STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nursing & Rehab Center of Southpor	630 Fodale Avenue Southport, NC 28461

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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

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F 0684 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 record review, and staff interviews the facility failed to conduct a comprehensive nursing assessment and neurological assessments after a Nurse Aide (Nurse Aide #3) reported a newly identified injury on a residents (Resident #1) face to the nurse on duty (Nurse #5) following an unwitnessed injury that resulted in facial bruising around the right eye and above the right eye on the forehead. A nurse did not complete a comprehensive assessment of the resident until a few hours after the initial discovery of the facial bruising and the resident was observed to have bruising to the right shoulder, right lateral knee (outer side), left knee and left toe. A reddened area was also observed to the left neck area. This occurred for 1 of 1 resident reviewed for accidents (Resident #1).Findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses including terminal cancer -multiple myeloma (a type pf blood cancer) without remission, history of malignant breast cancer, osteopenia (loss of bone density), vitamin D deficiency, dementia, and a history of a fall with a spinal fracture. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #1 was severely cognitively impaired. Falls occurred prior to admission with no falls since admission. Anticoagulant medication were administered. Resident #1 required extensive assistance with bed mobility, transfers, activities of daily living, and received Hospice services.A care plan dated 8/9/25 revealed Resident #1 had an increased risk of falls related to confusion, de-conditioning, history of falls, incontinence, psychoactive drug use, and being unaware of safety needs. The goal of care was the risk of falls or fall related injuries would be minimized with current interventions.During a phone interview on 10/16/25 at 8:30 AM Nurse #5 stated he worked on 10/1/25 from 7:00 PM through 7:00 AM and was Resident #1's assigned nurse. Nurse #5 stated he received report on 10/1/25 at 7:00 PM from Nurse #1 who did not report anything to him regarding Resident#1. Nurse #5 went into Resident#1's room between 9:00 to 9:30 PM on 10/1/25 to administer medications and noticed the right side of Resident #1's face at the temporal area had red marks. Nurse #5 stated Resident #1 typically laid on her right side with both hands under her face, like praying hands. Resident #1 took her medications without difficulty. Nurse #5 stated he asked Nurse Aide #1 who had been there since 3:00 PM if she knew about the red marks and Nurse Aide #1 stated she pushed her head against the mattress today, he didn't ask further questions but assumed the day shift nurse (Nurse #1) had addressed the marks. He stated the Nurse Aide #3 was in Resident#1's room during the night and did not report anything to him. Nurse #5 reported Resident #1 slept most of the night. When Nurse #5 went in the room around 3:00 AM Resident #1 was tangled in the sheets but the light was off, so he repositioned her in the bed and didn't notice anything on her face. Nurse #5 reported he went in Resident #1's room again around 4:00 AM to give scheduled lorazepam (an antianxiety medication) and Resident #1 was sleeping and he held the medication. Around 5:00 AM Nurse Aide #3 called out to him from down the hall saying what's with the marks on her face. Nurse #5 stated he thought Nurse Aide #3 was referring to the red marks Nurse #5 had observed at the 9:00 PM medication pass so he told Nurse Aide #3 that he knew about the marks. Nurse #5 stated he did not go down and assess Resident #1 at that time when Nurse Aide #3 reported marks. He stated Nurse Aide #3 did not say that he had observed bruising. Nurse #5 stated he went in Resident #1's room around 6:00 AM to give scheduled lorazepam, which Resident #1 took, but he did not turn the lights on, and he did not assess for marks, and stated he did not see bruising on Resident #1's face. Nurse #5 stated he left his shift at 7:00 AM and did not report anything to the oncoming day shift nurse (Nurse #1). Nurse #5 stated he should have gone to assess Resident #1 at 5:00AM when Nurse Aide #3 reported marks to him, but he did not. During an interview on 10/15/25 at 3:48 PM Nurse Aide #3 stated he worked the night shift on 10/1/25 from 11:00 PM until 7:00 AM and was assigned to Resident #1. He stated Resident #1 was sleeping when he came in for his shift and slept most of the night. He went into the room a couple of times during the night to check for incontinence and she was sleeping on her right side. He stated Resident #1 had dementia and agitation, so he did not want to wake her up while she was sleeping. Nurse Aide #3 reported that Resident #1 remained on her right side during the night, so he never saw any bruising. When he went in for the 5:00 AM check Resident #1 was awake and needed changing. Nurse Aide #3 stated he noticed right away the bruising on Resident #1's face when he turned her. Nurse Aide #3 stated he got a second nurse aide (Nurse Aide #4) who came in and witnessed the bruising. Nurse Aide #3 stated he reported the bruising to Nurse #5 at that time. Nurse Aide #3 stated Resident #1 was in bed the entire shift and had no falls or injuries during that time.A phone interview was conducted on 10/15/25 at 6:00 PM with