STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345207	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

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LIBERTY COMMONS N&R CTR OF COLUMBUS CTY	1402 PINCKNEY STREET , WHITEVILLE, North Carolina, 28472

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E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 7/7/25 through 7/10/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #8TB011.	E0000		07/23/2025
F0000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 7/7/25 through 7/10/25. Event ID# 8TB011. The following intakes were investigated: 881662, 881664, 881669, 881665, 881670, 881667, and 881672. 19 of the 19 complaint allegations did not result in deficiency.	F0000		07/23/2025
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification.	F0641	Corrective actions Resident #91 Minimum data set Quarterly assessment with Assessment Reference date of 6/2/2025 reviewed and during the assessment look back period the resident received intake by artificial route during hospitalization during the assessment look back period but has not received any intake by artificial route while a resident of the facility during the assessment look back period. Assessment correction completed on 7/23/2025 for section K0710 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. A 100 % audit of the current residents' most recent Minimum data set assessments that have been accepted in IQIES in the past 14 days will be completed in order to identify if section K0520A or K0520B was coded as "yes" for receiving intake by artificial route. For those residents identified as receiving intake by artificial route, the assessment will be reviewed to ensure it was coded accurately on the Minimum data set assessment at	07/31/2025

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 reverse for further 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.

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

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F0641 SS = D	Continued from page 1 §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) accurately in the areas of fluid intake per day by intravenous (IV) or tube feeding and the use of antipsychotic medication on a daily basis for 1 of 24 residents whose MDS assessments were reviewed (Residents #91). The findings included: Resident #91 was admitted to the facility on 03/07/25 with diagnoses that included, in part, Alzheimer's disease, dementia without psychotic disturbance or mood disturbance, anorexia, and dysphagia. Review of Resident #91's quarterly Minimum Data Set assessment dated 06/02/25 documented she had an average fluid intake per day by IV or tube feeding of 501 cc (cubic centimeter)/day or more while a resident and also during the entire 7 days (of the look back period). It also noted antipsychotic medications were received on a routine basis. Review Resident #91's May 2025 and June 2025 electronic Medication Administration Records (eMAR's) revealed she had not been administered an antipsychotic medication and had not received fluids by IV or tube feeding during the assessment look back period. In an interview with the MDS Coordinator on 07/08/25 at 1:05 PM she stated she had reviewed the 06/02/25 MDS assessment and the resident's medical records. She concluded that Resident #91 had not received fluids by IV or tube feeding and had not taken any antipsychotic medications during the assessment look back period. She stated a float nurse had completed this particular	F0641	Continued from page 1 item K0710A and K0710B. Any assessment identified as having inaccurate coding of section K0710A or K0710B will have a correction of that assessment completed. Any necessary Minimum data set corrections identified from the audit will be completed no later than 7/23/2025. Systemic Changes By 7/23/2025 the regional Minimum data set consultant will complete an in-service training with the facility Minimum Data Set Nurse and the floater nurse that includes the importance that the assessment is coded accurately. Special emphasis will be placed on the following area of the Minimum Data Set assessment: K0710: Percent intake by artificial route The MDS needs to be thoroughly reviewed for accuracy prior to saving and signing section K0710 of the assessment. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Administrator or designee will begin auditing 5 random recently completed minimum data set assessments for accuracy in coding on the Minimum data set assessment for item K0710A and K0710B to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This audit will be done weekly x 4 weeks using the audit tool titled "Accurate Coding of MDS Audit Tool". Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The title of the person responsible for implementing the acceptable plan of correction; Administrator and/or Director of Nursing.	

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F0641 SS = D	Continued from page 2 assessment. In an interview with the Director of Nursing on 7/10/25 at 2:23 PM she stated data entered into an MDS assessment should always be accurate.	F0641		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, Registered Dietitian and Nurse Practitioner interviews, the facility failed to address a Registered Dietitian recommendation to obtain weekly weights for 1 of 4 residents reviewed for nutrition (Resident # 75). Findings included: Resident #75 was admitted on 5/1/25 with medical diagnosis including chronic kidney disease, hypertension, and prostate cancer. Review of Resident #75's physician orders revealed an order dated 5/1/25 for Cardiac diet, Soft & Bite Sized texture with thin consistency liquids.	F0692	1. Corrective action for resident(s) affected by the alleged deficient practice: On 7/10/2025, Resident #75 was weighed immediately upon identification of the deficiency. Weekly weights have been initiated and documented per the Registered Dietitian's recommendation. The Nurse Practitioner and RD were notified of the corrective action. 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 this deficient practice. On 7/29/2025, a facility-wide audit was conducted by the Director of nursing and designee to identify residents with active RD recommendations for weekly weights. Any missed weights were immediately obtained and documented. Residents' with missing weights were assessed by the Director of Nursing or designee for current nutritional status, including recent weight trends and current dietary interventions. Any discrepancies or signs of nutritional risk were addressed by the RD and care plans were updated accordingly. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/24/2025, the Staff Development Coordinator began in-servicing all Full time, part time and as needed Nurses, Medication Aides staff (including agency) on Implementing RD Recommendations for Weekly Weights This training will include all current staff including agency. This training included: The importance of adhering to RD recommendations.	07/31/2025

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F0692 SS = D	Continued from page 3 Review of Resident #75's electronic health record revealed the following weights recorded: 5/2/25 194.8 pounds (Lb.) 5/3/25 196.6 lb. 5/10/25 No weight recorded Review of Resident #75's care plan dated 5/5/25 indicated a nutritional problem or potential nutritional problem related to receives a therapeutic, mechanically altered diet, chronic kidney disease and dementia. Interventions included observe for, record and report to the physician as needed significant weight loss (3lbs in 1 week, greater than 5% in 1 month, greater than7.5% in 3 months, greater than10% in 6 months), Registered Dietitian to evaluate and make diet change recommendations as needed and weight per protocol and as needed. Review of a Registered Dietitian (RD) note dated 5/13/2025 at 12:07 PM indicated Resident #75 had a weight of 196.6 lb. recorded on 5/3/25. The note indicated the plan was obtain a new weekly weight and monitor weights weekly, per policy and follow up as needed. 5/13/25 No weight recorded. 5/20/25 No weight recorded. 5/27/25 No weight recorded. 6/4/25 No weight recorded. 6/11/25 181.2 lb. incorrect documentation standing 6/11/25 189.2 lb. 6/18/25 No weight recorded 6/25/25 No weight recorded 7/2/25 184 lb.	F0692	Continued from page 3 Proper documentation and follow-up procedures. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff identified above who does not receive scheduled in-service training will not be allowed to work until training has been completed by 7/31/2025. 4. Monitoring and Quality Assurance The Director of Nursing will monitor Registered Dietician Recommendations weekly for 2 weeks and monthly for 3 months to ensure all recommendations initiated timely to include not limited to weekly weight monitoring. Monitoring will be started the week of 8/4/2025. Reports will be presented to the monthly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.	

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F0692 SS = D	Continued from page 4 An interview with the Minimum Data Set (MDS) Coordinator on 7/10/25 at 9:55 AM revealed that residents were weighed weekly for 4 weeks following admission and then monthly. The MDS Coordinator stated that the RD sent an email to the interdisciplinary team with her recommendations. The MDS Coordinator stated that she and the Assistant Director of Nursing (ADON) were responsible for implementing the RD's recommendations. The MDS Coordinator was unable to state why the recommendation for weekly weights was not implemented and why Resident #75 was not weighed weekly per the facility protocol. An interview with the Registered Dietician (RD) was conducted on 7/10/25 at 12:35 PM. The RD stated that she expected that weekly weights would be obtained for 4 weeks for all new admissions and readmissions and then as specified. The RD stated that Resident #75's weights should have been obtained weekly per protocol. The RD indicated that weekly weights were important for monitoring the resident's status and evaluating the medical condition. An interview with the Nurse Practitioner (NP) on 7/10/25 at 1:08 PM revealed that she expected that weekly weights would be obtained for 4 weeks at least and then as indicated. The NP stated that weights were important for monitoring. Weight loss was to be tracked and evaluated. The NP stated that she was not aware that Resident #75 lost weight. An interview was conducted with the ADON on 7/10/25 at 2:30 PM. The ADON indicated that she was in the role of acting Director of Nursing for the past several months. The ADON revealed that weekly weights were to be obtained for 4 weeks after admission and as indicated. The ADON stated she and the MDS Coordinator received the RD recommendations and were responsible for implementing them. The ADON stated it was an oversight that the recommendation for Resident # 75 to be weighed weekly was not implemented and that the weekly weights on admission were not obtained.	F0692		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require	F0698	Plan of Correction for F0698 – Dialysis Care and Services The facility failed to: Remove an ordered pressure dressing 4–6 hours	07/31/2025

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F0698 SS = D	Continued from page 5 dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff and Nurse Practitioner interviews, the facility failed to: remove an ordered pressure dressing to a newly inserted arterial/venous (A/V) dialysis shunt site 4-6 hours after the resident returned from dialysis, check the resident's arterial/venous dialysis shunt when resident returned from dialysis and clarify orders that were entered inaccurately. This was for 1 of 1 resident (Resident #55) reviewed for dialysis. Findings included: Resident #55 was admitted to the facility on 06/20/24. Diagnoses included end stage renal disease requiring hemodialysis (a treatment needed for residents with poor kidney function), and insertion of A/V dialysis shunt (a passage that is inserted in the body to allow fluid from one part of the body to another and used as an access port to dialyze residents) to left arm. A review of the physician orders revealed an order written on 03/20/25 for hemodialysis on Tuesday, Thursday, Saturday at 5:30 AM and an order to check Permacath (a special intravenous device inserted into a blood vessel and used over an extended period of time for dialysis treatments) on right side of chest for bleeding and signs and symptoms of infection. On 06/21/25, new physician orders were written to remove pressure dressing over shunt site 4-6 hours after returning from dialysis every day shift on Monday, Thursday, and Saturday, check right upper arm shunt site for bleeding, signs and symptoms of infection, bruit (a sound that can be heard when assessing an A/V dialysis shunt) and thrill (a sensation you can feel when assessing an A/V dialysis shunt) and document adverse findings in nursing notes. The Minimum Data Set annual assessment dated 06/25/25 revealed Resident #55 was cognitively intact and he demonstrated no behaviors. He was coded as receiving hemodialysis services.	F0698	Continued from page 5 post-dialysis. Check the A/V shunt site upon return from dialysis. Clarify inaccurately entered orders for Resident #55. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 7/09/2025 The pressure dressing for Resident #55 was removed immediately upon identification of the issue by the floor nurse. The A/V shunt site was assessed and documented with no negative findings. The inaccurate orders were clarified with the dialysis provider and updated in the resident's medical record. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents receiving dialysis services have the potential to be affected by this deficient practice. On 7/29/2025 A full audit was conducted of all residents receiving dialysis by the Director of Nursing or designee to ensure: Timely removal of pressure dressings. Proper post-dialysis shunt assessments. Accuracy of dialysis-related orders. Any discrepancies were corrected and documented. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/24/2025, the Staff Development Coordinator began in-servicing all Full time, part time and as needed Nurses, Medication Aides staff (including agency) on post-dialysis care and accurate order management This training will include all current staff including agency. This training included: Timely Removal of Pressure Dressings A/V Shunt Site Checks and documentation	

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F0698 SS = D	Continued from page 6 A review of Resident #55's care plan updated on 06/25/25 revealed a plan of care for receiving hemodialysis 3 times per week with interventions that included to monitor newly inserted A/V dialysis shunt for complications such as infection, fluid imbalances, and hemorrhage from dialysis vascular access port, apply firm and direct pressure using 2 fingers to bleeding shunt site, maintain firm pressure for at least 10 minutes, do not draw blood or take blood pressure in arm with shunt, keep dressing on site as ordered, no intravenous or blood draws in left arm, observe, document, and report to the physician any signs or symptoms of infection to access site. The Medication Administration Record (MAR) for June 2025 revealed the following: - The order to remove the pressure dressing over shunt site 4-6 hours after returning from dialysis every day shift on Monday, Thursday and Saturday revealed Nurse #5 recorded a checkmark and her initials on 06/26/25 (Thursday) and Nurse #7 recorded a checkmark and her initials on 06/30/25 (Monday) indicating the nurses removed the pressure dressing to Resident 55's shunt site. - The order to check Resident #55's right upper arm shunt site for bleeding, signs and symptoms of infection, and bruit and thrill every shift revealed Nurse #5 recorded a checkmark and her initials on 06/26/25 indicating she checked the shunt site. The MAR for July 2025 revealed the following: - The order to remove the pressure dressing over shunt site 4-6 hours after returning from dialysis every day shift on Monday, Thursday and Saturday revealed Nurse #5 recorded a checkmark and her initials on 07/05/25 (Saturday) and Nurse #7 recorded a checkmark and her initials on 07/07/25 (Monday) indicating the nurses removed the pressure dressing to Resident 55's shunt site. - The order to check Resident #55's right upper arm shunt site for bleeding, signs and symptoms of infection, and bruit and thrill every shift revealed Nurse #5 recorded a checkmark and her initials on	F0698	Continued from page 6 Documentation and Accountability Order Clarification: Immediate review and clarification of dialysis orders upon resident return. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff identified above who does not receive scheduled in-service training will not be allowed to work until training has been completed by 7/31/2025. 4. Monitoring and Quality Assurance The Director of Nursing will monitor post-dialysis care and accurate order management for all dialysis residents weekly for 2 weeks and monthly for 3 months to ensure orders accurately implemented per resident dialysis schedule and ensure post-dialysis protocol compliance. Monitoring will be started the week of 8-4-25. Reports will be presented to the monthly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.	

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F0698 SS = D	Continued from page 7 07/05/25 indicating she checked the shunt site. An observation of Resident #55 on 07/09/25 (Wednesday) at 10:30 AM, revealed Resident #55 had a pressure dressing in place to his left arm over his A/V dialysis shunt. There were no signs or symptoms of bleeding noted on the outside of the dressing. An interview with Resident #55 on 07/09/25 at 10:30 AM. Resident #55 stated he was supposed to have the dressing removed from his shunt site on his dialysis days which he stated were Tuesday, Thursday, and Saturday. Resident #55 stated he did not know why the dressing was not removed on Tuesday 07/08/25. Resident #55 added, sometimes the nurses would remove it the next day or so. An interview was conducted with Nurse #5 on 07/09/25 at 3:30 PM. Nurse #5 confirmed Resident #55 dialyzed on Tuesday, Thursday, and Saturdays. She stated when Resident #55 returned from dialysis usually around 12:30 PM, she would review the communication sheet that was provided to the Dialysis Center for any new orders, she would obtain Resident #55's vital signs and check the dressing site to be sure it was dry and intact with no signs or symptoms of bleeding. She stated she would not remove the dressing to the A/V dialysis shunt and that when Resident #55 went back to dialysis on his next scheduled day, the dialysis nurse would remove it. Nurse #5 reviewed the orders written in the MAR to check the right upper arm shunt for bleeding, signs and symptoms of infection and bruit and thrill and to remove the pressure dressing 4-6 hours after returning from dialysis. Nurse #5 stated she never removed the dressing to check the A/V shunt and that the A/V shunt was on Resident #55's left arm not the right arm as the order was written. She added, she thought the Dialysis Nurse removed the dressing when Resident #55 returned for his next scheduled visit. Nurse #5 stated Resident #55 had a newly inserted A/V dialysis shunt and she should have been checking it when he returned back from dialysis on his scheduled days to be sure there was no occlusion (clotting) or signs of infection. Nurse #5 added, she should have clarified the order to indicate it was Resident's left arm that had the A/V dialysis shunt and not the right arm. An interview was conducted with Nurse #7 via phone on 07/10/25 at 10:12 AM. Nurse #7 reported the way she understood the order to be was to remove the pressure	F0698		

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F0698 SS = D	Continued from page 8 dressing from the shunt site on his left arm on dialysis days, and she stated she signed off that she removed it on Monday 06/30/25 and Monday 07/05/25 as it was indicated to be done on the MAR because the dressing was still on Resident #55. Nurse #7 stated the order did not make sense to remove the dressing on a Monday, Thursday, and Saturday and the order should have read to remove the pressure dressing on Tuesday, Thursday and Saturday when he dialyzed. Nurse #7 confirmed the order for checking the arm each shift should have read left arm and not right arm. She stated she should have clarified the order with the Assistant Director of Nursing (ADON). Nurse #7 verified she was assigned to Resident #55 on Tuesday 07/08/25 and that Resident #55 went to dialysis as scheduled. Nurse #7 stated the resident returned back around 1:00 PM. Nurse #7 stated she did not remove the dressing 4-6 hours after his return from dialysis as the order indicated. She further stated she did not remove the dressing on Tuesday 07/08/25 because it was not ordered to remove it on Tuesdays. She explained that she understood that Resident #55 dialyzed on Tuesday and had a dressing in place that should have been removed per the order (4-6 hours after dialysis). Nurse #7 stated that although she did not remove the pressure dressing on Tuesday 07/08/25 she looked at the resident's hand for swelling and looked at the intact dressing for any bleeding. Nurse #7 stated she did not check for bruit and thrill, but that she knew how to check for a bruit and thrill. An interview was conducted with the ADON on 07/10/25 at 2:10 PM. The ADON reviewed the orders that she entered on 06/21/25 and stated she entered the orders incorrectly and it should have read to remove the pressure dressing over shunt 4-6 hours after dialysis on Tuesday, Thursday and Saturday and to check the left arm not the right arm each shift. She reported she entered the orders incorrectly and it was a human error. The ADON corrected the orders at this time. She stated that the nursing staff were aware that Resident #55 dialyzed on Tuesdays, Thursdays, and Saturdays and that he had a left arm A/V dialysis shunt, and they should have questioned the inaccuracy of the entered orders. The ADON reported her expectation for the assigned nurses post dialysis was to remove the dressing 4-6 hours after dialysis, check the site and feel for thrill and listen for bruit. The ADON added Resident #55's A/V dialysis shunt was new and not mature yet and it should be assessed each shift for clotting or signs or infection. An interview was conducted with the Nurse Practitioner	F0698		

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F0698 SS = D	Continued from page 9 on 07/10/25 at 1:30 PM. The Nurse Practitioner stated she expected the orders to remove the A/V shunt pressure dressing 4-6 after dialysis and to check the left arm (not the right) to be entered correctly. She state that the nursing staff who were assigned to Resident #55 on dialysis days should have read the orders, clarified the orders and removed the dressing that was in place 4-6 hours after his dialysis on Tuesdays, Thursdays, and Saturdays. The Nurse Practitioner added, Resident #55 had a newly inserted A/V dialysis shunt and that shunt should be getting assessed whenever the dressing was removed to ensure it was patent (no blockage or clotting) and had no signs of infection.	F0698		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and staff interviews, the facility failed to discard expired medications stored for use and discard loose pills observed in 3 of 5 medication (med) carts (the 200 hall, 400 hall and 600 hall medication carts) and	F0761	Plan of Correction for F0761 – Label/Store Drugs and Biologicals Properly The facility failed to: Discard expired medications. Remove loose, unlabeled pills from 3 of 5 medication carts (200, 400, and 600 halls). 1. Corrective Action for Affected Areas On 7/30/2025 All expired medications and loose pills were immediately removed and properly discarded from the 200, 400, and 600 hall med carts. The medication carts were cleaned and inspected by the Director of Nursing (DON) and Pharmacy Consultant. 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 this deficient practice. All residents have the potential to be affected by expired medications. On 7/30/2025, the DON initiated a facility-wide audit of all medication carts, emergency kits, and medication storage areas to identify and remove any expired medications. The audit was completed by 7/30/2025 and all expired medications were disposed of according to policy. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/24/2025, the Staff Development Coordinator began in-servicing all Full time, part time and as needed	07/31/2025

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F0761 SS = E	Continued from page 10 failed to discard expired medications stored in 2 of 3 medication storage rooms (100 hall and 300 hall) reviewed for medication storage. Findings included: a. An observation was conducted on 7/9/25 at 8:39 AM of the 200 hall med cart in the presence of Medication Aid (MA #1), The observation revealed the following medications were stored on the cart. - A fluticasone propionate/salmeterol inhaler opened on 6/2/25 and expired 30 days after opening on the box. - There were 3 loose pills in the drawers of the cart (1 white oblong pill and 2 white round pills). An interview was conducted with MA #1 on 7/9/25 at 8:39 AM. MA #1 stated there should not be any expired medications or loose pills on the chart. b. An observation was conducted on 7/9/25 at 11:51 AM of the 400 hall cart in the presence of Nurse #5. The observation revealed there were 2 loose pills in the drawers of the cart (1 white oblong pill and 1 round pill). An interview was conducted with Nurse #5 on 7/9/25 at 11:51 AM. Nurse #5 stated there should not be loose pills in the drawers of the cart. c. An observation was conducted on 7/9/25 of the 600 hall med cart in the presence of MA #2. The observation revealed: - An opened bottle of stock Vitamin C with the expiration date of 10/24. - A loose small oval yellow pill was found in the drawer of the cart. An interview was completed with MA #2 on 7/9/25 at 12:24 PM. MA #2 stated there was not supposed to be any expired medication on the cart or loose pills on the cart. d. An observation was conducted on 7/9/25 at 2:12 PM of the 100/200 hall medication storage room in the presence of MA #3. The observation revealed an opened package of promethazine hydrochloride 25 milligrams (mg) suppositories with expiration date of 6/11/25. An interview was conducted on MA #3 on 7/9/25 at 2:12 PM. MA #3 stated she thought the night shift nurses	F0761	Continued from page 10 Nurses, Medication Aides staff (including agency) on Label/Store Drugs and Biologicals Properly This training will include all current staff including agency. This training included: Medication Storage and Expiration Policy Daily visual checks by medication nurses. Weekly audits by unit managers. Monthly inspections by the Pharmacy Consultant. A “No Loose Pills” protocol requiring immediate disposal of any unidentified or loose medications. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff identified above who does not receive scheduled in-service training will not be allowed to work until training has been completed by 7/31/2025. 4. Monitoring and Quality Assurance The Director of Nursing will monitor weekly for Label/Store Drugs and Biologicals Properly 2 weeks and monthly for 3 months to ensure medication storage and expiration policy compliance. Monitoring will be started the week of 8-4-25. Reports will be presented to the monthly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.	

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F0761 SS = E	Continued from page 11 were supposed to check for expired medications in the medication rooms. She further stated there should not be any expired medications in the medication storage room e. An observation of was conducted on 7/9/25 at 2:15 PM of the 300 hall medication storage room in the presence of Nurse #1. The observation revealed an unopened bottle of Gas Relief tablet (simethicone 80mg) with the expiration date of 11/24. An interview was completed with Nurse #1 on 7/9/25 at 2:15 PM. Nurse #1 explained that there was not supposed to be expired medications in the medication storage rooms. An interview was completed with the Director of Nursing (DON) on 7/10/25 at 11:36 AM. The DON stated there was a process in place for checking the medication storage rooms and the med cart for expired pills. She stated the night shift nurses and the Unit Managers were responsible for checking the carts and medication storage rooms. She stated that it was obvious they were not doing a very thorough job, and they needed to pay more attention to the expiration dates. The DON explained that she knows they are looking at the med carts and medication storage rooms because the nurses brought her expired medications all the time. She indicated the nursing staff needed to pay more attention to expired medications and loose pills in the carts and medication storage rooms.	F0761		
F0842 SS = E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F0842	The facility failed to maintain accurate and complete medical records for 3 of 3 residents reviewed: Resident #49 – Wound care not documented on TAR or in the EMR; inaccurate documentation of implanted device assessment. Resident #28 – Antihypertensive medication (Hydralazine) not documented as held per physician order. Resident #55 – Dressing removal from A/V dialysis shunt not documented. 1.Corrective action for resident(s) affected by the alleged deficient practice: Resident #49, #28, #55 identified in the CMS-2567 were immediately assessed by the Director of Nursing (DON) on 7/10/2025. The resident's medical record and care plan was reviewed and updated to reflect current clinical needs and interventions. All staff involved in	07/31/2025

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F0842 SS = E	Continued from page 12 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident;	F0842	Continued from page 12 the resident's care were re-educated on proper assessment and documentation procedures. The resident's condition was assessed and monitored for any further complications with no identified concerns. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: A facility-wide audit was initiated on 7/29/2025 by the DON and/or designee to identify any other residents who may have been affected by similar issues. All residents identified through the audit had their care plans and clinical documentation reviewed and updated as necessary. Any discrepancies were corrected immediately. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/24/2025, the Staff Development Coordinator began in-servicing all Full time, part time and as needed Nurses, Medication Aides staff (including agency) on Accurate and Complete Medical Records This training will include all current staff including agency. This training included: Wound Care Documentation: Medication Administration: Follow physician orders Accountability and Review This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff identified above who does not receive scheduled in-service training will not be allowed to work until training has been completed by 7/31/2025. 4. Monitoring and Quality Assurance The Director of Nursing will monitor for Accurate and Complete Medical Records weekly for 2 weeks and monthly for 3 months by reviewing 5 resident medical records to ensure accuracy in Wound care documentation, Medication administration accuracy and Device and dialysis-related entries. Monitoring will be started the week of 8/4/25.	

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F0842 SS = E	Continued from page 13 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, Wound Physician, and Nurse Practitioner interviews, the facility failed to maintain accurate medical records by 1.) not documenting the administration of wound care to an unstageable sacral wound on the Treatment Administration Record (TAR) or in the electronic medical record and not accurately documenting the assessment of an implanted device (a device placed under the skin typically in the chest wall and used for long term intravenous (IV) access) for Resident #49. 2.) not accurately documenting that an antihypertensive medication (Hydralazine 25 milligrams) was held for systolic blood pressure less than 125 mmHg (millimeters of mercury) according to the physician orders (Resident #28). 3.) not accurately documenting the removal of a dressing from an arterial/venous (A/V) dialysis shunt (Resident #55). This occurred for 3 of 3 residents whose medical records were reviewed. Findings included: 1a.) A physician’s order dated 1/3/25 for Resident #49 revealed Dakins solution 0.5% (Sodium Hypochlorite). Apply to sacrum topically every day shift for wound care. Pack wound with iodoform packing strips mixed with Santyl (a debriding agent) and cover with dry padded dressing. Review of Resident #49’s TAR dated March 2025 and April 2025 revealed Dakins solution 0.5%. Apply to sacrum topically every day shift for wound care. Pack wound with iodoform packing strips mixed with Santyl and cover with dry padded dressing was not signed by a nurse as administered on the following dates:	F0842	Continued from page 13 Reports will be presented to the monthly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.	

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F0842 SS = E	Continued from page 14 3/1/25 3/7/25 3/8/25 3/15/25 3/16/25 4/12/25 4/22/25 Review of Resident #49's progress notes from 3/1/25 through 4/22/25 revealed no documentation that wound care was administered by the assigned nurse or wound treatment nurse. During a phone interview on 7/10/25 at 9:00 AM Nurse #6 the assigned day shift nurse on 3/1/25, 3/8/25, 3/15/25, and 3/16/25 stated the nurses were responsible for wound care when the treatment nurse was not available. She stated she recalled administering wound care to Resident #49 during March 2025 and recalled the wound treatment nurse during that time (Nurse #9) also administered wound treatments to Resident #49. Nurse #6 stated the wound care was done and it was a documentation error, and the treatments should have been signed off on the TAR as completed. During a phone interview on 7/10/25 at 10:00 AM Nurse #7 the assigned day shift nurse on 3/7/25, 4/12/25, and 4/22/25 stated the nurses were responsible for wound care when the treatment nurse was not available. She stated she was certain the wound care was completed each day by either her or the treatment nurse. Nurse #7 stated the wound care was not signed off as administered in error. b. A physician's order dated 4/30/25 for Resident #49 revealed Gentamicin sulfate (antibiotic) external cream 0.1%. Apply to sacrum topically every day and evening shift for wound care. Pack with Gentamicin and packing strips and cover with dry dressing. Review of Resident #49's TAR dated May 2025 revealed Gentamicin sulfate (antibiotic) external cream 0.1%. Apply to sacrum topically every day and evening shift for wound care. Pack with Gentamicin and packing strips	F0842		

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F0842 SS = E	Continued from page 15 and cover with dry dressing was not signed as administered on the following dates and shift: 5/3/25 day shift 5/6/25 evening shift 5/9/25 day shift 5/17/25 day shift 5/18/25 day shift 5/21/25 day shift 5/26/25 day shift During a phone interview on 7/10/25 at 9:00 AM Nurse #6 the assigned day shift nurse on 5/17/25 and 5/18/25 stated she recalled administering wound care to Resident #49 during May 2025 and recalled that the wound treatment nurse during that time (Nurse #9) also administered wound treatments to Resident #49. Nurse #6 stated it was a documentation error, and the treatments should have been signed off on the TAR as completed. During a phone interview on 7/10/25 at 10:00 AM Nurse #7 the assigned day shift nurse on 5/6/25, 5/9/25, and 5/26/25 stated she was certain the wound care was completed by either her or the treatment nurse on the dates listed. Nurse #7 stated the wound care was not signed off as administered in error. Attempts were made on 7/10/25 at 10:20 AM to contact the assigned nurse on 5/3/25 with no response. During a phone interview on 7/10/25 at 10:33 AM Nurse #1 the assigned nurse on 5/21/25 stated the wound treatment nurse administered Resident #49's treatment on 5/21/25 and did not sign it off on the TAR. During a phone interview on 7/10/25 at 11:00 AM the wound treatment nurse during the months of March 2025 through May 2025 stated she did administer the wound treatments to Resident #49 on the days that she worked in the facility. She stated when she was not working it was the responsibility of the assigned nurse to do the wound care. She indicated the wound care not being signed off in Resident #49's medical record by her or the assigned nurse was done in error.	F0842		

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F0842 SS = E	Continued from page 16 An interview was conducted on 7/10/25 at 8:30 AM with the Wound Physician. She stated she was in the facility weekly for Resident #49's wound evaluation. The Wound Physician stated Resident #49 had multiple significant comorbidities and a chronic sacral wound that may never completely heal. The Wound Physician stated according to her weekly evaluations and measurements that the wound had not shown signs of worsening or deterioration, and she believed the wound treatments were being administered. An interview was conducted on 7/10/25 at 1:00 PM with the Director of Nursing (DON). She stated wound care should be administered according to the physician orders and accurately documented in the resident's electronic medical record. c.) A physician's order dated 3/27/25 for Resident #49 revealed to monitor the implanted device site for signs and symptoms of infection every shift for prevention. During an interview on 7/10/25 at 11:30 AM Nurse #5 the assigned nurse stated she did not think Resident #49 had an implanted device. Nurse #5 assessed Resident #49 and found the location of the implanted device and then stated she was not aware Resident #49 had the device. Review of Resident #49's TAR dated June 2025 and July 2025 revealed Nurse #5 signed off on the TAR during the day shift that the implanted device was monitored for signs and symptoms of infection on the following dates: 6/11/25 6/12/25 6/18/25 6/25/25 6/26/25 6/27/25 7/2/25 7/5/25	F0842		

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F0842 SS = E	Continued from page 17 7/9/25 During a follow up interview on 7/10/25 at 12:00 PM Nurse #5 stated she was an agency nurse and started her contract with the facility in June 2025. She stated she had completed full body assessments on Resident #49 each day that she was the assigned nurse. Nurse #5 stated the implanted device was under the skin in the upper right chest wall and Resident #49's skin was smooth with no signs of redness or irritation at the site therefore you could not tell that the device was even there. She stated if there had been any signs of redness or superficial infection she would have seen it during her physical assessment each day and Resident #49 had not had a fever or other symptoms. Nurse #5 stated she should have paid closer attention when signing off on Resident #49's Treatment Administration Record and should have accurately documented on the TAR. During an interview on 7/10/25 at 1:20 PM the Nurse Practitioner stated there had been no concerns reported to her regarding Resident #49's implanted device. She stated the site should be monitored every shift for signs and symptoms of infection and expected that the nurses were accurately documenting the assessment of the device in the medical record. During an interview on 7/10/25 at 12:55 PM the Director of Nursing (DON) along with the Assistant Director of Nursing (ADON) stated Resident #49 had the implanted device for an extended period of time due to having a history of cancer and received outpatient medications through the device at one time. The ADON stated Resident #49 had no issues related to the device. The DON stated the nurses were required to assess the site for signs or symptoms of infection and accurately document the assessment on the TAR. 2.) Physician orders dated 8/23/24 for Resident #28 included Hydralazine (antihypertensive medication) 25 milligrams (mg). Give one tab by mouth three times a day and hold if the systolic blood pressure was less than 125. Review of Resident #28's Medication Administration Record (MAR) dated May 2025 revealed Hydralazine 25 mgs. Give one tab by mouth three times a day and hold if the systolic blood pressure was less than 125 was signed off as administered on the following dates and	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345207	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

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LIBERTY COMMONS N&R CTR OF COLUMBUS CTY	1402 PINCKNEY STREET , WHITEVILLE, North Carolina, 28472

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = E	Continued from page 18 times: 5/9/25 at 9:00 PM signed as administered by Medication Aide #2 5/14/25 at 9:00 AM signed as administered by Nurse #11 5/14/25 at 2:00 PM signed as administered by Nurse #11 5/14/25 at 9:00 PM signed as administered by Nurse #11 5/28/25 at 9:00 AM signed as administered by Nurse #11 During an interview on 7/10/25 at 9:30 AM Nurse #11 stated she was aware of the order to hold Resident #28's hydralazine if the systolic blood pressure was less than 125. Nurse #11 stated the medication was held on the dates listed and it was documented as administered in error. During an interview on 7/10/25 at 1:10 PM Medication Aide #2 stated she routinely provided care to Resident #28 and was aware to hold the Hydralazine if the systolic blood pressure was less than 125. She stated the hydralazine was held and not administered on 5/9/25 and it was documented as administered in error. Review of Resident #28's Medication Administration Record (MAR) dated July 2025 revealed Hydralazine 25 mgs. Give one tab by mouth three times a day and hold if the systolic blood pressure was less than 125 was signed off as administered on the following dates and times: 7/4/25 at 2:00 PM signed as administered by Nurse #7 7/5/25 at 9:00 AM signed as administered by Nurse #5 7/7/25 at 2:00 PM signed as administered by Nurse #7 7/9/25 at 9:00 AM signed as administered by Nurse #5 7/9/25 at 2:00 PM signed as administered by Nurse #5 During a phone interview on 7/10/25 at 10:00 AM Nurse #7 stated she was aware of the order to hold Resident #28's hydralazine if the systolic blood pressure was less than 125. Nurse #7 stated the medication was held on the dates listed and was documented as administered in error.	F0842		

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F0842 SS = E	Continued from page 19 During an interview on 7/10/25 at 12:00 PM Nurse #5 stated she held Resident #28's hydralazine on the dates listed and it was documented as administered in error. An interview was conducted on 7/10/25 at 12:30 PM with Resident #28. She was alert and oriented to person, place, and time. She stated staff held the hydralazine at times, but she was not sure of what days the medication was held. Resident #28 stated she had no concerns with her medications. During an interview on 07/10/25 at 12:53 PM the Director of Nursing (DON) along with the Assistant Director of Nursing (ADON) stated the nursing staff were to follow the physician orders to hold the hydralazine as needed and accurately document if the medication was held on the Medication Administration Record (MAR). 3. Resident #55 was admitted to the facility on 06/20/24 with multiple diagnoses that included end stage renal disease requiring hemodialysis (a treatment needed for residents with poor kidney function) and insertion of A/V dialysis shunt (a passage that is inserted in the body to allow fluid from one part of the body to another and used as an access port to dialyze residents) to left arm. A review of the physician orders revealed an order written on 03/20/25 for hemodialysis on Tuesday, Thursday, Saturday at 5:30 AM. On 06/21/25, new physician orders were written to; apply direct pressure with gauze and gloved fingertips if bleeding occurs to A/V dialysis shunt; if direct pressure did not control blood loss, apply tourniquet above the site and contact emergency personnel, remove pressure dressing over shunt site 4-6 hours after returning from dialysis every day shift on Monday, Thursday, and Saturday, and check left upper arm shunt site for bleeding, signs and symptoms of infection, bruit (a sound that can be heard when assessing an A/V dialysis shunt) and thrill (a sensation you can feel when assessing an A/V dialysis shunt) and document adverse findings in nursing notes.	F0842		

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F0842 SS = E	Continued from page 20 The Medication Administration Record (MAR) for June 2025 revealed the following: - The order to remove the pressure dressing over shunt site 4-6 hours after returning from dialysis every day shift on Monday, Thursday and Saturday revealed Nurse #5 recorded a checkmark and her initials on 06/26/25 (Thursday) and Nurse #7 recorded a checkmark and her initials on 06/30/25 (Monday) indicating the nurses removed the pressure dressing to Resident 55's shunt site. - The order to check Resident #55's right upper arm shunt site for bleeding, signs and symptoms of infection, and bruit and thrill every shift revealed Nurse #5 recorded a checkmark and her initials on 06/26/25 indicating she checked the shunt site. The MAR for July 2025 revealed the following: - The order to remove the pressure dressing over shunt site 4-6 hours after returning from dialysis every day shift on Monday, Thursday and Saturday revealed Nurse #5 recorded a checkmark and her initials on 07/05/25 (Saturday) and Nurse #7 recorded a checkmark and her initials on 07/07/25 (Monday) indicating the nurses removed the pressure dressing to Resident 55's shunt site. - The order to check Resident #55's right upper arm shunt site for bleeding, signs and symptoms of infection, and bruit and thrill every shift revealed Nurse #5 recorded a checkmark and her initials on 07/05/25 indicating she checked the shunt site. An observation of Resident #55 on 07/09/25 (Wednesday) at 10:30 AM, revealed Resident #55 had a pressure dressing in place to his left arm over his A/V dialysis shunt. There were no signs or symptoms of bleeding noted on the outside of the dressing. An interview was conducted with Resident #55 on 07/09/25 at 10:30 AM. Resident #55 stated he was supposed to have the dressing removed from his shunt site on his dialysis days which he stated were Tuesday, Thursday, and Saturday. Resident #55 stated he did not know why the dressing was not removed on Tuesday	F0842		

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F0842 SS = E	Continued from page 21 07/08/25. Resident #55 added, sometimes the nurses would remove it the next day or so. An interview was conducted with Nurse #5 on 07/09/25 at 3:30 PM. Nurse #5 confirmed Resident #55 dialyzed on Tuesday, Thursday, and Saturdays. She stated when Resident #55 returned from dialysis usually around 12:30 PM, she would review the communication sheet that was provided to the Dialysis Center for any new orders, she would obtain Resident #55's vital signs and check the dressing site to be sure it was dry and intact with no signs or symptoms of bleeding. She stated she would not remove the dressing to the A/V dialysis shunt and that when he went back to dialysis on his next scheduled day, the dialysis nurse would remove it. Nurse #5 reviewed the order written in the MAR and confirmed that it read to remove pressure dressing 4 – 6 hours after dialysis. Nurse #5 stated "I guess I have been doing it wrong." Nurse #5 stated she should not have signed off in the Medication Administration Record that she removed the dressing on 06/26/25 or on 07/05/25 since she did not remove the dressing as ordered. Nurse #5 stated she needed slow down and to read the orders more clearly. Nurse #5 stated she should not have signed off in the MAR that she checked the site on 06/26/25 and 07/05/25 since she never removed the dressing. An observation with Nurse #5 on 07/09/25 at 3:45 PM revealed Nurse #5 checked Resident #55's left arm and noted the dressing was still on from 07/08/25 (Tuesday). Nurse #5 removed the pressure dressing from Resident #55's left A/V shunt site. The site was noted to be clean, dry and intact. An interview was conducted with Nurse #7 via phone on 07/10/25 at 10:12 AM. Nurse #7 reported the way she understood the order to be was to remove the pressure dressing from the shunt site on his left arm on dialysis days, but she stated she signed off that she removed it on Monday 06/30/25 and Monday 07/05/25 as it was indicated to be done on the MAR because the dressing was still on Resident #55. Nurse #7 stated she should have clarified the order with the Director of Nursing so that it read to remove the dressing on Tuesday, Thursday and Saturday. An interview was conducted with the Assistant Director of Nursing (ADON) on 07/09/25 4:05 PM. The ADON reviewed the order that she entered on 06/21/25 and	F0842		

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F0842 SS = E	Continued from page 22 stated she entered the order incorrectly and it should have read to remove the pressure dressing over shunt 4-6 hours after dialysis on Tuesday, Thursday and Saturday. The ADON corrected the order at this time. A follow up interview was conducted with the ADON on 07/10/25 at 2:10 PM. The ADON reported she entered the order incorrectly and it was a human error. She stated that the nursing staff were aware that Resident #55 dialyzed on Tuesdays, Thursdays, and Saturdays and they should have questioned the inaccuracy of the entered ordered. An interview was conducted with the Director of Nursing on 07/10/25 at 2:10 PM. She stated further education and in service was needed for all nursing staff to read the orders carefully for medication administration and completing ordered tasks. The DON stated nursing staff should not be documenting a task that they did not complete as that was inaccurate documentation.	F0842		