STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 05/05/2025

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LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 4/28/25 through 5/1/25. Additional information was obtained on 5/2/25, 5/3/25, and 5/5/25. Therefore, the exit date was changed to 5/5/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# S6U911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/28/25 through 5/1/25. Event ID# S6U911. Additional information was obtained on 5/2/25, 5/3/25, and 5/5/25. Therefore, the exit date was changed to 5/5/25. The following intakes were investigated NC00226994, NC00218797, NC00219773 and NC00228536. 4 of the 4 complaint allegations did not result in deficiency.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, and former Medical Director and staff interviews, the facility failed to prevent a medication error when Nurse #1 administered Ativan (a medication used to treat anxiety) to Resident #60 that had been prescribed for Resident #57. This deficient practice affected	F 658	F658 The facility failed to prevent a medication error when Nurse #1 administered Ativan (a medication used to treat anxiety) to Resident #60 that had been prescribed for Resident #57. This deficient	5/22/25

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

Electronically Signed | 05/19/2025

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F 658	Continued From page 1 1 of 5 residents reviewed for unnecessary medications (Resident #60). The findings included: Resident #60 was admitted to the facility on 5/30/24 with diagnoses of diabetes type 2, hypertension and atrial fibrillation. Resident #60 did not have a diagnosis of anxiety. A quarterly Minimum Data Set (MDS) assessment dated 12/6/24, indicated Resident #60 was cognitively intact and did not receive antianxiety medication. A review of Resident #60's March 2025 physician orders included an order for Oxycodone 5 mg one tablet by mouth four times a day for pain. There were no orders for Ativan. A review of Resident #57's physician orders included an order dated 1/28/25 for Ativan 0.5 milligrams (mg) every 24 hours as needed for fourteen days. This order was completed on 2/11/25. An incident report dated 3/5/25, written by Nurse #1, revealed upon giving report to the oncoming shift nurse, a miscount with narcotics was found. Resident #60 received Ativan 0.5 mg ordered for Resident #57, instead of Oxycodone (a medication used to treat pain) 5mg as ordered. The incident was reported to the Director of Nurses (DON), former Medical Director as well as Resident #60, who was his own Responsible Party. New orders were received to hold the scheduled Oxycodone for 6:00 PM and monitor vital signs throughout the rest of the day and night.	F 658	practice affected 1 of 5 residents reviewed 1. Corrective action for resident(s) affected by the alleged deficient practice: All residents have the potential to be affected. On 3/5/2025 the resident was assessed by the Director of Nurses for any change in condition with no noted changes. On 3/5/2025 the Director of Nurses notified the physician. The resident is own RP and was as well notified. An order was received to hold the next ordered Oxycodone and continue to monitor the resident. The resident was placed on acute charting and monitored by the assigned licensed nurses with no change in condition noted. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. On 3/5 2025 and again on 5/16/2025 the Director of Nurses audited ordered narcotics to assure all narcotic counts were correct with no concerns identified. Incident Reports were reviewed for the last 7 days for any other medication errors with no concerns identified. On 3/5/2027 and again on 5/16/2025 the electronic medication administration records were reviewed for the last 7 days for medications documented as administered as ordered with no concerns identified. Change in condition was reviewed by the nursing team as part of the daily clinical review process with no noted concerns identified. . 3. Measures /Systemic changes to	

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F 658	Continued From page 2 A review of Resident #60's March 2025 Medication Administration Record (MAR) indicated the 6:00 PM dose of Oxycodone 5mg was not given. On 4/30/25 at 3:10 PM, an interview occurred with Nurse #1. She explained that typically Resident #60's Oxycodone was the last medication card in the narcotic lock box. She grabbed the last medication card thinking it was Oxycodone for Resident #60, signed out the Oxycodone on the narcotic count sheet and provided the medication to Resident #60 at 6:00 PM as ordered. During the narcotic count with the oncoming nurse at 7:00 PM, it was discovered that Ativan for a different resident, had been pulled instead of the Oxycodone for Resident #60. Nurse #1 stated she immediately reported the incident to the DON, went and assessed Resident #60, and reported the error to Resident #60 and the former Medical Director. Nurse #1 stated that Resident #60 was showing no side effects of receiving the medication. Nurse #1 stated that she should have verified that the correct medication had been pulled by reading the medication label. Nurse #1 stated that the former Medical Director advised her to hold the 6:00 PM scheduled dose of Oxycodone and monitor for any adverse side effects. A phone interview was conducted with the former Medical Director on 5/1/25 at 9:05 AM and stated that she had been notified of the medication error, but didn't feel that it would have caused Resident #60 any harm. She had ordered for the dose of Oxycodone to be held and for staff to monitor Resident #60 throughout the rest of the day and night for any negative side effects. The former	F 658	prevent reoccurrence of alleged deficient practice: On 3/5/2025 the DON educated and coached the nurse 1:1 on the prevention of medication errors and the importance of following the six rights of med pass. On 3/5/2025 the Director of Nurse began education of all licensed nurses to include agency nurses on the prevention of medication errors. Topics included: • What a med error is • Types of medication errors • The 6 rights of med pass • Reporting med error process • Prevention of med errors • Safe administration of medications On 5/16/2025 re-education on the prevention of medication errors as stated above was begun by the Director of Nurses for all licensed nurses to include agency. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and management nurses as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any applicable staff who does not receive inservice education by 5/ 21 /2025, will not be allowed to work until training been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.	

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F 658	Continued From page 3 Medical Director did not feel this was a significant error, however felt Resident #60 should have received Oxycodone as ordered. The DON was interviewed on 5/1/25 at 10:48 AM and stated that Nurse #1 had provided Resident #60 with another resident's Ativan instead of his ordered Oxycodone on 3/5/25. She acknowledged that the error was immediately reported to her. The DON explained that Resident #60 was assessed for any negative side effects which continued throughout the rest of the evening and night, Resident #60 as well as the former Medical Director were notified of the error and an order was received to hold the 6:00 PM dose of Resident #60's Oxycodone and to continue monitoring his vital signs. The DON stated that immediate education was started with Nurse #1 as well as all other nursing staff regarding medication errors and verifying the medication is the correct one ordered for the residents. The DON confirmed that Resident #60 did not have any negative outcomes or adverse reactions from receiving Ativan instead of Oxycodone. The DON stated that she completed a spot check every morning of the narcotic count sheets and verified the count with the nurse. The facility alleged past noncompliance (PNC) on 3/11/25, however this could not be determined due to a new citation for a significant medication error.	F 658	Quality assurance monitoring will be completed by the Director of Nurses to assure compliance with the medication administration process for administration of medications following the physician orders. Auditing will be completed weekly x 2 and monthly x 3 or until resolved. Reports will be presented to the QA committee by the Administrator or Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager.	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		5/22/25

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F 760	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Pharmacy Consultants, Nurse Practitioner (NP), and Medical Director interviews, the facility failed to discontinue a medication per physician's order resulting in the resident receiving the previous ordered dose of acetaminophen (used to relieve mild to moderate pain) and the newly ordered dose of acetaminophen. This was for 1 of 5 residents (Resident #27) reviewed for unnecessary medications. The findings included: Resident #27 was admitted to the facility on 2/02/21 with diagnoses that included chronic pain syndrome, osteoarthritis, and type 2 diabetes mellitus with diabetic neuropathy. The quarterly Minimum Data Set (MDS) assessment dated 2/14/25 indicated Resident #27's cognition was intact. She received routine pain medications, no PRN (as needed) pain medications, and reported pain frequently at a rating of 8 out of 10. Resident #27's active care plan, last reviewed 2/14/25, included the focus area of pain. The interventions included, in part, administer medication as ordered, and observe for adverse reactions with every interaction with the resident. Report to physician if noted. A physician's order for Resident #27 dated 3/02/23 indicated acetaminophen (APAP) extended release (ER) oral tablet 650 milligrams (mg) by mouth three times a day for chronic pain "Do not crush" do not exceed 3 grams (3000 mg)	F 760	F760 The facility failed to discontinue a medication per physician's order resulting in the resident receiving the previous ordered dose of acetaminophen (used to relieve mild to moderate pain) and the newly ordered dose of acetaminophen. This was for 1 of 5 residents (Resident #27) reviewed for unnecessary medications 1. Corrective action for resident(s) affected by the alleged deficient practice: Corrective action for resident(s) affected by the alleged deficient practice: On 4/30 /2025 Resident # 27; the previous order for acetaminophen was discontinued from the electronic medical record. The Nurse Practitioner was notified of the error and the resident (who is her own RP) was notified of the error. Resident was assessed with no negative findings noted. Labs were ordered for liver function and acetaminophen level and labs returned within normal limits. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 05/16/2025, the Director of Nurses initiated an audit of 100% of medication orders for the last 14 days for all current residents. The audit consisted of a review of all newly ordered medications to confirm that new orders had been initiated and that any orders to discontinue medications had been discontinued as	

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F 760	Continued From page 5	F 760		

APAP from all sources within 24 hours. The total daily dose of acetaminophen ordered to be administered was 1,950 mg.

A physician's order for Resident #27 dated 4/15/25 indicated acetaminophen oral tablet 500 MG tablet, give 2 tablets (1000 mg) by mouth two times a day for pain. The total daily dose of acetaminophen ordered to be administered from the new order was 2,000 mg. The previous order for acetaminophen ER 650 that was initiated on 3/02/23 for Resident #27 was not discontinued and remained an active order. Due to the previous order for acetaminophen ER 650 not being discontinued when there was a new acetaminophen order, the combined total daily dose of acetaminophen ordered to be administered was 3,950 mg.

A review of the medication administration record (MAR) for Resident #27 from 4/15/25 through 4/30/25 showed acetaminophen 650 mg was administered three times a day (at 6:00 AM, 12:00 PM, and 9:00 PM), and acetaminophen 1000 mg was administered two times a day (at 9:00 AM and 5:00 PM).

An interview was conducted on 4/30/25 at 2:04 PM with the Unit Manager that entered the acetaminophen 1000 mg order. The order for Resident #27, dated 4/15/25, was reviewed with the Unit Manager, she verified the order read to change acetaminophen to 1000 mg twice a day. She stated she did remember receiving and entering the acetaminophen order when Resident #27 returned from an appointment with the orthopedic physician. She stated she did not change the acetaminophen order as it read, she only entered the new order. She stated it was an ordered. No concerns were identified.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

Beginning on 05/ 16/2025, the Director of Nurses initiated education on the Prevention of Medication Errors and the Order Process following return from a consultation for all Licensed Nurses (RN's and LPN's), Full Time, Part Time, PRN, and Agency Nurses. The education included:

- Physician orders are to be reviewed upon return from a consult to assure new orders are initiated timely and orders that have been discontinued are addressed timely. Failure to discontinue an order can result in a medication error and potential resident harm related to the administration of a drug that is now not indicted for the resident. (unnecessary med)
- When a resident returns' from a consultation, it is important to review and confirm all new medications ordered as well as medications that were discontinued.
- What is a medication error.

As of 05/ 21/2025, any employee who has not received this training will not be allowed to work until the training has been completed. This includes all Licensed Nurses full time, part time, agency staff, and PRN staff. This in-service will be incorporated into the new employee facility orientation.

Process Improvement Plan initiated:

When an order is received, the nurse will review the order, input the order in PCC

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F 760	Continued From page 6 oversight that she did not discontinue the previous scheduled acetaminophen order. An interview was conducted on 5/01/25 at 10:41 AM with the Nurse Practitioner (NP). She stated she was made aware of the extra order of acetaminophen for Resident #27 on 04/30/25 and she ordered a liver enzymes lab, which she also stated came back with no abnormalities. She stated no liver damage had appeared to have occurred. She explained the extra acetaminophen order was discontinued on 4/30/25. She further explained she also ordered an acetaminophen level for Resident #27 however those results had not been returned yet and she anticipated the results to be okay as well. A phone interview was conducted on 5/02/25 at 6:15 PM with Pharmacy Consultant #1. She stated when looking at acetaminophen orders and the maximum dose that they recommended 3 grams (g)/3000 mg/day total, but technically it would take 4g/4000mg/day over a long period of time to cause liver damage. A phone interview was conducted on 5/02/25 at 6:35 PM with Pharmacy Consultant #2. She stated herself and Pharmacy Consultant #3 performed monthly reviews at the facility which included medication dosage amounts residents were receiving per day. She also stated Pharmacy Consultant #3 completed the monthly review on the evening of 4/30/25. Pharmacy Consultant #2 did not see any notes referring to the acetaminophen order for Resident #27 at that time. She explained when they looked at acetaminophen orders the maximum dose that they recommend was 3 grams (g)/3000 mg/day total, but technically it would take 4g/4000mg/day	F 760	and will sign the consultation report. A second nurse will review the order and ensure the order has been input into PCC correctly and any previous order has been discharged as necessary and will sign the consultation report. The consultation report will then be forwarded to the DON for review during morning clinical meeting. Once all three agree that the order was implemented correctly, the consultation report will be forwarded to Medical Records to be downloaded into PCC. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses will monitor the Order Process utilizing the F760 Quality Assurance Tool by completing an audit weekly x 2 then monthly x 3 months or until resolved. The audit will include review of residents returning from consultations to assure the order process is in compliance. Reports will be presented to the Quality Assurance Committee by the Administrator or Director of Nurses 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 QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and the Dietary Manager.	

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over a long period of time (She did not know how long would be considered a long time) to cause liver damage (liver damage was the concern for excessive amounts of acetaminophen). The recommendation of 3000 mg/day was put in place as a precautionary due to the possibility of the residents having an undiagnosed condition or health condition that may interfere with larger doses of acetaminophen. She indicated that they see a lot of acetaminophen orders that exceed the 3000 mg/day recommended dose, up to 4000mg/day orders. She did not feel the amount of 3950 mg of Tylenol for Resident #27 would cause any liver damage. She also stated the pharmacist would have sent the facility a physician recommendation for Resident #27's acetaminophen orders requesting a lower dosage and liver panel during the pharmacist review but would not be surprised if the physician denied the recommendation to lower the total acetaminophen daily dosage as it happens "all the time."

A phone interview was conducted on 5/03/25 at 9:48 AM with Pharmacy Consultant #3. She verified the pharmacy performed the monthly medication reviews for the facility. She explained during the medication review process she would review active orders on the resident's medication administration record (MAR). Pharmacy Consultant #3 indicated she looked for several things during the review including duplicate orders, high risk medications, and dosage amounts. She explained that it was standard for acetaminophen orders to include the verbiage "do not exceed 3 grams (3000 mg) APAP from all sources within 24 hours". She also explained if the order did not include this verbiage during the review she would send the facility a

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recommendation to add to the acetaminophen order. She indicated that some physicians add this verbiage themselves to the order, and some don't due to the facility and/or the pharmacy adding it as the standard practice. She stated the maximum dose of acetaminophen in adults was 4g/4000mg/day and for the elderly it was lowered to 3g/3000mg/day as a precautionary measure. This in part was because some elderly residents may not have the ability to describe signs/symptoms of an underlying medical conditions that may go undiagnosed and may affect the maximum dose of 4g/4000mg/day acetaminophen. She added some facility systems automatically add the verbiage. Pharmacist Consultant #3 explained when she reviewed an acetaminophen order that exceeds the 3000mg/day amount, she reviewed the chart to see when the last liver function lab was completed, notified the facility making them aware, and requested a physician review and liver function labs if there was not a current one in the chart. She stated she completed the monthly review for the facility on 4/30/25 at 6:30 PM. She indicated if the acetaminophen order had been discontinued 4/30/25 prior to her review it would not have been included on Resident #27's active order lists. She was also very familiar with Resident #27 and stated they did monitor her pain levels and pain medications. She then stated Resident #27 had a "high pain threshold."

A phone interview was conducted on 5/02/25 at 7:40 PM with the Director of Nursing (DON) regarding their processes for receiving and checking orders. The DON stated the process they had in place was that when a resident returns from a doctor's appointment the returning paperwork was given to the resident's nurse. That

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nurse would enter the orders into the electronic system, notify the responsible party, and then the unit manager would do a second check to ensure the orders were entered correctly. After the unit manager checked the orders, the paperwork would be left for the physician to review. If a completely new medication was ordered by the outside physician, the primary care provider would be called, if it was a change in a medication the resident was already receiving, the paperwork would be put in the physician's binder for review when he came in. With Resident #27's orders, the Unit Manager entered the original orders, so the second check was not done at that time. During the morning meeting the DON checks to see if the responsible party and physician had been notified. With the acetaminophen orders for Resident #27, the Unit Manager entered the original order and so the 2nd nurse check wasn't completed. The interview further revealed monthly order reconciliation was completed by the pharmacist and the pharmacist review for Resident #27 was completed on the afternoon of 4/30/25.

An interview was conducted on 4/30/25 at 2:45 PM with the Director of Nursing. She stated she was unaware the acetaminophen order for Resident #27 was not changed per order and she expected all physician orders to be transcribed and followed through with. The DON indicated that one of the scheduled acetaminophen orders should have been discontinued per order.

A phone interview was conducted on 4/30/25 at 2:12 PM with the Medical Director which explained he was not aware of the acetaminophen orders for Resident #27 because he was new to the facility and had only been there

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F 760	Continued From page 10 for 2 weeks. He stated he would look at her medications to modify for an alternate pain medication regimen. He indicated he did not think there was any negative outcome to her liver because she had only taken the extra acetaminophen since 4/17/25.	F 760		