

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345496	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Liberty Commons Nursing & Rehabilitation Center Of		STREET ADDRESS, CITY, STATE, ZIP CODE 791 Boone Station Drive Burlington, NC 27215	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff and detective interviews, the facility failed to protect the resident's right to be free from misappropriation of resident's property, when Resident # 123's responsible party (RP) observed a payment to a staff member on the resident's bank statement. On 3/10/25 the resident's RP observed a payment of \$372.94 on the resident's bank statement to an unknown account related to the admission Director. This occurred for 1 of 1 resident reviewed for misappropriation of property (Resident #123). Findings included: Resident #123 was admitted to the facility on [DATE]. Review of Resident #123's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed as moderately cognitively impaired. Review of the initial allegation report regarding misappropriation of resident's property dated 3/13/25 revealed the facility was made aware of the incident on 3/13/25 at 11:30 AM. The report details read in part Family member observed payment to a staff member on the resident's bank statement. The accused staff was suspended until the completion of the investigation to minimize the risk for misappropriation of resident property. The local Law enforcement was notified on 3/13/25. The initial allegation report was completed by the Director of Nursing (DON) on 3/13/25. Review of the investigation report dated 3/20/25, revealed the incident was investigated under misappropriation of resident's property. The incident occurred on 3/10/25 and the facility was made aware of the incident on 3/13/25 at 11:30 AM. The allegation details were Resident #123's family member observed a payment to a staff member on the resident's bank statement. The accused staff was suspended pending investigation. All alert and oriented residents were interviewed by facility leadership team on 3/13/25 regarding any concerns with misappropriation of resident property. The allegation details included that all residents who are not able to be interviewed will have assessments completed to identify any signs of potential misappropriation of resident property. The allegation was not substantiated. County Department of Social Services (DSS) and Law enforcement were notified on 3/13/25. Review of the addendum to original 5-day investigation report dated 3/25/25 stated that due to updated related new information from law enforcement this allegation was substantiated. The Local law enforcement had charged the accused staff member related to the allegation. The accused staff was terminated on 3/13/25. During an interview on 1/8/26, at 11:00 AM, the admission Coordinator reported that she had been serving as the Business Office Assistant (BOA) at the time of the incident. She stated that she was assisting the Business Office Manager during that period. She further indicated that, during her tenure as BOA, she had never reviewed nor had access to any resident's financial data. The admission Coordinator stated that she received a call from Resident #123's family member (date unknown) and the family member informed her that an employee's name appeared on Resident #123's bank statement. The admission Coordinator stated that she immediately notified the previous Business Office Manager (BOM) and transferred the call to the BOM. She further stated that the Business Office Consultant visited the facility the following day, conducted checks, and initiated education and training for all</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 345496	If continuation sheet Page 1 of 8

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observations, manufacturer instructions, and staff interviews, the facility failed to date open multi-dose vials of insulin on the 300 hall medication cart, failed to date multi-dose vials of semaglutide (glucagon-like peptide-1 (GLP-1) receptor agonist medication used for managing type 2 diabetes and promoting weight loss) on the 100 hall and 300 hall medication carts, and failed to discard expired a bottle of proton pump inhibitor tablets on the 300 hall medication cart. The failure to date multi dose vials of medication or dispose of expired medication was discovered in 2 of 3 medication carts reviewed for medication storage (100 hall and 300 hall medication carts). Findings Included: 1. On 1/6/26 at 8:05 AM, an observation of the 100-hall medication cart with Nurse #2 revealed one (1) open and undated multi-dose vial of semaglutide. Review of the manufacturer's instructions indicated to discard semaglutide multi-dose pen 56 days after opening. On 1/6/26 at 8:10 AM, during an interview, Nurse #2 indicated the nurses who worked on the medication carts were responsible for discarding open and undated multi-dose vials. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medication vials. The nurse stated she had not checked the date of opening on semaglutide vial in her medication administration cart at the beginning of her shift. Nurse #2 stated she had not administered open and undated medication during her shift. 2. On 1/6/26 at 8:45 AM, an observation of the 300-hall medication cart with Nurse #3 revealed one (1) open and undated insulin glargine pen and one (1) open and undated semaglutide pen. A review of the manufacturer's instructions indicated to discard insulin glargine multi-dose insulin pens 28 days after opening and semaglutide multi-dose pens 56 days after opening. In the second drawer of the medication cart there was one container of half-empty omeprazole (proton pump inhibitor that treats excess stomach acid) 40 milligram tablets that expired on 1/11/25. On 1/6/26 at 8:50 AM, during an interview, Nurse #3 indicated that the nurses who worked on the medication carts were responsible for discarding open and undated or expired multi-dose vials. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medication vials. Nurse #3 stated that she had not checked the date of opening on insulin glargine, semaglutide multi-dose vials or the expiration date of the omeprazole in her medication administration cart at the beginning of her shift. The nurse stated she had not administered expired medication during her shift. On 1/7/26 at 11:35 AM, during an interview, the Director of Nursing indicated that the nurses were responsible for checking the date of opening, and the expiration dates of the medications at the beginning of the shift. On 1/7/26 at 11:50 AM, during an interview, the Administrator expected no expired medications to be left in the medication carts.</p>		