STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Commons Nsg & Rehab Ctr of Johnston Cty	2315 Highway 242 North Benson, NC 27504

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289 Based on record review, and interviews with staff, family, and physician the facility failed to obtain an x-ray as ordered when a resident fell . This was for one (Resident # 1) of three residents reviewed for completion of diagnostic tests. The findings included: Resident # 1 was admitted to the facility on [DATE] with diagnoses of stroke, muscle weakness, dysphagia, hypertension, chronic kidney disease, chronic obstructive pulmonary disease, hyperlipidemia, and hearing loss. Resident # 1's admission Minimum Data Set assessment, dated 2/28/24, coded the resident as severely cognitively impaired. On 3/11/24 at 12:33 AM Nurse # 1 documented the following information in a nursing entry. Resident # 1 had an unwitnessed fall. The physician and the responsible party had been notified. Nurse # 1 was interviewed on 4/24/24 at 8:45 AM and reported the following. The NA (Nurse Aide) had alerted her that Resident # 1 was on the floor on 3/11/24. She had assessed the resident from head to toe. She did not appear to be in pain and had no obvious physical injuries. They checked on her frequently throughout the rest of the night, and the resident appeared to be fine. NA # 1 was interviewed on 4/24/24 at 2:14 PM and reported the following. She had been assigned to care for Resident # 1 during the night of the fall. She had been checking on Resident # 1 prior to the fall. The resident had been in bed, The resident's room had been very close to the nursing station. She (NA #1) was at the nursing station when she heard a noise. She entered the room and found Resident # 1 on the floor. She (NA # 1) alerted the nurse who checked the resident. The resident appeared to be okay when the nurse checked her. After the fall, she (NA # 1) checked on Resident # 1 frequently throughout the night and she appeared to be fine. On 3/11/24 the NP (Nurse Practitioner) noted the following. She was seeing Resident # 1 who had experienced a fall. Initially the resident had not complained of pain after the fall, but at the time of the NP's assessment, she was complaining of neck pain and limited range of motion. The resident had no further concerns. The NP noted she would order scheduled Acetaminophen and an x-ray. On 3/11/24 an order was entered into the record for a cervical and lumbar spine x-ray. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER: Liberty Commons Nsg & Rehab Ctr of Johnston Cty		STREET ADDRESS, CITY, STATE, ZIP CODE: 2315 Highway 242 North Benson, NC 27504	

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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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the record, Resident # 1 was discharged from the skilled nursing facility on the following day (3/12/24) and admitted to the assisted living section of the facility. There was no record of the spine x-ray being completed prior to the resident's transfer to assisted living. A review of medical records revealed on 3/12/24, Resident # 1 had a new record which was not part of her previous skilled nursing record. Therefore, the 3/11/24 x-ray order did not show up in the assisted living record. Interview with Resident # 1's responsible party on 4/23/24 at 12:13 PM revealed that she had visited on 3/14/24. Resident # 1 was uncomfortable in her neck, and she learned the x-ray had not been completed on 3/11/24. This was mentioned to the NP, who ordered the x-ray again. On 3/14/24 the NP noted the following information in Resident # 1's assisted living record. She saw Resident # 1 again. The resident was complaining of neck pain and was unable to rotate her neck without grimacing. The NP noted she would reorder the x-ray. On 3/14/24 an order was entered into Resident # 1's assisted living record for an x-ray of the neck and lumbar spine. Review of X-ray results revealed the x-ray was completed on 3/14/24 and showed the following. The resident had subluxation (incomplete of partial dislocation) of the Cervical 3 (C3) and C4. There was also narrowing of the C4 to C5. There was moderate degenerative changes of cervical spine. There was a reversal of the cervical lordosis consistent with the presence of pain and/or muscle spasm. Clinical correlation was recommended. On 3/14/24 Resident # 1 was transferred to the hospital ED (Emergency Department) for further evaluation. Review of 3/14/24 ED records revealed the following. Under the physician's assessment of the neck, the physician noted, no cervical vertebral body tenderness. No step-off injury. No warmth erythema. A CT (computerized tomography) was completed. It revealed a Type II dens fracture without displacement, osteopenia, and degenerative changes of the spine. (The dens, which is also referred to as a the odontoid, refers to a bony element from the second cervical vertebrae). A discussion was held with the family, and they did not wish for the resident to have any type of surgery. After consulting with neurosurgery, the resident was placed in a cervical collar and transferred back to the facility's assisted living for care. On 3/18/24 the NP noted the following in the resident's assisted living record. She had seen the resident who denied neck pain at the time. Resident # 1's physician was interviewed on 4/24/24 at 9:00 AM and reported the resident had not experienced any serious issues from the delay in the x-ray being performed. The Director of Nursing (DON) was interviewed on 4/23/24 at 3:00 PM and reported the following. The facility had identified the x-ray had not been done as completed and investigated the cause. They found that the NP had entered the order into the computer on 3/11/24. Nurse # 2 had then gone into the computer and confirmed (acknowledged) the order. Nurse # 2 thought that the NP had called the mobile x-ray company and had not been aware it was his responsibility to do so when he confirmed the order. Then on 3/12/24 the resident was transferred to a different section of the facility, and the uncompleted order no longer appeared on the resident's new record. (continued on next page)

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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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/24 the DON presented the facility had completed a corrective action plan. The corrective action plan included the following: Corrective action for resident involved It was noted on 3/11/2024, Resident #1 experienced an unwitnessed fall. NP was notified and ordered a lumbar and spine x-ray. Nurse confirmed order in [electronic medical record], but did not contact x-ray vendor to come to facility to complete x-ray. On 3/12/2024, Resident # 1 transferred from skilled to ALF (assisted living facility). There was a delay in orders for obtaining an x-ray for Resident # 1. On 3/14/2024, it was noted by NP that initial x-ray had not been completed and 2nd x-ray was ordered and completed. Resident # 1 was sent to ER for further evaluation on 3/14/2024 following results of facility x-ray. X-ray results at the hospital indicated a cervical type ll dens fracture without displacement. Family decided against surgical intervention and resident returned to facility on 3/15/2024. Resident # 1 returned to facility with [cervical] collar for conservative treatment. Corrective action for potentially impacted residents On 3/ 15 /24 the Director of Nurses reviewed all x-ray orders received for the last 7 days to identify if x-ray orders had been obtained timely and the results reported to the physician/RP. Results: No other residents affected Systemic Changes On 3/15/2024 the DON/ADON/SDC (Director of Nursing/ Assistant Director of Nursing/ Staff Development Coordinator) met and decided to make it a part of our quality assurance program and developed a plan of correction. On 3/15/2024 SDC began in-service of all licensed nursing staff (including agency) on the x-ray order process. This training included: The x-ray order process to include contacting the x-ray company and follow through to assure the ordered x-ray is completed. Post fall review and post fall care and documentation. Notification of Dr/RP if an ordered test is not completed. The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 3/19/2024 will not be allowed to work until the training is completed. Quality Assurance The DON/ADON will monitor compliance with the x-ray or (continued on next page)

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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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[NAME] process weekly for 2 weeks beginning 3/22/2024 and monthly for 3 months or until resolved for timely follow through in completing physician orders. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM (Health Information Manager), and the Dietary Manager. Completion date: 3/19/24 The following was done to validate the facility's corrective action plan. On 4/23/24 beginning at 9:20 AM a tour of the facility was completed. Residents were interviewed and there were no reports of any facility failure to obtain diagnostic studies. Additionally sampled residents, who had x-rays ordered, were reviewed. The x-rays had been completed as ordered for these additionally sampled residents. The facility presented documentation of inservices and audits completed per their corrective action plan. Nurses were interviewed during the survey and reported they had attended the inservice training. On 4/25/24 the facility's plan of correction date of 3/19/24 was validated.

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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 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 13289

Based on record review and staff interviews for two of ten sampled residents (Residents # 2 and # 6) the facility failed to ensure medical records were complete and accurate regarding medication administration (Resident # 2) and pressure sore assessment and care (Resident # 6). The findings included:

1. A review of Resident # 2's MARs (Medication Administration Records) from February through April 2024 revealed the following information.

The MAR included a chart code. A check mark meant a medication was administered. By each dose of Resident # 2's Carvedilol there was a space for the nurse to enter Resident # 2's pulse and BP. The directions to hold the medication for a systolic BP less than 100 and a pulse less than 60 appeared on the MARs.

During an interview with the DON (Director of Nursing) on 4/24/24 at 3:00 PM the DON reported that each nurse, who administers medications is assigned electronic initials which are then entered on the electronic MAR when they administer medications. (The initials at times include numbers along with a nurse's initials).

On 2/16/24 at 9:00 AM, Nurse # 3's assigned electronic initials appeared with a check mark. The resident's blood pressure was 110/66 and her pulse was 56.

Nurse # 3 was interviewed on 4/24/24 at 1:45 PM and reported the following. She would not have administered the medication if the resident's pulse was in the 50's. At times the NAs (Nurse Aides) will tell them of a pulse, and she does not think the pulse is accurate. She will go back and check it. Therefore, she would have gone back to check the pulse on 2/16/24, found it to be above 60, administered the medication, but not noted what the repeat pulse was in the record.

On 2/16/24 at 9 PM Nurse # 4's assigned electronic initials appeared with a check mark. The resident's BP was 131/65 and her pulse was 58.

On 4/24/24 at 3:52 PM Nurse # 4 was interviewed and reported the following information. She would not have administered the Carvedilol if the resident's pulse had been 58. That was the whole reason she took vitals. She did not know why the check mark indicated the medication was administered.

On 2/21/24 at 9:00 AM Nurse # 4's assigned electronic initials appeared by a check mark by Carvedilol. The resident's BP was 142/71 and her pulse was 57. Nurse # 4 was interviewed on 4/24/24 at 3:26 PM and reported she was familiar with Resident # 2 and routinely cared for the resident. She (Nurse # 4) was well aware of the parameters and had held the medication on other occasions. It did not make sense to her why the check mark appeared on 2/21/24 because she would not have given it. She felt there had been some error in the computer check but did not know why.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/29/24 at 9:00 PM Nurse # 6's assigned electronic initials appeared by a check mark by Carvedilol. The resident's BP was 148/59 and her pulse was 59. Nurse # 6 could not be reached for interview during the survey. On 3/1/24 at 9:00 PM Nurse # 7's assigned electronic initials appeared by a check mark by Carvedilol. The resident's BP was 148/58 and pulse 53. Nurse # 7 could not be reached during the survey. On 3/7/24 at 5 PM Nurse # 8's assigned electronic initials appeared by a check mark by Carvedilol. The resident's BP was 146/74 and her pulse was 58. Nurse # 8 was interviewed on 4/24/24 at 3:50 PM and reported the following. She would not have given the Carvedilol if the resident's pulse was 58. She was aware of the parameters and it would have been held. She did not know why the check mark was on the MAR. She was aware that at times the computer with the electronic MAR would glitch at times. At times it would also lock her out and she would have to call IT (information technology) to gain access back into the system. On 3/24/24 at 5 PM Nurse #9's assigned electronic initials appeared by a check mark by Carvedilol. The resident's BP was 126/70 and the pulse was 56. Nurse # 9 was interviewed on 4/24/24 at 3:45 PM and reported the following. She would not have given the medication with a pulse of 56. She did not know why the check mark was by the initials. The nurse further reported that at times the computer with the electronic MAR would at times glitch and freeze up. She would have to wait for about five minutes before it would allow her back in, and she speculated that might have contributed to the check mark being entered inaccurately. On 3/26/24 and 3/30/24 the evening doses were blank on the MAR. According to the MAR, nurses were to code if a resident had refused the mediation or was away from the facility. Neither of these were denoted. During an interview with the Director of Nursing (DON) on 4/25/24 at 11:22 AM, the DON reported nurses should be documenting at each administration according to the chart code/legend. There should not be blanks. On 4/3/24 at 5 PM the DON's assigned electronic initials appeared by a check mark by the Carvedilol. The resident's BP was 96/60 and her pulse was 57. During an interview with the DON on 4/24/24 at 3:00 PM, the DON stated she had not even realized she had even been assigned a set of electronic initials for the MAR until the surveyor requested that she try to identify which nurses' initials corresponded to which nurse. She had called the IT department and they told her that the assigned electronic initials on 4/3/24 were hers. She reported she had not been at the facility very long and had never administered medications since being employed at the facility. It did not make sense that her initials were on the MAR and it was an error of some sort in the electronic record, but she did not know how it had occurred. On 4/14/24 at 9 AM Nurse # 3's assigned electronic initials appeared by a check mark by the Carvedilol. The resident's blood pressure was 134/69 and her pulse was 54. Nurse # 3 was interviewed on 4/24/24 at 1:45 PM and reported she would not have administered the medication with a pulse of 54. Nurses were observed as they administered medications on 4/25/24 beginning at 8:10 AM. The electronic MAR was not observed to glitch during the time of the medication pass. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2a. Resident # 6 was admitted to the facility on [DATE]. On the resident's admitted [DATE], Nurse # 10 documented Resident # 6 had a pressure sore to her sacrum and the wound nurse was notified. Nure # 10 was interviewed on 4/25/24 at 11:09 AM revealing the notation that the resident had a pressure sore on 3/26/24 was not accurate. Nurse # 10 reported the following information. The hospital had reported the resident had a sacral pressure sore when they called report to the facility on [DATE]. On 3/26/24 when she looked at the area, it was scar tissue and no longer open and in need of treatment. On the skin assessment sheet of 3/26/24, there were different areas to check if they were applicable to the resident. One of the areas was a pressure sore. She wanted to denote there had been a pressure sore at one point, and therefore she checked pressure sore. She (Nurse # 10) did not feel the other areas on the skin assessment would apply and there was no area to check scar tissue. 2b. On 4/1/24 Resident # 6 had a physician's order for wound care. There was no site specified in the order for which wound care was needed. The area was to be cleansed with wound cleanser and covered with a dry dressing every three days and PRN (as needed). On 4/10/24 this order was revised to denote the area in need of wound care was the resident's right heel. It was also revised on 4/10/24 to reflect the area should be cleaned with skin prep before the dressing was applied, and the frequency of the dressing change was to be every five days and PRN. This order stayed in effect until 4/24/24. A review of Resident # 6's April 2024 TAR (Treatment Administration Record) revealed the right heel dressing change was checked as completed on the following days: 4/2/24, 4/6/24, 4/15/24, 4/20/24. This reflected more days passed before the dressing was changed as ordered. The facility Wound Nurse was interviewed on 4/25/24 at 10:30 AM and Resident # 6's record reviewed. The facility Wound Nurse reported the following information. The electronic medical record system was new to her. She came from a different clinical background which did not utilize the system. She was continuing to learn the system. There were standing orders that could be put in place for pressure sores. On 4/1/24 Resident # 6 was first identified to have a right heel pressure blister. Standing orders included to cleanse the area with skin prep and cover the area for protection. The first order had not been entered into the computer as a complete order to reflect that it was the right heel that needed treatment or the use of the skin prep. Also, when the order was placed in the computer, the days on which the dressing should have been changed should have had an open area on the TAR so that a treatment could be recorded. The system had xed out days when the treatment was due. There was no place to chart the dressing changes on the TAR on some of the days it was due, but the dressings had been completed. The resident had another pressure sore that required more frequent checks, and every time she was in the room, she checked and applied skin prep to the heel on the correct schedule or as needed. The treatment nurse validated that the resident's record was incomplete in regards to dressing changes. The Director of Nursing was interviewed on 4/25/24 at 11:22 AM and reported that the electronic system should automatically populate the days on the TAR on which the dressings needed to be completed. She did not know why the system had not done so and reported there could be more training on the facility's electronic medical system. 2c. Review of Resident # 6's pressure sore assessments revealed the following information: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/2/24-Sacral pressure sore 3.3 cm X 1.0 cm X 0.2 cm Stage II 4-9-24- Sacral pressure sore 2.1 cm X 1 cm X 0.1 cm Stage II 4/17/24-Sacral pressure sore 1 cm X 0.9 cm X 0.1 cm suspected deep tissue injury 4/23/24 Sacral pressure sore 1.4 cm X 1 cm X 0.1 cm Stage II pressure sore The facility wound nurse was interviewed on 4/25/24 at 10:30 AM and reported the following information. The pressure sore assessment of 4/17/24 was incorrect in the record, and the assessments were also incomplete in the electronic record. Resident # 6 had both a pressure sore to her sacral area and to her right heel. On 4/17/24 she had inadvertently entered the right heel pressure sore measurements as the sacral pressure sore measurements. She had also been measuring the right heel pressure sore every time she measured the sacrum, but she had not been entering all of the assessments in the resident's record. According to the Wound Care Nurse, the actual care of the wounds was her priority. She (the Wound Care Nurse) had the right heel measurements in her personal notes but had not yet had time to complete all the documentation in Resident # 6's record. Therefore, the record was not complete.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 13289 Based on record review and staff interview the facilities Quality Assurance/Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey of 2/25/22. This was for one repeat deficiency. The area of deficiency dealt with failure to maintain accurate and complete medical records. The continued failure of the facility during two federal surveys over the course of two years showed a pattern of the facility's inability to sustain an effective Quality Assurance/Performance Improvement program. The findings included: This citation is cross referred to: F 842 During the complaint investigation of 4/25/23, for two of ten sampled residents (Residents # 2 and # 6) the facility failed to ensure medical records were complete and accurate regarding medication administration (Resident # 2) and pressure sore assessment and care (Resident # 6). During the recertification survey of 2/25/22 the facility failed to maintain an accurate Medication Administration Record (MAR) for 1 of 5 residents reviewed for activities of daily living. On 4/25/24 at 11:10 AM the Administrator was interviewed revealing the following information. The Administrator was not employed at the facility when the facility was previously cited for medical records. Since her employment, they had a quality assurance program and met monthly to address identified issues and problems. The nursing staff had not brought up any issues with problems documenting accurately and completely in residents' electronic medical records so that any problems with medical records could be addressed within their quality assurance program.