

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Liberty Commons Nursing & Rehab Center of Southpor		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, Medical Director (MD), and Physician Assistant (PA) interviews, the facility failed to notify the provider of significant weight gain greater than 5-pound discrepancy from the last weight for a resident with Congestive Heart Failure (CHF) and on diuretic medication (a medication that helps the body remove excess fluid) when the resident's weight indicated a 27 pound weight gain in one week. This deficient practice occurred for 1 of 1 sampled resident reviewed for notification of change. (Resident #108)</p> <p>Findings included:</p> <p>Resident #108 was admitted on [DATE]. His medical diagnoses included Congestive Heart Failure (CHF), coronary artery disease (CAD), and pulmonary hypertension.</p> <p>An admission physician order written to start on 04/18/25 revealed weekly weight times four weeks than monthly, and Demadex (used to reduce swelling).</p> <p>Review of Resident #108's weekly weights revealed:</p> <p>04/18/24 hospital weight was 148.6 pounds (lbs.)</p> <p>04/18/25 was 126.6 lbs.</p> <p>04/19/25 was 126 lbs.</p> <p>04/26/25 was 153.2 lbs., a weight gain of 27.2 lbs. in 7 days</p> <p>04/28/25 was 156 lbs.</p> <p>Further review of Resident #108's medical record revealed there were no additional weights.</p> <p>Further review of the medical record for Resident #108 revealed there was no evidence the physician was notified of weight changes.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 04/30/25 at 10:05 AM with Nurse #1. He stated he helped the NA on 04/26/25 to weigh Resident #108 since two nursing staff were needed to do resident's weight using a mechanical lift. He said he noticed the resident's weight was more than 20 lbs. greater than his last weight, but since there was not a specific physician order telling him to notify the MD if resident's weight was greater or less than 5 lbs., he did not need to, even if the resident had a history of CHF. He said he just went by what he saw on the physician orders, and since it did not say to contact the MD with significant weight change, he did not need to.</p> <p>An interview on 04/30/25 at 10:15 AM with the Director of Nursing (DON) revealed it was her expectation that Resident #108's physician should have been notified by his nurse of the resident's greater than 5-lb. weight gain in a week, given the residents' history of CHF, even if there was no physician order.</p> <p>An interview was conducted on 04/30/25 at 10:25 AM with the Physician Assistant (PA). The PA stated this was the first time he heard of Resident #108's one week weight gain of 27 pounds since admission on [DATE]. He stated no staff had reported to him any weight concerns. The PA expected he or the MD to be notified if Resident #108's weekly weights were greater than 5-lbs. from the previous weight, especially if the resident had a diagnosis of CHF. The PA said he expected the MD to have been notified, in order to treat the weight gain and to determine if related to CHF, and if additional medication was to be ordered or a change in treatment needed.</p> <p>An interview was conducted on 05/01/25 at 9:45 AM with the Medical Director (MD). The MD stated this was the first time she had heard of Resident #108's weight gain of 27 pounds from 04/26/25. The MD said she expected to be notified if residents' weights were greater than 5 pounds after a re-weight, which would include any resident having a diagnosis of CHF. The MD said she was not made aware or notified by nursing staff of resident's weight gain and should have. The MD said Resident #108's weight gains had no health outcome, and she expected the PA, MD, or on-call physician to have been notified, so they could treat the weight gain, and determine if it was related to CHF.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, Medical Director (MD), and Physician Assistant (PA) interviews, the facility failed to determine the accuracy of a weekly weight for a resident with Congestive Heart Failure (CHF) and on diuretic medication (a medication that helps the body remove excess fluid) when the resident's weight indicated a 27 pound weight gain in one week for 1 of 4 residents reviewed for nutrition. (Resident #108)</p> <p>Findings included:</p> <p>Resident #108 was admitted on [DATE]. His medical diagnoses included Congestive Heart Failure (CHF), coronary artery disease (CAD), and pulmonary hypertension.</p> <p>An admission physician order written to start on 04/18/25 revealed weekly weight times four weeks then monthly, and Demadex (used to reduce swelling).</p> <p>Resident #108's admission Minimum Data Set (MDS) dated [DATE] indicated the resident was moderately cognitively impaired, had CHF, CAD, and needed total assistance with activities for daily living (ADLs).</p> <p>Review of Resident #108's weekly weights revealed:</p> <p>04/18/24 hospital weight was 148.6 pounds (lbs.)</p> <p>04/18/25 was 126.6 lbs.</p> <p>04/19/25 was 126 lbs.</p> <p>04/26/25 was 153.2 lbs., a weight gain of 27.2 lbs. in 7 days.</p> <p>04/28/25 was 156 lbs.</p> <p>Further review of Resident #108's medical record revealed there were no additional weights.</p> <p>An interview was conducted on 04/29/25 at 1:15 PM with Resident #108. The resident was alert, resting in bed, with feet elevated. He stated he was breathing fine, was not on any oxygen, had swollen ankles and feet, ate very little breakfast, but ate a normal lunch. He said he did not know if he had any weight gain or loss since his admission.</p> <p>An interview was conducted on 04/30/25 at 10:05 AM with Nurse #1. He stated he helped the NA on 04/26/25 to weigh Resident #108 since two nursing staff were needed to do resident's weight using a mechanical lift. He said he noticed the resident's weight was 27 lbs. greater than his last weight, but since there was no order do a re-weight for weights greater or less than 5 pounds, he did not need to do a re-weight. Nurse #1 could not recall the NA that weighed Resident #108.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 04/30/25 at 10:15 AM with the Director of Nursing (DON) revealed it was her expectation that Resident #108 should have been reweighed immediately after noting a possible 27 lb. weight gain on 04/26/25. The DON stated any weights with a 5-pound discrepancy from the last weight should be re-weighed, especially since the resident had a history of CHF. She said she did not know why Nurse #1 did not get the NA to re-weigh Resident #108 but should have.</p> <p>An interview was conducted on 04/30/25 at 10:25 AM with the Physician Assistant (PA). The PA stated this was the first time he heard of Resident #108's one week weight gain of 27 pounds since admission on [DATE]. The PA stated if Resident #108's weekly weight was greater than 5-lbs. from the previous weight, and had a history of CHF, that a re-re-wight should have been done. The PA said Resident #108's weight 27 gain had no health outcome but could have.</p> <p>An interview was conducted on 05/01/25 at 9:45 AM with the Medical Director (MD). The MD stated this was the first time she had heard of Resident #108's weight gain of 27 pounds from 04/19/25 to 04/26/25. The MD stated it was expected that if any resident had a weight loss or gain greater than 5 pounds from the previous weight, to have a re-weight confirming the second weight, which was not done, and was important in this case due to the resident having a diagnosis of CHF. The MD said Resident #108's weight gain of 27 lbs. could not have been accurate, since the resident had no respiratory health outcome, and that the weight was not close to the hospital's discharge weight.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on record review and staff interviews, the facility failed to provide 8 hours of Registered Nurse (RN) coverage for 1 of 419 days reviewed for staffing (08/11/24).</p> <p>Findings included:</p> <p>The PBJ (Payroll Based Journal) Staffing Data Report Fiscal Year - Quarter 4, 2024 (July 1 - September 30) documented the facility had no RN Coverage on 08/11/24.</p> <p>Review of the daily assignment sheets from 03/8/24 through 04/30/25 revealed the RN who was originally scheduled to work 7:00 PM - 7:00 AM beginning on 08/11/24 had called off. The staff member who replaced the RN on the schedule was a Medication Aide.</p> <p>In an interview with the Director of Nursing (DON) and the Administrator on 05/01/25 at 11:49 AM the DON stated she had been the nurse on call and had taken the call when the RN called off work on 08/11/24. She noted it was her responsibility to find RN coverage for the shift and she had not. The Administrator stated she expected the on call staff member who had the on call phone to find coverage for the assignment. The Administrator explained that the process when there was a call off was that the on call staff member or nurse who had the call off phone was responsible for filling the assignment on the schedule. On 8/11/24 the on call nurse was notified of the call off but she did not find a replacement and no RN coverage was in the building on 8/11/24.</p>

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, the Nurse Practitioner, and Physician interviews the facility failed to obtain an ordered Pro BNP (pro-B-type natriuretic peptide) a blood test that measures the levels of Pro BNP, a protein produced by the heart and used to help diagnose and monitor heart failure. This occurred for 1 of 1 resident (Resident #23) reviewed for laboratory services.</p> <p>Findings included.</p> <p>Resident #23 was admitted to the facility on [DATE] with diagnoses including hypertensive heart disease and Stage 5 chronic kidney disease with heart failure.</p> <p>The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #23 was cognitively intact.</p> <p>A physician's order dated 4/3/25 for Resident #23 entered by Nurse #3 revealed to obtain a Pro BNP level.</p> <p>Review of Resident #23's electronic medical record from 4/3/25 through 5/1/25 revealed no documentation of the Pro BNP lab result.</p> <p>Review of the progress notes from 4/3/25 through 5/1/25 revealed no documentation that Resident #23 had experienced any acute symptoms of heart failure such as shortness of breath, swelling in the abdomen or lower extremities, chest pain, or fatigue. Her blood pressure was stable.</p> <p>During an interview on 4/30/25 at 12:00 PM the Nurse Practitioner stated the Pro BNP was ordered for Resident #23 to monitor heart failure. He stated he reviewed the electronic medical record and could not find the lab result. He indicated Resident #23 was not symptomatic, and the lab would be reordered.</p> <p>During an interview on 05/01/25 at 10:30 AM the Physician stated the Pro BNP lab was ordered for Resident #23 to evaluate her cardiovascular status due to heart failure and chronic kidney disease. She stated Resident #23 received hemodialysis three days a week which pulled fluid off to keep her at dry weight (the weight after excess fluid is removed) and therefore had no significant outcome from not obtaining the ordered lab and she had not been symptomatic of acute heart failure or fluid overload. She stated she expected labs to be obtained according to the physician orders.</p> <p>During an interview on 5/1/25 at 2:00 PM Resident #23 was observed sitting up in a bedside chair in her room. She was alert and oriented to person, place, and time. She was smiling and talkative and was not aware of the ordered lab. She stated she received hemodialysis three days a week, she felt fine, and stated she had no complaints at this facility.</p> <p>An attempt was made on 5/1/25 at 2:19 PM to contact Nurse #3 who entered the order for the Pro BNP on 4/3/25. There was no response.</p> <p>(continued on next page)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/01/25 at 2:00 PM the Director of Nursing stated she completed a record review and could not find the Pro BNP lab result for Resident #23. She stated she determined that the Physician entered the order into the electronic medical record but then the nurse who completed the new order failed to edit the order so that it would trigger on the Medication Administration Record (MAR) which was why it continued to be missed. She stated the process included that the physician entered the orders into the residents electronic medical record, then the nurse would go in and edit the order so that it would flow to the Medication Administration Record (MAR). The nurse was supposed to print the residents face sheet (this provides the residents identifying information) and fill out the lab requisition form (informs the lab of what tests to perform) and then records the order in the lab book located at the nurses station. She stated Nurse #3 who was responsible for the error no longer worked at this facility. She stated labs were reviewed daily in clinical meetings to ensure they were done and to ensure that the physician had reviewed the results. She stated they missed the lab in clinical meetings because of the order not being edited and completed by Nurse #3 therefore it did not show on her lab reports. She stated she planned to review the process for ordered labs and education would be provided to staff.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to implement infection control policies and procedures when Nurse Aide #1 failed to apply all the required Personal Protective Equipment (PPE) before entering a room with a resident on special contact-droplet precautions. This occurred for 1 of 1 staff observed for infection control practices (Nurse Aide #1).</p> <p>The findings included:</p> <p>Review of the facility's contact precautions signage last revised 01/20/22 read in part: All healthcare personnel must: Clean hands before entering and when leaving room. Wear gloves when entering room and remove before leaving room. Wear a gown when entering room and remove before leaving.</p> <p>The facility's Infection Prevention and Control Program policy last revised on 08/2024 read in part: When a resident is infected or colonized with any Multidrug-Resistant Organism (MDRO) that has secretions or excretions that are unable to be covered or contained then contact precautions should be used.</p> <p>Review of Resident #111's April/2025 physician orders included: Admit to skilled level of care for Extended Spectrum Beta Lactamase (ESBL), Escherichia Coli (E. coli), Methicillin Resistant Staphylococcus Aureus (MRSA), and chronic kidney disease stage IV, Vancomycin, and contact precautions related to ESBL dated 04/29/25.</p> <p>An interview and observation were conducted on 04/30/25 at 8:05 AM with Nursing Assistant (NA#1). NA #1 was observed entering room [ROOM NUMBER] to deliver Resident #111's breakfast meal tray without first cleaning her hands or applying appropriate contact precaution personal protection equipment (PPE) of gown and gloves. She was observed leaning against the left side of resident's bed while setting up his meal tray. She then exited the resident's room without washing her hands. When NA #1 was asked in the hall why she did not clean hands, or apply PPE she said she did not have to if the resident was on enhanced barrier precautions. The NA then looked at the isolation sign hanging on the resident's door and realized the resident was on contact precautions and not on enhanced contact precautions. She said, after reading the sign, that she made a mistake, thinking the resident was on enhanced contact precautions and not contact precautions. She stated she should have washed her hands prior to entering and exciting resident's room and applied a gown and gloves while in the room.</p> <p>An interview was conducted on 04/30/25 at 8:10 AM with Nurse #2. Nurse #2 stated Resident #111 was on contact precautions for having multiple Multidrug-Resistant Organism (MDRO) with secretions or excretions so he was ordered by the Physcian to be on contact precautions, the only resident in the facility on contact precautions. Nurse #2 indicated staff were supposed to clean hands and put on the PPE prior to entering the room.</p> <p>An interview was conducted with NA #1 on 04/30/25 at 8:15 AM and she stated, it's confusing, I thought as long as I was not providing patient care it was ok since I was just taking the tray in the room. I did not realize there was a resident in the facility on contact precautions. She said she needed to pay closer attention to the isolation signs on residents' doors.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 04/30/25 at 12:15 PM with the Physician Assistant (PA). The PA indicated he expected staff to read the contact isolation signage and put on the PPE prior to entering Resident #111's room.</p> <p>An interview was conducted on 04/30/25 at 12:20 PM with the Director of Nursing (DON). She stated, Sometimes her nursing staff were not reading the signs. The DON further stated, we haven't had a contact precaution isolation in a while. The DON indicated she expected NA #1 to have read the signage on the resident's door and put on the appropriate PPE that was listed on the signage, which the NA did not do.</p> <p>An interview was conducted on 05/01/25 at 10:45 AM with the Administrator. She indicated staff should read the isolation signs to understand the precautions before entering a room.</p>		