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	07/12/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, staff interviews, and a physician interview, the facility failed to ensure a collected urine specimen was delivered to the laboratory for an analysis for 1 of 1 resident reviewed for urinary tract infections and urinary catheters. This resulted in another urine specimen having to be collected for analysis and delayed the start of treatment for a urinary tract infection (Resident #73). The findings included: Resident #73 was admitted to the facility on [DATE] with diagnoses including pneumonia. Nursing documentation dated 5/18/2024 at 6:40 pm by Nurse #1 reported Resident #73 complained of burning on urination and a urine specimen was collected. Nurse #1 further recorded the physician, and Resident #73's Representative was aware of Resident #73's complaint of burning with urination and a urine specimen was collected for analysis. A review of the laboratory patient log sheet dated 5/18/2024 recorded a urine for Resident #73 in a refrigerator near the rehabilitation nursing station for a urinalysis and culture and sensitivity test. There was no date or signature on the laboratory patient log sheet dated 5/18/2024 that laboratory personnel had picked up the urine specimen on 5/18/2024. There were no urinalysis results for the urine specimen collected on 5/18/2024 for Resident #73. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #73 was moderately cognitively impaired, frequently was incontinent of urine and required assistance with toileting. Nursing documentation dated 5/21/2024 at 2:33 am by Nurse #3 reported a urine specimen was collected for a urinalysis and culture and sensitivity test and picked up by the laboratory staff on 5/21/2024 at 2:30 am. A review of the laboratory patient log sheet dated 5/21/2024 recorded a urine for Resident #73 in a refrigerator near the rehabilitation nursing station for a urinalysis and culture and sensitivity test. The laboratory patient log sheet dated 5/21/2024 showed laboratory personnel had signed picking up the urine specimen collected on 5/21/2024. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345519	A. Building B. Wing	07/12/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The urine specimen dated 5/21/2024 recorded the results of the urinalysis was reported at 5/21/2024 at 9:19 pm. The urinalysis report did not specify who received the urinalysis report or how resident #73's urinalysis was reported to the facility. A review of the urinalysis dated 5/21/2024 for the urine specimen collected on 5/21/2024 reported the following elements present in the urine: white blood cells, bacteria, squamous epithelial cells and moderate amount of mucous. A physician progress note dated 5/22/2024 recorded Resident #73's Representative stated Resident #73 complained of dysuria (painful or difficulty urinating) a few days ago but not on 5/22/2024, and Resident #73's urine looked like it could be infected. The culture and sensitivity test on the urine specimen dated 5/21/2024 indicated the urine specimen was obtained by conducting straight catheterization (insertion of a tube into the urinary bladder to collect urine). The culture and sensitivity test reported on 5/23/2024 at 9:14 am the microorganism, extended spectrum beta-lactamase (ESBL), was present in Resident #73's urine and had the greatest sensitivity to Sulfamethoxazole-Trimethoprim (an combination of two antibiotics used to treat urinary tract infections). On 5/23/2024, a physician order was written for Resident #73 to receive Sulfamethoxazole-Trimethoprim 800-160 milligrams (mg) tablet two times a day for a urinary tract infection for ten days. A review of the May and June 2024 Medication Administration Record (MAR) for Resident #73 recorded Sulfamethoxazole-Trimethoprim 800-160 mg tablet was administered from 5/23/2024 at 5:00 pm to 6/2/2024 at 9:00 am twice a day for ten days. Resident #73's care plan last reviewed on 6/22/2024 did not include a focus for urinary tract infection. On 7/11/2024 at 4:02 pm in an interview with Nurse #1, she stated on 5/18/2024 a urine specimen was collected from Resident #73 and was placed in the refrigerator for the laboratory personnel to pick up during the night hours. She stated due to the laboratory personnel was not reporting to the facility on weekends and the nursing staff not aware the laboratory personnel would not be picking up Resident #73's urine specimen from 5/18/2024, another urine specimen had to be recollected. She explained a urine specimen had to be discarded if in the refrigerator for more than forty-eight hours. Nurse #1 stated due to the laboratory personnel not picking up the urine specimen collected on 5/18/2024, there was a delay in obtaining results from a urine specimen to start antibiotics for resident #73's urinary tract infection. On 7/11/2024 at 4:52 pm in an interview with the Administrator, she stated she had a contract with a laboratory company that came to the facility nightly to pick up urine specimens for analyzing and was unable to recall a time receiving notification that the laboratory company would not be reporting to the facility to collect urine or blood specimens. (continued on next page)

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	07/12/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/12/2024 at 2:06 pm in an interview with the Director of Nursing, she stated a urine specimen was collected on 5/18/2024 for Resident #73 and was not aware why the laboratory personnel did not pick up the urine specimen. She explained Resident #73's urine specimen was listed on a laboratory patient log dated 5/18/2024. She further stated Nurse #1 and nursing staff need to follow up and check to ensure urine specimens have been picked up by the laboratory personnel. She stated treatment for Resident #73's urinary tract infection was delayed due to laboratory personnel not picking up the 5/18/2024 urine specimen and staff having to recollect a urine specimen for analysis for Resident #73. On 7/12/2024 at 8:39 am in an interview with the Administrator, she stated based on the review of other laboratory patient logs dated 5/18/2024, laboratory personnel were in the facility to pick up urine or blood specimens that had been collected on other residents. She explained laboratory personnel should have picked up the collected urine specimen of Resident #73 on 5/18/2024 and Nurse #1 should had checked the refrigerator the next day to ensure the urine specimen was picked up by the laboratory personnel. She said, due to having to recollect Resident #73' s urine specimen, there was a delay in diagnosing Resident #73 with a urinary tract infection and beginning antibiotic treatment. On 7/12/2024 at 12:50 pm in a phone interview with Physician #1, he explained with the antibiotic stewardship program, antibiotics were not ordered when Resident #73 complained of burning with urination on 5/18/2024. He stated he was waiting for the urinalysis to confirm Resident #73 had a urinary tract infection and the culture and sensitivity report to ensure Resident #73 would receive the correct antibiotic for the urinary tract infection. He stated he reviewed the results of the urinalysis from the specimen sent on 5/21/2024 on 5/22/2024 and did not order antibiotics until 5/23/2024 when the culture and sensitivity results were available also. He stated Resident#73 received one course of antibiotics and did not require further treatment for the urinary tract infection.

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	07/12/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, staff interviews and a pharmacist interview, the facility failed to document the return of a discontinued medication, Hydroxyzine HCl (an antihistamine used to help control anxiety or symptoms of itching) to the pharmacy for 1 of 1 resident (Resident #73) reviewed for the provision of pharmacy services. The findings included: Resident #73 was admitted to the facility on [DATE]. A physician order for Hydroxyzine HCl 25 milligrams (mg) every six hours as needed for anxiety or itching for 14 days was written on 5/29/2024. A review of the pharmacy 's medication packing slips for proof of delivery to the facility indicated ten tablets of Hydroxyzine HCl 25mg were delivered to the facility for Resident #73 on 5/29/2024 and on 6/5/2024 for total of 20 tablets dispensed from the pharmacy. A review of the May and June 2024 Medication Administration Record (MAR) recorded Hydroxyzine HCl 25mg was administered to Resident #73 for a total of seven doses on the following dates: - 5/31/2024 at 9:36 pm. - 6/3/2024 at 10:06 pm. - 6/4/2024 at 10:59 pm. - 6/5/2024 at 9:34 pm. - 6/7/2024 at 8:54 pm. - 6/9/2024 at 9:38 pm. - 6/11/2024 at 9:14 pm. There was no documentation on a medication return to pharmacy form that accounted for the remaining 13 tablets of Hydroxyzine 25 mg when the physician order was automatically discontinued after 6/11/2024. (continued on next page)

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	07/12/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Nurse #4 on 7/12/2024 at 11:14 am, she stated Resident #73's Hydroxyzine HCl 25 mg tablet was discontinued after the fourteen days per physician order and stated she did not know when Resident #73's discontinued Hydroxyzine HCl medication was returned to the pharmacy. She explained discontinued medications still in bubble packs were placed in an open box labeled return to pharmacy in the locked medication room and were picked up by the pharmacy at night. She stated the night nurse, assistant Director of Nursing or the Director of Nursing completed the return to pharmacy form listing all the medications in the return to pharmacy box that were picked up by pharmacy nightly. In an interview with the Assistant Director of Nursing on 7/12/2024 at 1:06 pm, she stated the facility did not have a return to pharmacy form indicating Resident #73's Hydroxyzine HCl was returned to the pharmacy after the medication was discontinued after 6/11/2024. She explained due to unavailability of carbon copy return to pharmacy forms in the pharmacy, the facility had not been able to obtain carbon copy return to pharmacy forms and copying the original return to pharmacy form was necessary for the facility's records. She explained sometimes the original return to pharmacy form was not copied and the original copy was sent to the pharmacy. In an interview with the Director of Nursing (DON) on 7/12/2024 at 11:26 am, she stated the nursing staff were to complete the return to pharmacy form when returning discontinued medications to the pharmacy. She explained nursing staff should have removed Resident #73's discontinued medication, Hydroxyzine HCl, from the medication cart, placed the medication in the return to pharmacy box in the locked medication room and completed the return to pharmacy form for pharmacy to pick up. She stated the pharmacy and the facility did not have documentation on a return to pharmacy form that Resident #73's discontinued Hydroxyzine HCL medication had been returned to the facility. The DON was not able to explain what happened to the unaccounted 13 tablets of Resident #73's Hydroxyzine HCl tablets after the physician order was discontinued on 6/11/2024. In a phone interview with Pharmacist #1 on 7/12/2024 at 1:34 pm, he stated Hydroxyzine HCl 25 mg for Resident #73 was discontinued after the 14th day (6/11/2024) based on the physician's order, and the pharmacy had no documentation on a return to pharmacy form that Resident #73's discontinued medication, Hydroxyzine HCl 25 mg tablet, was returned to the pharmacy. He explained there was no time frame in returning discontinued medications to the pharmacy, and the facility usually kept discontinued medications until the physician made a decision not to reorder the medication. He stated discontinued medications returned to the pharmacy were listed on a return to pharmacy form and discontinued medications were picked up six days a week Monday through Saturday. He explained the return to pharmacy form was a carbon copy: one copy was sent with the medications returned to the pharmacy and one copy was maintained at the facility for documentation of the returned medications to the pharmacy. He stated it was the facility's responsibility to request the return to pharmacy forms from the pharmacy and he could not recall a period of time not having the return to pharmacy forms available for the facility. Pharmacist #1 further stated the pharmacy did not track the number of medications dispensed, administered and returned except for controlled medication, and Hydroxyzine HCl was not a controlled medication.