		2315 HIGHWAY 242 NORTH BENSON, NC 27504	
(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 THE DEFICIENCY)	N SHOULD BE COMPLETIC E APPROPRIATE DATE
F 755	Continued From page	e 24	F 75	5	
		mitted to the facility on		corrected by the dates indica F755 The facility failed to do return of discontinued medica	cument the
		Hydroxyzine HCI 25 / six hours as needed for 14 days was written on		resident. 1. Corrective action for resi affected by the alleged defici Resident #73 discharged from 7/30/2024.	ent practice:
	slips for proof of deliv ten tablets of Hydrox delivered to the facilit 5/29/2024 and on 6/5	y for Resident #73 on /2024 for total of 20 tablets		 2. Corrective action for residue the potential to be affected by deficient practice: All residents who receive me have the potential of being affected by the potential by the potential by the potential of being affected by the potential by th	y the alleged dications
	Administration Record Hydroxyzine HCI 25m	and June 2024 Medication d (MAR) recorded ng was administered to tal of seven doses on the 36 pm. 36 pm. 59 pm. 4 pm. 4 pm.		alleged deficient practice. On 08/ 6 /2024 the Director of audited medications discontin last 14 days for documentation discontinued medication bein documented as returned on t medication return form. The included: Medications that has discontinued were not noted cart. Medications had been n pharmacy per policy.	nued for the on of the ig the pharmacy results ad been to be on the
	 - 6/11/2024 at 9:14 pm. There was no documentation on a medication return to pharmacy form that accounted for the remaining 13 tablets of Hydroxyzine 25 mg whethe physician order was automatically discontinued after 6/11/2024. In an interview with Nurse #4 on 7/12/2024 at 11:14 am, she stated Resident #73's Hydroxyzi HCI 25 mg tablet was discontinued after the fourteen days per physician order and stated sl did not know when Resident #73's discontinued 			 3. Measures /Systemic char prevent reoccurrence of alleg practice: On 08/06/2024, the Director of Nurses/Assistant Director of initiated education on the phar medication return process for Nurses (RN's and LPN's), Me Aides, Full Time, Part Time, a and agency nurses on the for education: Topics included: Return of Medication. U 	ged deficient of Nurses armacy r all Licensed edication as needed, llowing

Facility ID: 970198

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		ID HUMAN SERVICES MEDICAID SERVICES				M APPROVE 0. 0938-03
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345519	B. WING		07	C 7/ 12/2024
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LIBERTY	COMMONS NSG & REHA	AB CTR OF JOHNSTON CTY		2315 HIGHWAY 242 NORTH		
				BENSON, NC 27504		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 755	Continued From page	25	F 75	5		
	pharmacy. She expla medications still in bu an open box labeled locked medication roo the pharmacy at nigh nurse, assistant Direc Director of Nursing co pharmacy form listing return to pharmacy bu pharmacy nightly. In an interview with th Nursing on 7/12/2024 facility did not have a indicating Resident # returned to the pharm was discontinued afte She explained due to copy return to pharmat the facility had not be copy return to pharmat	abble packs were placed in return to pharmacy in the bom and were picked up by t. She stated the night ctor of Nursing or the completed the return to g all the medications in the box that were picked up by the Assistant Director of that 1:06 pm, she stated the return to pharmacy form 73's Hydroxyzine HCI was hacy after the medication er 6/11/2024. unavailability of carbon acy forms in the pharmacy, then able to obtain carbon acy forms and copying the		 discontinued medications and co substance should be returned via McNeill's Long-Term Care deliver person. Medications for hospitali patients should be kept by the fac at least 30 days before returning pharmacy. Controlled medication be packaged in a separate return from the non-control medications returned medication must be writ a Drug Return Form. Controlled medications and non-controlled medications and non-controlled medication must be listed on sep forms. Please completely fill out forms before returning them. It is the responsibility of the f staff to properly write up medicati returned to our pharmacy, papero must be signed and dated. All discontinued medications should written up and returned to our ph at least once weekly. 	be returned via the erm Care delivery ons for hospitalized e kept by the facility for before returning to the olled medications should separate return box trol medications. Any on must be written up on rm. Controlled non-controlled be listed on separate mpletely fill out your rning them. onsibility of the facility rrite up medications to be harmacy, paperwork and dated. All lications should be urned to our pharmacy	
	for the facility's record sometimes the origina was not copied and th the pharmacy.	macy form was necessary ds. She explained al return to pharmacy form ne original copy was sent to ne Director of Nursing (DON)		• Discontinued medications ar removed from the medication tim prevent the potential of a medica as a result of a discontinued med being administered after the med has been discontinued.	ely to tion error lication	
	on 7/12/2024 at 11:26 staff were to complete form when returning of the pharmacy. She e should have removed discontinued medicat the medication cart, p return to pharmacy be room and completed	6 am, she stated the nursing e the return to pharmacy discontinued medications to explained nursing staff		All education for current staff will completed by 08/11/2024. Any er who has not received this training be allowed to work until the training been completed. This includes a Licensed Nurses and Medication full time, part time, agency nurses needed staff. This in-service will incorporated into the new employ facility orientation.	nployee g will not ng has Il Aides, s and as be	

Facility ID: 970198

ATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DAT	O. 0938-03
IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	CON	COMPLETED		
						С
345519		B. WING		07	7/12/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	COMMONS NSG & REH	AB CTR OF JOHNSTON CTY		2315 HIGHWAY 242 NORTH BENSON, NC 27504		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 755	Continued From page	e 26	F 75	5		
		ot have documentation on a form that Resident #73's				
		vzine HCL medication had		4. Monitoring Procedure to er	sure that	
	been returned to the	facility. The DON was not		the plan of correction is effective		
	able to explain what I			specific deficiency cited remain	s corrected	
	unaccounted 13 table			and/or in compliance with		
	Hydroxyzine HCI tabl	ets after the physician order		regulatory/requirements.		
	was discontinued on	0/11/2024.		The Director of Nurses/designe	o will	
	In a phone interview	with Pharmacist #1 on		monitor compliance utilizing the		
	-	h, he stated Hydroxyzine HCl		Assurance Tool for the Return of	-	
		73 was discontinued after		Discontinued Medications to the	e	
	the 14th day (6/11/20	24) based on the physician's		Pharmacy Process. Monitoring	of	
	-	acy had no documentation		documentation of the return of		
		acy form that Resident #73's		discontinued medications utilizi	•	
		tion, Hydroxyzine HCl 25 mg		Pharmacy Mediation Return Fo		
	tablet, was returned t			completed for a sample of 5 res Audits will be completed weekly		
		no time frame in returning tions to the pharmacy, and		then monthly x 3 months or until		
		pt discontinued medications		Reports will be presented to the		
		ade a decision not to reorder		Quality Assurance Performance	-	
	the medication. He st			Improvement committee by the		
	medications returned	to the pharmacy were listed		Administrator or Director of Nur	ses to	
		acy form and discontinued		ensure corrective action is initia		
		ked up six days a week		appropriate. Compliance will be		
		urday. He explained the		and the ongoing auditing progra		
		orm was a carbon copy: one ne medications returned to		reviewed at the Quality Assurar Meeting. The monthly Quality A		
		le copy was maintained at		Meeting is attended by the Adm		
		entation of the returned		Director of Nursing, Minimum D		
	•	narmacy. He stated it was		Coordinator, Therapy Manager,		
	the facility's responsi	bility to request the return to		Information Manager and Dieta	ry	
		n the pharmacy and he could		Manager.		
		time not having the return to				
	pharmacy forms avai					
		r stated the pharmacy did				
		of medications dispensed, urned except for controlled				
		roxyzine HCI was not a				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/27/2024 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345519	B. WING		C 07/12/2024
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP COD	E
LIBERTY	COMMONS NSG & REHA	AB CTR OF JOHNSTON CTY		315 HIGHWAY 242 NORTH BENSON, NC 27504	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION
F 755	Continued From page		F 755		
F 758 SS=D	controlled medication Free from Unnec Psy CFR(s): 483.45(c)(3)	chotropic Meds/PRN Use	F 758		8/12/24
	affects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe resident, the facility m §483.45(e)(1) Reside psychotropic drugs an unless the medication specific condition as o in the clinical record; §483.45(e)(2) Reside	hotropic drug is any drug that associated with mental rior. These drugs include, drugs in the following ensive assessment of a nust ensure that ents who have not used re not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic I dose reductions, and			
	drugs; §483.45(e)(3) Reside psychotropic drugs pu unless that medicatio	ursuant to a PRN order n is necessary to treat a ondition that is documented			
		rders for psychotropic drugs . Except as provided in			

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/27/2024 FORM APPROVED OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345519	B. WING		07/12/2024
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•
LIBERTY	COMMONS NSG & REH	AB CTR OF JOHNSTON CTY		315 HIGHWAY 242 NORTH SENSON, NC 27504	
(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 APPROPR DEFICIENCY)	BE COMPLETION
F 758	prescribing practition appropriate for the PI beyond 14 days, he of rationale in the reside indicate the duration §483.45(e)(5) PRN of drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of This REQUIREMENT by: Based on record rev facility failed to implet effects for a resident (medications used to of 5 residents reviewed medications (Residen The findings included Resident #197 was a 7/3/2024 with diagno depression and anxie Resident #197's base reviewed on 7/4/2022 antipsychotic medica performing an Abnorn Scale (AIMS), a scale of involuntary movern medications (medicat to attenuate hallucina	attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order. rders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication. T is not met as evidenced iew and staff interviews, the ment monitoring for the side receiving antipsychotics treat mental disorders) for 1 ed for unnecessary nt #197) I: dmitted to the facility on ses including dementia, ety. eline care plan dated 4 included the use of tions. Interventions included mal Involuntary Movement e that measures the severity ients caused by neuroleptic tions known form their ability	F 758	The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all feder and state regulations the facility has ta or will take the actions set forth in this plan of correction. The plan of correct constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F758 The facility failed to implement monitoring of side effects for 1of 5 residents receiving antipsychotic medications used to treat a mental disorder. 1. Corrective action for resident(s) affected by the alleged deficient pract On 7 / 11 /2024 orders for side effects for 1 for side of monitoring were entered for resident for the side of the side o	ral aken ion e
	antipsychotics. A review of the active	physician orders recorded		ordered antipsychotic medicatior the assigned nurse. On 7/23/2024 the resident was	ns by

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345519	B. WING		07/'	C 12/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				2315 HIGHWAY 242 NORTH		
LIBERTY	COMMONS NSG & REHA	AB CTR OF JOHNSTON CTY		BENSON, NC 27504		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE
F 758	Continued From page	a 29	F 7	58		
1 / 00	Resident #197 was o					
	medications:			discharged to home. 2. Corrective action for res	idents with	
		e of antipsychotic used to		the potential to be affected b		
	treat anxiety and slee			deficient practice:	, are aneged	
		/ four hours as needed for		All residents who receive me	edications	
	agitation for 14 days			have the potential of being a		
		psychotic medication used		alleged deficient practice.		
		lers) 0.5mg every four hours				
	as needed for agitation			On 08/ 6 /2024 the Directo	or of	
	7/4/2024.			Nurses/Assistant Director of	Nurses	
	- Risperidone (a type	of antipsychotic medication		audited all residents with ord	lered	
		Ith conditions) 0.5mg once a		antipsychotic medications fo	r the	
	day for agitation on 7	/3/2024.		presence of an order to mon	itor the	
	- Quetiapine Fumarat	te (antipsychotic medication		medication's side effects. Th	ne results	
	that treats several kin	nds of mental health		included: Batch orders were	noted to be	
	conditions) 25 mg 1/5	5 tablet every evening for		present for antipsychotic me	dications'	
	agitation on 7/3/2024			side effects and behaviors.		
	A physician progress	note dated 7/4/2024		3. Measures /Systemic ch	anges to	
	recorded Resident #1	197's psychological history		prevent reoccurrence of alle	ged deficient	
	included anxiety, dep	ression, dementia, agitation,		practice:		
	delusions and halluci	nations.		On 08/06/2024, the Director	of	
				Nurses/Assistant Director of		
	A pharmacy review of			initiated education on the sid		
		ducted on 7/4/2024. The		monitoring of antipsychotic r		
		dation requested a diagnose		for all Licensed Nurses (RN'		
		tisperdal, Seroquel and		Medication Aides, Full Time,		
	Haldol which had not			needed, and agency nurses	on the	
		cess at the facility at this		following :		
	time.			Topics included:		
	A	41		Residents with an order		
		cation interventions consent		antipsychotic medication are		
		Quetiapine Fumarate,		effect monitoring orders in p	lace for each	
		operidol as medications used		shift.	ad l	
	to treat Resident #19	<i>i</i> s agitation.		Residents with an order		
				antipsychotic medication are	e to nave an	
	These was a All 40	and a second lange to the		a nata na ina nata a sa sa sa sa 10	hahay dawr	
	There was no AIMS a Resident #197's med	assessment located in		order in place to monitor the targeted to that medication f		

Event ID: 829O11

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		ID HUMAN SERVICES MEDICAID SERVICES			F	VTED: 08/27/2024 ORM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3)	DATE SURVEY COMPLETED
		345519	B. WING			C 07/12/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
				2315 HIGHWAY 242 NORTH		
	COMMONS NSG & REHA	AB CTR OF JOHNSTON CTY		BENSON, NC 27504		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 758	 #197 had received Ri 7/4/2024 and Quetian tablet every evening so no documentation that received a dose of Loc Resident #197's July the monitoring to indi- antipsychotic side effection discontinued on 7/3/2 There was no nursing Resident #197 exhibi- behaviors since admi- the admission Minima assessment dated wi- date (ARD) of 7/10/20 and was incomplete. In an interview with N 3:55 pm, she explained admitted on 7/3/2024 antipsychotic medicar previous admission in the electronic MAR. So discontinue the order side effects from the 2024 before she coul that included the mor effects. She stated sh batch order for Resid antipsychotic medicar explanation why she order for antipsychotic electronic MAR. Nurse 	2024 Medication d (MAR) reported Resident isperidone 0.5mg daily since bine Fumarate 25 mg 1/5 since 7/3/2024. There was at Resident #197 had brazepam or Haloperidol. 2024 MAR further reported cate the number of ects every shift was 2024. g documentation indicating ted any psychological ssion. hum Data Set (MDS) th an admission reference 024 was recorded in process lurse #1 on 7/11/2024 at ed when Resident #197 was , the order to monitor for tion side effects from a n May 2024 was still listed on She stated she had to to monitor of antipsychotic previous admission in May d activate a new batch order nitoring of antipsychotic side ne did not reactivate a new ent #197 who was receiving tions and could not give an did not activate the batch cs for Resident #197 on the se #1 further stated an AIMS	F 7	 antidepressants, antia and antipsychotic med The presence or a side effects or a target to be indicated on the record by the number Additional docum may be needed in the well as notification of t physician/responsible All education for curre completed by 08/11/20 who has not received be allowed to work un been completed. This Licensed Nurses and full time, part time, ago needed staff. This in-s incorporated into the r facility orientation. 4. Monitoring Procet the plan of correction specific deficiency cite and/or in compliance or regulatory/requirement The Director of Nurses monitor compliance of Assurance Tool for the Medication Side Effec compliance with the o Audits will be complet then monthly x 3 mont Reports will be preser Quality Assurance Peter 	anxiety medications dications. absence of either ted behavior(s) are electronic medical occurring each shift. entation of behaviors progress notes as the party. ent staff will be 024. Any employee this training will not til the training has s includes all Medication Aides, ency nurses and as service will be new employee dure to ensure that is effective and that en remains corrected with its. s/designee will tilizing the Quality e Antipsychotic tt Process for rder process. ed weekly x 2 weeks ths or until resolved. nted to the weekly rformance	
		usually conducted by the been completed at this time		Improvement committe Administrator or Direct		

Facility ID: 970198

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
345519		B. WING		C 07/12/2024		
NAME OF P			STREET ADDRESS, CITY, STATE, ZIP COD		07	/12/2024
NAME OF PROVIDER OR SUPPLIER			2	315 HIGHWAY 242 NORTH BENSON, NC 27504		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 758	morning clinical meet assessment had not k Resident #197 admis the weekend, the faci clinical meeting to dis for an AIMS assessm In an interview with th 7/12/2024 at 9:11 am #197 receiving the an and Quetiapine Fuma should complete an A monitor for and docur effects of the antipsyc antipsychotics were of that included the mon for antipsychotic med activated for Residem clinical meeting had r holiday prior to the we	the explained usually in ings will catch when AIMS been completed but due to sion prior to a holiday and lity had not held a morning cuss Resident #197's need ent. The Director of Nursing on , she stated due to Resident tipsychotics, Risperidone arate daily, the nursing staff UMS assessment and ment on the MAR side chotics. She explained when ordered by the physician, orders for nurses to activate itoring and documentation ications that was not t #197. She stated morning not been held due to a bekend to ensure AIMs n completed since Resident	F 758	ensure corrective action is initiate appropriate. Compliance will be r and the ongoing auditing program reviewed at the Quality Assurance Meeting. The monthly Quality Ass Meeting is attended by the Admir Director of Nursing, Minimum Da Coordinator, Therapy Manager, H Information Manager and Dietary Manager.	monitored n se surance nistrator, ta Set Health	

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