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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nursing and Rehabilitation Center	1402 Pinckney Street Whiteville, NC 28472

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE] 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 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.

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.

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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nursing and Rehabilitation Center	1402 Pinckney Street Whiteville, NC 28472

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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. 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 altereddiet, 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 standing6/11/25 189.2 lb.6/18/25 No weight recorded6/25/25 No weight recorded7/2/25 184 lb. 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.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nursing and Rehabilitation Center	1402 Pinckney Street Whiteville, NC 28472

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nursing and Rehabilitation Center	1402 Pinckney Street Whiteville, NC 28472

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE]. 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 [DATE] revealed Resident #55 was cognitively intact and he demonstrated no behaviors. He was coded as receiving hemodialysis services. 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 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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nursing and Rehabilitation Center	1402 Pinckney Street Whiteville, NC 28472

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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 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 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.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nursing and Rehabilitation Center	1402 Pinckney Street Whiteville, NC 28472

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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: 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. (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nursing and Rehabilitation Center	1402 Pinckney Street Whiteville, NC 28472

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nursing and Rehabilitation Center	1402 Pinckney Street Whiteville, NC 28472

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 7/9/25 (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nursing and Rehabilitation Center	1402 Pinckney Street Whiteville, NC 28472

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nursing and Rehabilitation Center	1402 Pinckney Street Whiteville, NC 28472

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 [DATE] 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. The Medication Administration Record (MAR) for June 2025 revealed the following: (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nursing and Rehabilitation Center	1402 Pinckney Street Whiteville, NC 28472

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 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 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. (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nursing and Rehabilitation Center	1402 Pinckney Street Whiteville, NC 28472

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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.