STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Rehabilitation Center	121 Racine Drive Wilmington, NC 28403

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 32968 Based on observations and staff interviews the facility, 1a) failed to remove black greenish substance from the commode base caulking in resident rooms (106,112, 214, 220, 303, and 410), 1b) failed to replace resident's missing florescent overbed light covers in rooms (201A, 201B, 203A, 203B, 207A, 207B, 208A, 208B, 212A, 212B, 214A, 214B, and 215B). These failures occurred on 4 of 4 hallways (100, 200, 300, and 400 Hall) observed for a safe, clean, homelike environment. Findings included: 1a. An initial observation on 01/08/25 at 8:10 AM revealed resident commodes (Rooms: 106, 112, 214, 220, 303, and 410) were noted to have black greenish substance located around the base of the commodes. An interview was conducted on 01/08/25 at 2:00 PM with the Housekeeping Supervisor. The Housekeeping Supervisor stated her staff was responsible for sweeping and mopping residents' rooms daily and the Maintenance Department was responsible for caulking and removing black greenish substances from commode bases. 1b. A follow-up observation on 01/09/25 at 7:30 AM with the Maintenance Director revealed missing florescent overbed light covers in rooms, which were occupied with residents at the time of the observation. (201A, 201B, 203A, 203B, 207A, 207B, 208A, 208B, 212A, 212B, 214A, 214B, and 215B). An interview and observation was conducted on 01/09/25 at 7:45 AM with the Maintenance Director. The Maintenance Director stated there were multiple resident room areas that still needed to be addressed. He stated he did not have an assistant but was slowly keeping up with facility repairs. He said he did not know what the black greenish substance was around some of the commodes on the 100,200,300 and 400 halls and did not notice resident rooms with missing overhead light covers. He said maintenance was responsible for repairing or replacing items in the facility, including removing blackened substances around commodes and re-caulking, as well as replacing missing fluorescent overbed light covers. No staff had reported to him the black greenish substance around the base of the commodes and no staff had reported to him the missing light covers. (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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	A follow-up facility tour was conducted on 01/09/25 at 11:15 AM of the 100 and 200 halls with the Administrator. The tour revealed: black greenish substance around the base of resident commodes and missing fluorescent overbed light covers. He stated the residents' rooms observed in the 100 and 200 halls with commodes that had black greenish substance around their bases and missing fluorescent overbed light covers needed to be addressed by the Maintenance Director. He revealed they were making progress and were improving residents' living environment to make it more home-like, and that it would take time. The Administrator stated it was his expectation for all the residents to have a safe and homelike environment that was clean and in good repair.

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40044 Based on observations, record review, staff and the Nurse Practitioner interviews, the facility failed to comprehensively and effectively assess a resident's skin resulting in a delay in identifying and addressing a large, excoriated area (superficial wound or raw irritated patches with visible marks often caused by scratching, rubbing, or other mechanical trauma) behind the left knee of an immobile resident (Resident #25). The resident had a history of yeast developing in the folds of her skin. This deficient practice occurred for 1 of 1 resident reviewed for non-pressure related skin conditions. Findings included. Resident #25 was admitted to the facility on [DATE]. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #25 was cognitively intact. She exhibited no behaviors and had no rejection of care. She required extensive two-person assistance with activities of daily living. Her weight was 240 pounds. A care plan revised 12/19/24 revealed Resident #25 had the potential for impaired skin integrity and was at risk for pressure ulcer development related to limited mobility and incontinence. Interventions included in part to report to the nurse immediately if redness, open areas, or skin irritation, and complete weekly full body skin assessments. A weekly skin evaluation documented by Nurse #5 dated 01/04/25 for Resident #25 revealed no new skin issues. During a phone interview on 01/09/25 at 12:00 PM Nurse #5 who completed the most recent weekly skin assessment dated [DATE] stated she typically completed the skin evaluations during the time the nurse aides were providing personal care. She stated she could have missed the excoriation on Resident #25's legs and abdomen because she just did a quick glance during her assessment. She stated she should not have rushed through the assessment. A Nursing Report Sheet (paper with written comments used by the nurse to report information regarding residents to the oncoming shift. It is not a part of the residents medical record) initially dated 01/06/25 but then crossed through and dated 01/07/25 revealed a note that Resident #25 had a left leg rash and rawness behind the left knee. The Director of Nursing (DON) reported this was documented by Nurse #7. During a phone interview on 01/22/25 at 4:20 PM Nurse #7 stated on the morning of 01/08/25 at approximately 6:30 AM, just before the end of her shift, Resident #25 had complaints of itching and burning to her left leg. She stated she observed a large red area behind the left knee, and she thought it was a rash. She reported this to Nurse #1, the oncoming nurse during end of shift report at approximately 6:45 AM. She stated Nurse #1 told her that she would notify the Wound Nurse and the Nurse Practitioner or Physician and make a note in the resident's medical record. She reported that she typically was not assigned to Resident #25 and did not know how long the rash could have been there. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #25's progress notes from 01/01/25 through 01/08/25 was completed on 01/08/25 at 10:30 AM and revealed no documentation of any skin irritation. During an interview and observation conducted on 01/08/25 at 10:45 AM, Resident #25 was observed lying in bed. She was alert and oriented to person, place, and time. She complained of left knee pain. Nurse #1 was notified and entered Resident #25's room to evaluate. A large, excoriated area that appeared red and irritated was noted behind her left knee. Resident #25 stated the area behind her knee had been there for a month. She stated the nurses were aware but there had been no medications applied to the area. Resident #25 stated she didn't know what caused the area to be red and inflamed. Further observation of Resident #25 revealed she had excess skin folds hanging from her abdomen and thighs. Resident #25 stated she had gained a lot of weight and due to her excessive skin folds she relied on staff to check her skin between the large skin folds to determine if there were any concerns. She stated she would not refuse allowing staff to perform skin assessments in case she needed any type of treatment for her skin. During an interview on 01/08/25 at 10:50 AM Nurse #1 stated she was the assigned nurse. She indicated she was not aware that Resident #25 had excoriation behind her left knee. She stated she would notify the Wound Nurse. During a follow up phone interview on 01/22/25 at 4:15 PM Nurse #1 stated she was not made aware of the excoriated area behind Resident #25's left knee during shift change report on the morning of 01/08/25. She stated that had she been made aware she would have notified the Wound Nurse and Physician sooner so that treatment orders could be implemented. During an interview on 01/08/25 at 11:05 AM the Wound Nurse stated she was not aware of the excoriated area behind Resident #25's left knee until now. She did not say when the last time she had evaluated Resident #25, but she only evaluated residents when the nurses informed her of any skin concerns. The Wound Nurse stated the area behind the left knee had not been there for a month as indicated by Resident #25. She stated she would notify the Nurse Practitioner and implement treatment orders. A progress note dated 01/08/2025 at 11:07 AM for Resident #25 documented by the Wound Nurse revealed open excoriation was noted to the left leg folds. The physician was notified, and new orders were received. A physician's order dated 01/08/25 for Resident #25 revealed Nystatin external ointment 100000 units (antifungal). Apply to left leg folds topically every day and night shift for candida (fungal infection caused by an overgrowth of yeast). A skin evaluation form dated 01/09/25 documented by the Wound Nurse revealed Resident #25's left leg was noted with a red papular rash (solid raised bumps on the skin) behind the left knee with open excoriation noted at the crease of the left knee. The area behind the left knee measured 18 centimeters (cm) x 6 cm. The physician was notified, and an antifungal medication was applied to the area. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/09/25 at 12:42 PM the Nurse Practitioner stated she evaluated Resident #25 yesterday 01/08/25 after being notified of the excoriated skin condition. She implemented treatment orders at that time. She reported Resident #25 had large skin folds due to her weight and had issues before with yeast developing in the folds of her skin. She stated the nurses should be doing thorough skin assessments weekly to identify any issues or concerns so that treatment orders could be initiated promptly. During an interview on 01/09/25 at 1:00 PM the Director of Nursing (DON) stated Nurse #7 the night shift nurse identified the excoriation to Resident #25's knee on 01/06/25. She stated Nurse #7 made a handwritten note on the end of shift report sheet and wrote rash behind left knee but no description or measurements. She stated Nurse #7 did not document the area anywhere in the medical record. She stated the area should have been passed along in report the following morning and documented in the medical record. She indicated it should have been communicated to the Wound Nurse or to the Nurse Practitioner so that treatment could have been initiated sooner. She stated thorough skin assessments should be conducted and documented by the nurses and the Nurse Practitioner or Physician notified promptly for treatment orders. She indicated education would be provided. During a follow up phone interview on 01/22/25 at 4:30 PM the Director of Nursing stated upon further investigation, Nurse #7 stated to her that the area behind Resident #25's left knee was reported to Nurse #1 during shift report on the morning of 01/08/25. She indicated education would be provided regarding conducting thorough skin assessments and identifying and addressing any concerns.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40044 Based on record review, staff, Physician, and the Consultant Pharmacist interviews the facility failed to prevent significant medication errors by administering Resident #223 the incorrect dose of a blood pressure medication, Losartan 50 milligrams (an antihypertensive), and administering blood pressure medications without following the physician's ordered parameters to hold the medication (Residents #223 and #47). This resulted in Resident #223 experiencing hypotension (low blood pressure) and symptoms of head pressure, neck pain, and nausea. There was no significant outcome for Resident #47. This deficient practice occurred for 2 of 2 residents reviewed for medication administration. Findings Included. 1.) Resident #223 was admitted to the facility on [DATE] with diagnoses including hypertension. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #223 was cognitively intact. A physician's order dated 07/23/24 for Resident #223 revealed Losartan 50 milligram tablets. Give via PEG (percutaneous endoscopic gastrostomy) tube at bedtime for hypertension. Hold if systolic blood pressure is less than 140 mmHg (millimeters of mercury). A nursing progress note dated 08/22/24 at 03:19 AM revealed Resident #223 requested to speak with the nurse at approximately 2:30 AM due to complaints of burning sensation, head pressure, neck pain, and nausea. Resident #223's blood pressure was 62/40 mmHg with a manual cuff, and 59/36 mmHg obtained by second nurse with an automatic cuff. His blood pressure was obtained again manually and was 62/40 mmHg and the second nurse obtained a reading of 65/45 mmHg manually. Resident #223's oxygen saturation was maintained around 95% and dropped as low as 82% with pulse oximetry. The physician was called and gave orders to have the resident sent out to the hospital for evaluation for low blood pressure. Resident #223 stated he didn't want to go to the hospital, but the physician insisted on calling the ambulance for further evaluation. Emergency Medical Services (EMS) arrived, and his blood pressure was 95/60 mmHg and pulse oximetry at 95%. His heart rate and temperature were within normal limits. EMS staff asked if the resident wanted to go to the hospital for further evaluation and Resident #223 declined. The Physician was made aware. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on 01/09/25 at 10:33 AM Nurse #6 stated she was new to the facility at the time of the incident and was still in training. Nurse #6 stated she did give Resident #223 Losartan instead of holding the medication. She stated the blood pressure medication had hold parameters, but no box popped up in his electronic medical record to check the residents blood pressure. She stated that she administered the medication from the card that was in the medication cart. Later Resident #223 became lethargic, complained of headache, and nausea. His blood pressure was low, so they called the physician who instructed them to call 911. EMS arrived soon after. EMS asked if he wanted to go to the hospital, but the resident refused to go. She reported he did not go to the hospital, but they continued to do frequent blood pressure checks with no further complaints of headache or nausea and his blood pressure was trending up. She stated he was discharged home two days later. She stated the nurse that was orienting her questioned the dose after the resident became symptomatic when she told the nurse that she had administered it to him. She indicated she didn't realize she had given 100 milligrams instead of 50 milligrams, but she should have held the medication anyway according to the prescribed parameters. She indicated she received training on medication administration following the incident. A progress note dated 08/22/24 at 2:59 PM documented by Unit Manager #2 revealed Resident #223 was administered the right medication, but the wrong dose and the parameters were not followed per the Medication Administration Record. Resident #223's blood pressure dropped. The physician was notified, and actions were taken to improve his blood pressure. He refused to go to the hospital. Resident #223 was examined by the Physician at 8:00 this morning with this nurse present. No further adverse effects were noted. Resident #223 participated in physical therapy this morning and was up in his wheelchair. He and his family member were aware. During an interview on 01/08/25 at 1:30 PM Unit Manager #2 stated she was made aware of the incident the morning it occurred. Resident #223 was admitted for short term rehab therapy. They discovered that Nurse #6 gave the right medication but the wrong dose during the 9:00 PM medication pass. The order in Resident #223's electronic medical record revealed to administer 50 milligrams of Losartan, but the medication card read to give 100 milligrams. The order was changed from 100 milligrams to 50 milligrams, but the medication card was not updated because the new order was not sent to the pharmacy. She stated they also discovered that Resident #223's blood pressure recorded during the 9:00 PM medication pass was 117/69 mmHg so the resident should not have received the medication according to the parameters to hold the medication of the systolic blood pressure was less than 140 mmHg. She stated a few hours after receiving the medication around 2:30 AM the resident had complaints of headache and nausea, and his blood pressure was low. Resident #223 refused to go to the hospital, but EMS was called anyway. The resident continued to refuse to be sent out. The physician evaluated him later that morning and the assessment was within normal limits, and he had no further complaints. Resident #223 participated in physical therapy that morning and discharged home within a couple of days. A progress noted dated 08/24/24 at 3:19 PM Resident #223 discharged home with his family. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/08/24 at 1:00 PM the Director of Nursing (DON) stated on 08/21/24 Nurse #6 who was completing new hire orientation was working on the Rehab Hall on the night of the incident. Resident #223 was alert and oriented and called Nurse #6 to the room with complaints of nausea and other symptoms. His blood pressure was checked, and it was low. The physician was notified and ordered Resident #223 to be sent to the hospital for evaluation, but the resident refused to be sent out. EMS was notified to come evaluate and transport him but Resident #223 continued to refuse to go out. EMS also asked the resident if he wanted to go to the hospital, but he continued to refuse. She stated she was notified that morning, and they reviewed the Losartan medication card. She stated upon investigation they discovered that the Losartan order was changed on 07/23/24 from 100 milligrams to 50 milligrams. Nurse #6 gave 100 milligrams instead of the prescribed 50 milligram tablet. The order was updated in the electronic medical record, but the new order was not sent to the pharmacy. The nurses were still working from the old medication card that had the 100 milligram tablets. She stated the order should have been discontinued altogether and a new order entered for the 50 milligrams and the order sent to the pharmacy. The pharmacy would have sent a new card with the correct dosage and instructions. She stated they also discovered that the medication should have been held due to his systolic blood pressure being less than 140 mmHg, but Nurse #6 administered the medication. During an interview on 01/08/24 at 2:15 PM the Physician stated he was made aware of the medication error when it occurred. He indicated he evaluated Resident #223 following the incident. He stated Resident #223 was on long term antihypertensive therapy. Receiving the extra 50 milligrams would not have any severe outcome and there was no significant outcome regarding Resident #223 receiving Losartan 100 milligrams. He agreed that it was a medication error and stated he expected the nurses to follow the orders and the blood pressure parameters. During a phone interview on 01/09/25 at 1:38 PM the Consultant Pharmacist stated receiving a blood pressure medication when not indicated could cause symptoms such as low blood pressure, dizziness, nausea, and headache. 2.) Resident #47 was admitted on [DATE] with diagnoses including hypotension. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #47 was cognitively intact. A physician's order dated 12/05/24 for Resident #47 revealed Midodrine (prescribed to treat low blood pressure) 2.5 milligrams. Give 1 tablet by mouth three times a day for hypotension. Hold for systolic blood pressure greater than 95 mmHg (millimeters of mercury). Review of the Medication Administration Record (MAR) for Resident #47 dated January 2025 revealed on 01/02/25 Midodrine 2.5 milligrams was administered by Nurse #7 at the following times with blood pressure readings as follows: 01/02/25 a 6:00 AM with a blood pressure reading of 120/56 mmHg. (systolic/diastolic) 01/02/25 at 12:00 PM with a blood pressure reading of 120/62 mmHg. 01/02/25 at 5:00 PM with a blood pressure reading of 118/60 mmHg. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/08/25 at 1:00 PM the Director of Nursing (DON) stated there had been ongoing issues with staff not following medication parameters ordered by the physician. She indicated that according to the MAR, Nurse #7 signed off that the Midodrine was administered to Resident #47 although her blood pressure was outside of the prescribed parameters. She stated Nurse #7, who administered the Midodrine outside of parameters on 01/02/25, was out on medical leave and was unavailable for interview. During an interview on 01/08/25 at 2:15 PM the Physician stated he was made aware by Unit Manager #2 of Midodrine being administered outside of parameters to Resident #47 on 01/02/25. He reported that the medication was discontinued today as it was no longer indicated for her. He stated Resident #47 did not have any symptoms or outcome from receiving the medication. During an interview on 01/09/25 at 1:38 PM the Consultant Pharmacist stated she had identified not following blood pressure parameters in her monthly medication reviews. She reported this in her monthly reports that were sent to the DON. She stated she would work with the DON to help ensure parameters were being followed. She indicated taking Midodrine when not needed would increase the blood pressure unnecessarily, or cause side effects such as dizziness and headaches. During a follow up interview on 01/09/25 at 1:00 PM, the Director of Nursing stated they had provided education regarding not following physician orders to hold medications according to the prescribed parameters to all nursing staff beginning in August 2024. Education had also been provided verbally to individual staff members between August through December 2024. She stated she had been providing education and conducting audits regarding following medication parameters, but the problem continued. She reported further education and medication audits would be conducted.